

When should I refer my Atrial Fibrillation (AF) or Atrial Flutter (AFL) patient for consideration of Catheter Ablation treatment?



Consider referral for catheter ablation if your patient is symptomatic (quality of life is at least moderately impaired) and:

- They have tried ANTIARRHYTHMIC therapy (1-6 months) but still remain symptomatic.
- Drug therapy is not well-tolerated, or not preferred.
- Who have typical ATRIAL FLUTTER. Guidelines recommend ablation as first line therapy for typical AFL, and consider it curative given its high success rate and low complication rate.

Important Considerations

- Catheter ablation should be considered as an effective treatment for AF, but not necessarily a “cure” since both early and late (even 5 years after a successful procedure) recurrences of AF are not uncommon – including silent recurrences; approximately 40% of patients will require more than one procedure.
- Overall, about 75-80% of patients with paroxysmal AF receive clinical benefit.
- The success rate for persistent AF is generally 10-15% lower than for paroxysmal AF.
- Catheter ablation should NOT be considered as an ALTERNATIVE TO ANTICOAGULATION. Stroke prevention therapy with oral anticoagulation should still be maintained in patients with high stroke risk (e.g. 2% or more per year) regardless of procedural success. In addition, oral anticoagulation is required before and after ablation.
- The main risks of ablation are vascular complications (like groin hematomas or pseudoaneurysms), tamponade and stroke/TIA. Our specialists quote an overall complication rate of 3-5%, a small but serious risk of atrio-esophageal fistula of 1/1000 and a mortality rate of 1/2000.
- Ablation technology and techniques continue to evolve and improve upon current success rates.

