Letter by Gasparini and Boriani Regarding Article, “Cardiac Resynchronization Therapy in Patients With Permanent Atrial Fibrillation: Results From the Resynchronization for Ambulatory Heart Failure Trial (RAFT)”

To the Editor:

We read with great interest the article by Healey et al1 presenting data of patients with permanent atrial fibrillation (AF) enrolled in the Resynchronization for Ambulatory Heart Failure Trial (RAFT).2

Being a field in which no randomized trial has been specifically performed, these data might have an important impact on managing this large portion of the heart failure population.

The recent guidelines of the European Society of Cardiology3 consider patients with permanent AF as a class IIa level B only if atrioventricular junction (AVJ) ablation is performed, permitting to reach almost 100% biventricular (BIV) pacing. Starting from our experience published in 2008,4 it was almost clear that cardiac resynchronization therapy (CRT) response can be expected in patients with AF only if AVJ ablation is performed.

These data have been recently confirmed by the meta-analysis by Ganesan et al5 that clearly and undoubtedly pointed out a dramatic 42% reduction of all-cause mortality in patients with AF implanted with CRT and undergoing AVJ ablation.

Here, Healey et al1 give us the astonishing conclusion that patients with AF who are otherwise CRT candidates seem to gain a minimal benefit from CRT-D compared with standard International Classification of Diseases.6

The conclusion drawn by Healey et al1 even if formally absolutely correct, may be misleading and create a great confusion in a topic in which, after the Ganesan et al5 meta-analysis, the picture seemed to be clear. In fact, in our opinion, these conclusions do not adequately take into account that AVJ ablation has been performed in only one RAFT patient. Probably, a more correct final message could simply be that patients with AF, who are otherwise CRT candidates, not undergoing AVJ ablation do not reach effective BIV stimulation and, as a consequence, gain a minimal benefit from CRT-D compared with standard International Classification of Diseases.

Strong data from the LATITUDE study7 already pointed out that 100% BIV pacing cuts by 30% total mortality compared with 92% BIV pacing. Reaching 100% of effective BIV stimulation seems to be even more important in patients with AF.

There is a huge difference between implanting a CRT device in patients with AF and curing them with CRT. To effectively cure a patient implanted with CRT, it seems nowadays, that AVJ ablation, permitting to reach 100% of pure and effective BIV stimulation, is the only adequate tool for this scope. Patients with permanent AF implanted with CRT, without spontaneous/induced atrioventricular block, could be very similar to patients in sinus rhythm implanted with CRT but left with an atrioventricular interval of 300 ms. No effective BIV stimulation could be expected in these sinus rhythm patients and in AF patients without AVJ ablation.

The article by Healey et al1 reaches the paradox that, an evaluation of CRT efficacy with the premises for the most reliable methodological approach (a randomized clinical trial), rather than clarifying the picture, may result in more uncertainty and less clarity on the role of CRT in AF, increasing rather than decreasing, the need for new studies.

Disclosures

M. Gasparini is on the Advisory Board for Medtronic and Boston Scientific. G. Boriani has received speaker fees for Medtronic.

Maurizio Gasparini, MD
Humanitas Clinical and Research Center, Rozzano-Milano, Italy

Giuseppe Boriani, MD
Institute of Cardiology, University of Bologna, Bologna, Italy

References


Letter by Gasparini and Borioni Regarding Article, "Cardiac Resynchronization Therapy in Patients With Permanent Atrial Fibrillation: Results From the Resynchronization for Ambulatory Heart Failure Trial (RAFT)"
Maurizio Gasparini and Giuseppe Borioni

Circ Heart Fail. 2013;6:e22
doi: 10.1161/CIRCHEARTFAILURE.112.972612

Circulation: Heart Failure is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2013 American Heart Association, Inc. All rights reserved.
Print ISSN: 1941-3289. Online ISSN: 1941-3297

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circheartfailure.ahajournals.org/content/6/2/e22

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation: Heart Failure can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation: Heart Failure is online at:
http://circheartfailure.ahajournals.org//subscriptions/