To the Editor:

In a recent issue in *Circulation*, the AATAC trial (Ablation vs Amiodarone for Treatment of Atrial Fibrillation in Patients With Congestive Heart Failure and an Implanted ICD/CRTD) found that catheter ablation of atrial fibrillation not only reduced the recurrence of atrial fibrillation at long-term follow-up, but also significantly decreased unplanned hospitalization and mortality in patients with heart failure and persistent atrial fibrillation. This work is fantastic and vital because it is the first large trial to demonstrate that catheter ablation is superior to amiodarone on mortality. However, we think this conclusion may be overstated because of some issues that have not been discussed.

First, the recurrence-free rate of atrial fibrillation in the AATAC trial is much greater than in the RAAFT-2 trial (Radiofrequency Ablation vs Antiarrhythmic Drugs as First-Line Therapy of Atrial Fibrillation; 70% versus 45.5%, respectively) after a 2-year follow-up, although patients in the RAAFT-2 trial had normal left ventricular ejection fractions. How can this phenomenon be explained?

Second, 2 ablation strategies, the pulmonary vein isolation (PVI) alone and PVI plus posterior wall isolation were reported in the AATAC trial. The success rate of ablation is significantly higher in patients undergoing PVI plus posterior wall isolation than with PVI alone (79% versus 36%, P<0.001). It is interesting that the PVI-alone ablation has a similar success rate to amiodarone (36% versus 34%). Can the different success rates of ablation between PVI alone and PVI plus posterior wall isolation affect mortality or hospitalization? Is there diverse unplanned hospitalization or mortality between the PVI-alone and amiodarone groups? Did the lower mortality in the catheter ablation group result from the lower recurrence of atrial fibrillation or the operation of PVI plus posterior wall isolation?

Furthermore, the mortality in catheter ablation (8%) and amiodarone (18%) is relatively lower in the study than in previous studies. How do the investigators explain this?

Finally, implantable cardioverter defibrillator and cardiac resynchronization therapy have diverse prognoses in patients with heart failure and atrial fibrillation. However, in the AATAC trial, the proportion of implantable cardioverter defibrillator and cardiac resynchronization therapy in each group was not reported. This might affect the rehospitalization and mortality between groups. Besides, several factors that might impact the outcome were not evaluated in the AATAC trial, such as the anticoagulation treatment, the CHA2DS2-VASc scores, and the underuse of aldosterone antagonists.

We think a full evaluation of the above-mentioned issues is essential to consolidate the results.

**DISCLOSURES**

None.

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Letter from Liu and Yang Regarding Article, "Ablation Versus Amiodarone for Treatment of Persistent Atrial Fibrillation in Patients With Congestive Heart Failure and an Implanted Device: Results From the AATAC Multicenter Randomized Trial"
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