Atrial Fibrillation Monitoring
Mathematics Meets Real Life

Gerhard Hindricks, MD; Christopher Piorkowski, MD

In today’s clinical practice the diagnosis of atrial fibrillation (AF) is made by an ECG documentation that fulfills established criteria. That documentation is of utmost clinical importance because it is the basis for further therapeutic interventions, such as rhythm control strategies or introduction of oral anticoagulation. ECG documentation of AF, however, carries 2 distinct limitations. First, the occurrence is unpredictable in terms of onset and duration of arrhythmia episodes. Second, patient symptoms are of limited value identifying arrhythmia episodes and to subsequently enable successful ECG recordings. As such, multiple studies have described a high prevalence of asymptomatic or silent AF in various patient populations.

Studies have documented the incremental benefit in the rate of AF detection obtained with intensified monitoring efforts. After AF catheter ablation arrhythmia recurrences were documented in 17% versus 45% of the same patient population, depending on follow-up with 24-hour versus 7-day Holter monitoring. Daily transtelephonic monitoring, on the other hand, showed to be equally effective in detecting AF recurrences compared with the 7-day Holter. Therefore, 2 significant questions remain. First, how much unrecognized AF gets missed with even the best discontinuous monitoring strategies? Second, what is the additive clinical impact of knowing that delta? In a recent consensus document it is speculated (educated guess) that with the best discontinuous monitoring approximately 70% of patients with AF can be detected.

An exact answer can only be expected from data collected during continuous rhythm monitoring approaches. First, such insights were obtained in pacemaker patients. Various modes of transtelephonic monitoring were then compared with intermittent monitoring strategies of various durations and frequencies using a computer simulation model. The key findings of the study were (1) longer monitoring periods raise some concerns about the algorithm specificity, mainly because of oversensing resulting from muscle potentials and limited electrogram storage capacity of the device. Meanwhile, several additional studies on the feasibility of ILR-AFs for continuous AF monitoring have been published. The studies showed a higher AF detection rate as compared with discontinuous rhythm monitoring; however—as a limitation—the concerns about the algorithm specificity were not always adequately addressed.

In this issue of Circulation, Charitos and colleagues present an interesting and valuable comparison of continuous versus discontinuous AF monitoring based on a mathematical model built from patients with either ILR-AF or cardiac pacemakers. The complete rhythm history of the enrolled patients was reconstructed from the device data. Frequency and burden of AF was analyzed. As a novelty, the term AF density as a measure of the temporal distribution of AF episodes was introduced. Data from continuous monitoring were then compared with intermittent monitoring strategies of various durations and frequencies using a computer simulation model. The key findings of the study were (1) longer monitoring results in more AF detection, (2) even with intense intermittent monitoring a significant amount of AF episodes/burden can be missed, and (3) the temporal distribution of AF episodes has a significant impact on the sensitivity of AF detection with intermittent rhythm monitoring.

The authors have to be congratulated for the interesting study. The data present significant mathematical support for the aforementioned limitations observed with discontinuous AF monitoring. It is interesting to note that in this simulation close intermittent monitoring was able to detect up to 70% to 80% of the patients with AF recurrences—a number that has been similarly observed in respective clinical investigations. The term AF density is interesting and deserves further consideration in future clinical and scientific discussions. It is especially noteworthy that in patients with low AF density (66% of the entire study population), intermittent monitoring was effective to capture the arrhythmia. In those
patients the serial 24-hour Holters, serial 7-day Holters, and single 30-day Holter resulted in a sensitivity of >80% to 90%, respectively. On the other hand, the largest benefit of continuous AF monitoring was calculated for the minority of patients with high density and low burden AF, a finding that may be relevant after AF catheter ablation.

Despite the interesting data presented by Charitós and colleagues, some open questions remain. The largest deficit in clinical compatibility is the lack of any consideration on patients’ symptoms. Despite all limitations of symptoms in AF patients, there is a certain percentage where AF diagnosis is also guided by symptoms. Thus, the huge benefit in AF detection using continuous monitoring in this study should only be true for a completely asymptomatic patient population (ie, 100% asymptomatic patients over 100% of the monitoring time). This assumption does not reflect clinical reality. Further shortcomings relate to a highly selected cohort with preferentially elderly patients (68±12 years of age), with significant structural heart disease and a substantial number (33%) of patients after cardiac surgery. That is not the patient population typically undergoing rhythm control strategies. In addition, only slightly >10% of the patients had an ILR-AF, whereas almost 90% of the data were taken from cardiac pacemakers that had been implanted mainly because of sinus node dysfunction or advanced AV-block. Thus, significant limitations concerning the generalization of the data to other AF patient populations apply.

Overall, and despite our critical remarks, the authors have to be congratulated for their study. The results clearly show that continuous monitoring substantially increases the AF detection rate. However, before transferring the findings into clinical applications of wider ILR-AF–based rhythm monitoring significant questions remain: Which patients are likely to benefit from continuous monitoring, and what is the benefit? Is it safe to withdraw oral anticoagulation under the guidance of continuous rhythm monitoring? How do implantation costs and implantation complications balance to potential benefits? All this is currently unknown, and future prospective trials are warranted to answer these questions before routine clinical application of ILR-AFs for continuous rhythm monitoring can be recommended. Such studies urgently need to be done, because in AF … knowing is better than guessing.

Disclosures

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References
