Understanding the Risk to Develop Atrial Fibrillation
And What Cardiac Magnetic Resonance Can Add

Juerg Schwitter, MD

MESA (Multi-Ethnic Study of Atherosclerosis) is an observational cohort study to determine the prevalence, correlates, and progression of subclinical cardiovascular disease. MESA participants were 45 to 84 years of age and were asymptomatic of clinical cardiovascular disease in 2000 to 2002 at recruitment and were studied in 6 centers in the United States. This ambitious setting offered the unique opportunity to monitor an asymptomatic cohort of subjects over a long time period, and the investigators decided in 2000 to evaluate cardiac structure and function by cardiac magnetic resonance (CMR) to obtain most accurate measurements.

In this issue of Circulation: Cardiovascular Imaging, Habibi et al.1 report on the predictive value of left atrial (LA) volumes as well as functional LA parameters for incident atrial fibrillation (AF). Out of the 5004 participants, 597 patients (197 cases developed AF during follow-up and 400 patients were randomly selected from the MESA cohort irrespective of their case status) were selected for this study and followed over a mean of 7.6 years. In addition to LA volumes and functional parameters, left ventricular (LV) mass, N-terminal pro-brain natriuretic peptide (NT-proBNP) levels, arterial hypertension, and antihypertensive treatment were also identified as strong predictors of AF development. Body mass index, diabetes mellitus, smoking, total and high-density lipoprotein, and LV ejection fraction (EF) were not associated with incident AF.

Several of these findings are new and of major importance because AF is the most common cardiac arrhythmia, and it is associated with a substantial burden of cardiac and cerebrovascular morbidity and mortality. Over 2 million adults were diagnosed with AF in 2000 in the United States, and this number is expected to reach almost 6 million subjects in 2050.2 Among 66,357 patients admitted to 283 hospitals with acute decompensated heart failure, AF was present in 44% of patients with reduced EF versus 48% with preserved EF (HFpEF), and 30-day mortality in patients with AF and HFpEF was even higher than in heart failure with preserved EF patients.3 Accordingly, treatment strategies to prevent AF are of utmost importance. Diagnostic work-up and drug treatment seem most efficient economically when targeted to a high-risk population. The results presented by Habibi et al.1 are, therefore, of major significance because they allow to identify individuals at high risk to develop AF based on models integrating demographic information, LA volume, and functional information, as well as circulating biomarkers.

In future studies evaluating novel drug treatment strategies, patient selection could be enriched based on such model estimates of risk to include patients who will benefit most from treatment. This approach would permit to run trials for clinical outcomes at smaller sample size, which can produce results faster and at lower costs. CMR is a rapidly evolving technique that is becoming more widely available,4 and with appropriate standardization and harmonization, excellent image quality can be achievable in multicenter trials even in patients with implanted pacemakers5 and defibrillators.6

The present study is the first demonstrating the relative prognostic value of LA volumes and reduced LA reservoir (ie, total LA ejection fraction [LAEF]), reduced conduit (ie, passive LAEF), and reduced booster pump function (ie, reduced active LAEF) to predict incident AF. These CMR-based parameters all remained significant after adjusting for age, sex, ethnicity, hypertensive medication, and systolic blood pressure. However, when also adjusting for NT-proBNP and LV mass, active LAEF was no longer a predictor. In fact, active LAEF but not passive LAEF was inversely associated with NT-proBNP (r=-0.19; P=0.027), probably explaining why active LAEF did not remain in model 2, that is, after correction for NT-proBNP. Interestingly, NT-proBNP is well known as a predictor of incident AF,7,8 and in light of the present results, NT-proBNP seems to relate to active LAEF, whereas passive and total LAEF determined by CMR yield additional prognostic information. Of note, passive LAEF was a stronger predictor of incident AF (hazard ratio 0.68; P=0.003) than active LAEF (hazard ratio 0.74; P=0.014) in model 1 (which is not corrected for NT-proBNP). The occurrence of AF in HFpEF patients is heralding a worse outcome,9 and HFpEF is associated with a higher incidence of AF. Nevertheless, some typical characteristics of the HFpEF population, such as female sex, arterial hypertension, obesity, and diabetes mellitus, were not found to be prevalent in the AF population of this study. Compared with the control group without incident AF, the AF population had a higher incidence of hypertension and antihypertensive treatment, but there was no preponderance of females and no preponderance of diabetes.
Late gadolinium enhancement is able to quantify scar tissue, phasic function parameters are not all that CMR can provide. Detect differences can be reduced. Of course, LA volumes and LA ablation in a multicenter trial. Although feasibility in humans remains unknown, preclinical studies suggest consideration of LA structure and function, which will improve our understanding of the pathophysiology while sample sizes to detect differences can be reduced. Of course, LA volumes and phasic function parameters are not all that CMR can provide. Finally, interventional magnetic resonance imaging guiding LA ablation in humans provides an intriguing window to the personalized medicine end of the atrial imaging spectrum to complement this work’s population focus. Disclosures

Dr Schwitter serves as consultant to Medtronic and is primary investigator for several multicenter trials of Medtronic.

References


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