**Overzicht van alle aanbevelingen uit de ESC-richtlijn AF**

In de tabel zijn alleen de hoofdstukken uit de ESC-richtlijn met aanbevelingen benoemd. Een groot deel van hoofdstuk 11 bijvoorbeeld hebben geen aanbevelingen.

|  |  |  |  |
| --- | --- | --- | --- |
| **Recommendation** |  |  |  |
| **Diagnosis of AF (chapter 3.2)** | **Class** | **Level** | **Status** |
| ECG documentation is required to establish the diagnosis of AF.   * A standard 12-lead ECG recording or a single-lead ECG tracing of ≥30 s showing heart rhythm with no discernible repeating P waves and irregular RR intervals (when atrioventricular conduction is not impaired) is diagnostic of clinical AF. | I | B | Overgenomen |
| **Structured characterization of AF (chapter 6.1)** | **Class** | **Level** | **Status** |
| Structured characterization of AF, which includes clinical assessment of stroke risk, symptom status, burden of AF, and evaluation of substrate, should be considered in all AF patients, to streamline the assessment of AF patients at different healthcare levels, inform treatment decision-making, and facilitate optimal management of AF patients. | IIa | C | Overgenomen |
| **Screening to detect AF (Chapter 7)** | **Class** | **Level** | **Status** |
| Opportunistic screening for AF by pulse taking or ECG rhythm strip is recommended in patients ≥65 years of age. | I | B | Overgenomen |
| It is recommended to interrogate pacemakers and implantable cardioverter defibrillators on a regular basis for AHRE. | I | B | Overgenomen |
| When screening for AF it is recommended that:   * The individuals undergoing screening are informed about the significance and treatment implications of detecting AF. * A structured referral platform is organized for screen-positive cases for further physician-led clinical evaluation to confirm the diagnosis of AF and provide optimal management of patients with confirmed AF. * Definite diagnosis of AF in screen-positive cases is established only after physician reviews the single-lead ECG recording of ≥30 s or 12-lead ECG and confirms that it shows AF. | I | B | * Overgenomen * Vervallen * Overgenomen |
| Systematic ECG screening should be considered to detect AF in individuals aged ≥75 years, or those at high risk of stroke | IIa | B | Overgenomen |
| **Diagnostic evaluation of patients with AF (Chapter 8)** | **Class** | **Level** | **Status** |
| In patients with AF, it is recommended to:   * Evaluate AF-related symptoms (including fatigue, tiredness, exertional shortness of breath, palpitations, and chest pain) and quantify the patient symptom status using the modified EHRA symptom scale before and after initiation of treatment. * Evaluate AF-related symptoms before and after cardioversion of persistent AF to aid rhythm control treatment decisions. | I | C | Vervallen |
| **Integrated AF management (Chapter 9)** | **Class** | **Level** | **Status** |
| To optimize shared decision making about specific AF treatment option(s) in consideration, it is recommended that physicians:   * Inform the patient about the advantages/limitations and benefit/risks associated with the treatment option(s) being considered;   and   * Discuss the potential burden of the treatment with the patient and include the patient’s perception of treatment burden in the treatment decision. | I | C | Overgenomen |
| It is recommended to routinely collect PROs to measure treatment success and improve patient care. | I | C | Overgenomen |
| Integrated management with a structured multidisciplinary approach including healthcare professionals, patients, and their family/carers, should be used in all AF patients to improve clinical outcomes. | IIa | B | Overgenomen |
| **Prevention of thrombo-embolic events in AF (chapter 10.1)** | **Class** | **Level** | **Status** |
| For stroke prevention in AF patients who are eligible for OAC, NOACs are recommended in preference to VKAs (excluding patients with mechanical heart valves or moderate-to-severe mitral stenosis). | I | A | Overgenomen |
| For stroke risk assessment, a risk-factor-based approach is recommended, using the CHA2DS2-VASc clinical stroke risk score to initially identify patients at ‘low stroke risk’ (CHA2DS2-VASc score = 0 in men, or 1 in women) who should not be offered antithrombotic therapy. | I | A | Overgenomen |
| OAC is recommended for stroke prevention in AF patients with CHA2DS2-VASc score ≥2 in men or ≥3 in women | I | A | Overgenomen |
| OAC should be considered for stroke prevention in AF patients with a CHA2DS2-VASc score of 1 in men or 2 in women. Treatment should be individualized based on net clinical benefit and consideration of patient values and preferences | IIa | B | Overgenomen |
| For bleeding risk assessment, a formal structured risk-score-based bleeding risk assessment is recommended to help identify nonmodifiable and address modifiable bleeding risk factors in all AF patients, and to identify patients potentially at high risk of bleeding who should be scheduled for early and more frequent clinical review and follow-up. | I | B | Overgenomen |
| For a formal risk-score-based assessment of bleeding risk, the HAS-BLED score should be considered to help address modifiable bleeding risk factors, and to identify patients at high risk of bleeding (HAS-BLED score ≥3) for early and more frequent clinical  review and follow-up. | IIa | B | Overgenomen |
| Stroke and bleeding risk reassessment at periodic intervals is recommended to inform treatment decisions (e.g. initiation of OAC in patients no longer at low risk of stroke) and address potentially modifiable bleeding risk factors. | I | B | Minimaal aangepast door de periode jaarlijks toe te voegen. |
| In patients with AF initially at low risk of stroke, first reassessment of stroke risk should be made at 4 - 6 months after the index Evaluation. | IIa | B | Overgenomen |
| If a VKA is used, a target INR of 2.0 - 3.0 is recommended, with individual TTR≥70%. | I | B | Overgenomen |
| In patients on VKAs with low time in INR therapeutic range (e.g. TTR<70%), recommended options are:   * Switching to a NOAC but ensuring good adherence and persistence with therapy. | I | B | Overgenomen |
| * Efforts to improve TTR (e.g. education/counselling and more frequent INR checks). | II | B | Overgenomen |
| Antiplatelet therapy alone (monotherapy or aspirin in combination with clopidogrel) is not recommended for stroke prevention in AF. | III | A | Vervallen |
| Estimated bleeding risk, in the absence of absolute contraindications to OAC, should not in itself guide treatment decisions to use OAC for stroke prevention | III | A | Overgenomen |
| Clinical pattern of AF (i.e. first detected, paroxysmal, persistent, long-standing persistent, permanent) should not condition the indication to thromboprophylaxis | III | B | Overgenomen |
| **Occlusion or exclusion of the LAA** |  |  |  |
| LAA occlusion may be considered for stroke prevention in patients with AF and contraindications for long-term anticoagulant treatment (e.g. intracranial bleeding without a reversible cause). | IIb | B | Overgenomen |
| Surgical occlusion or exclusion of the LAA may be considered for stroke prevention in patients with AF undergoing cardiac surgery. | IIb | C | Overgenomen |
|  |  |  | *Extra aanbeveling toegevoegd* |
| **Ventricular rate control in patients with AF (chapter 10.2.1)** | **Class** | **Level** | **Status** |
| Beta-blockers, diltiazem, or verapamil are recommended as first-choice drugs to control heart rate in AF patients with LVEF≥40%. | I | B | Overgenomen |
| Beta-blockers and/or digoxin are recommended to control heart rate in AF patients with LVEF<40%. | I | B | Overgenomen |
| Combination therapy comprising different rate controlling drugs should be considered if a single drug does not achieve the target heart rate. | IIa | B | Overgenomen |
| A resting heart rate of <110 bpm (i.e. lenient rate control) should be considered as the initial heart rate target for rate control therapy. | IIa | B | Minimaal aangepast (onder 100-110) |
| Atrioventricular node ablation should be considered to control heart rate in patients unresponsive or intolerant to intensive rate and rhythm control therapy, and not eligible for rhythm control by LA ablation, accepting that these patients will become pacemaker dependent. | IIa | B | Overgenomen |
| In patients with haemodynamic instability or severely depressed LVEF, intravenous amiodarone may be considered for acute control of heart rate | IIb | B | Overgenomen |
| **Rhythm Control (Chapter 10.2.2.1)** | **Class** | **Level** | **Status** |
| Rhythm control therapy is recommended for symptom and QoL improvement in symptomatic patients with AF. | I | A | Overgenomen |
| **Cardioversion (Chapter 10.2.2.2)** | **Class** | **Level** | **Status** |
| For pharmacological cardioversion of recent onset AF, i.v. vernakalant (excluding patients with recent ACS or severe HF) or flecainide or propafenone (excluding patients with severe structural heart disease) is recommended. | I | A | Overgenomen |
| Intravenous amiodarone is recommended for cardioversion of AF in patients with HF or structural heart disease, if delayed cardioversion is consistent with clinical situation. | I | A | Overgenomen |
| Cardioversion of AF (either electrical or pharmacological) is recommended in symptomatic patients with persistent AF as part of rhythm control therapy. | I | B | Overgenomen |
| Pharmacological cardioversion of AF is indicated only in a haemodynamically stable patient, after consideration of the thromboembolic risk. | I | B | Overgenomen |
| Pre-treatment with amiodarone, flecainide, ibutilide, or propafenone should be considered to facilitate the success of electrical cardioversion. | IIa | B | Overgenomen |
| In selected patients with infrequent and recent onset AF and no significant structural or ischaemic heart disease, a single self-administered oral dose of flecainide or propafenone (‘pill in the pocket’ approach) should be considered for patient-led cardioversion, but only following efficacy and safety assessment | IIa | B | Overgenomen |
| For patients with sick-sinus syndrome, atrioventricular conduction disturbances or prolonged QTc (>500 ms), pharmacological cardioversion should not be attempted unless risks for proarrhythmia and bradycardia have been considered. | III | C | Vervallen |
| **Rhythm control/catheter ablation of AF (Chapter 10.2.2.3)** | **Class** | **Level** | **Status** |
| **General** |  |  |  |
| For the decision on AF catheter ablation, it is recommended to take into consideration the procedural risks and the major risk factors for AF recurrence following the procedure and discuss them with the patient. | I | B | Samengevoegd met aanbevelingen over leefstijlfactoren |
| Repeated PVI procedures should be considered in patients with AF recurrence provided the patient’s symptoms were improved after the initial PVI. | IIa | B | Overgenomen |
| **AF catheter ablation after failure of drug therapy** |  |  |  |
| AF catheter ablation for PVI is recommended for rhythm control after one failed or intolerant class I or III AAD, to improve symptoms of AF recurrences in patients with: |  |  | Overgenomen |
| * Paroxysmal AF, or | I | A |
| * Persistent AF without major risk factors for AF recurrence, or | I | A |
| * Persistent AF with major risk factors for AF recurrence. | I | B |
| AF catheter ablation for PVI should be considered for rhythm control after one failed or intolerant to beta-blocker treatment to improve symptoms of AF recurrences in patients with paroxysmal and persistent AF. | IIa | B | Overgenomen |
| **First-line therapy** |  |  |  |
| AF catheter ablation for PVI should/may be considered as first-line rhythm control therapy to improve symptoms in selected patients with symptomatic: |  |  |  |
| * Paroxysmal AF episodes, or | IIa | B | Overgenomen |
| * Persistent AF without major risk factors for AF recurrence. | IIb | C | Overgenomen (IIa geworden) |
| as an alternative to AAD class I or III, considering patient choice, benefit, and risk. |  |  |  |
| AF catheter ablation: |  |  |  |
| * Is recommended to reverse LV dysfunction in AF patients when tachycardia-induced cardiomyopathy is highly probable, independent of their symptom status. | I | B | Overgenomen (IIa geworden) |
| * Should be considered in selected AF patients with HF with reduced LVEF to improve survival and reduce HF hospitalization. | IIa | B | Overgenomen |
| AF catheter ablation for PVI should be considered as a strategy to avoid pacemaker implantation in patients with AF-related bradycardia  or symptomatic pre-automaticity pause after AF conversion considering the clinical situation. | IIa | C | Overgenomen |
| **Techniques and technologies** |  |  |  |
| Complete electrical isolation of the pulmonary veins is recommended during all AF catheter-ablation procedures. | I | A | Overgenomen |
| If patient has history of CTI-dependent AFL or if typical AFL is induced at the time of AF ablation, delivery of a CTI lesion may be considered. | IIb | B | Overgenomen (IIa geworden) |
| Use of additional ablation lesions beyond PVI (low voltage areas, lines, fragmented activity, ectopic foci, rotors, and others) may be considered but is not well established. | IIb | B | Overgenomen (IIa geworden) |
| **Lifestyle modification and other strategies to improve outcomes of ablation** |  |  |  |
| Weight loss is recommended in obese patients with AF, particularly those who are being evaluated to undergo AF ablation. | I | B | Samengevoegd |
| Strict control of risk factors and avoidance of triggers are recommended as part of a rhythm control strategy. | I | B | Samengevoegd |
| **Surgical ablation of AF (Chapter 10.2.2.4)** | **Class** | **Level** | **Status** |
| Concomitant AF ablation should be considered in patients undergoing cardiac surgery, balancing the benefits of freedom from atrial arrhythmias and the risk factors for recurrence (left atrial dilatation, years in AF, age, renal dysfunction, and other cardiovascular risk factors). | IIa | A | Overgenomen |
| Thoracoscopic—including hybrid surgical ablation—procedures should be considered in patients who have symptomatic paroxysmal or persistent AF refractory to AAD therapy and have failed percutaneous AF ablation, or with evident risk factors for catheter failure, to maintain long-term sinus rhythm. The decision must be supported by an experienced team of electrophysiologists and surgeons. | IIa | B | Overgenomen |
| Thoracoscopic—including hybrid surgical ablation—procedures may be considered in patients with persistent AF with risk factors for recurrence, who remain symptomatic during AF despite at least one failed AAD and who prefer further rhythm control therapy. | IIb | C | Overgenomen |
| **Stroke risk management peri cardioversion (Chapter 10.2.2.6)** | **Class** | **Level** | **Status** |
| In patients with AF undergoing cardioversion, NOACs are recommended with at least similar efficacy and safety to warfarin. | I | A | Overgenomen |
| For cardioversion of AF/AFL, effective anticoagulation is recommended for a minimum of 3 weeks before cardioversion | I | B | Samengevoegd met de direct bovenstaande aanbeveling |
| TOE is recommended to exclude cardiac thrombus as an alternative to 3-week pre-procedural anticoagulation when early cardioversion is planned. | I | B | Overgenomen |
| In patients at risk of stroke, it is recommended that OAC therapy is continued long term after cardioversion according to the long-term anticoagulation recommendations, irrespective of the method of cardioversion, the apparent maintenance of sinus rhythm, or characterization of AF as a ‘first-diagnosed episode’. | I | B | Overgenomen |
| When thrombus is identified on TOE, effective anticoagulation is recommended for at least 3 weeks before cardioversion of AF | I | B | Overgenomen |
| It is recommended that the importance of adherence and persistence to NOAC treatment both before and after cardioversion is strongly emphasized to patients. | I | C | Overgenomen |
| Effective anticoagulation should be initiated as soon as possible before every cardioversion of AF or AFL. | IIa | B | Overgenomen |
| Early cardioversion can be performed without TOE in patients with an AF duration of <48 h | IIa | B | Overgenomen |
| In patients with AF duration of >24 h undergoing cardioversion, therapeutic anticoagulation should be continued for at least 4 weeks, even after successful cardioversion to sinus rhythm (beyond 4 weeks, the decision about long-term OAC treatment is determined by the presence of stroke risk factors). | IIa | B | Overgenomen |
| When thrombus is identified on TOE, a repeat TOE to ensure thrombus resolution should be considered before cardioversion | IIa | C | Overgenomen |
| In patients with a definite duration of AF ≤24 h and a very low stroke risk (CHA2DS2-VASc of 0 in men or 1 in women) post-cardioversion anticoagulation for 4 weeks may be omitted. | IIb | C | Overgenomen |
| **Stroke risk management peri-catheter ablation (Chapter 10.2.2.6.2)** | **Class** | **Level** | **Status** |
| In AF patients with stroke risk factors not taking OAC before ablation, it is recommended that pre-procedural management of stroke risk includes initiation of anticoagulation and: | I | C | Overgenomen |
| * Preferably, therapeutic OAC for at least 3 weeks before ablation, or * Alternatively, the use of TOE to exclude LA thrombus before ablation. | IIa | C | Overgenomen |
| For patients undergoing AF catheter ablation who have been therapeutically anticoagulated with warfarin, dabigatran, rivaroxaban, apixaban, or edoxaban, performance of the ablation procedure without OAC interruption is recommended. | I | A | Overgenomen |
| After AF catheter ablation, it is recommended that:   * Systemic anticoagulation with warfarin or a NOAC is continued for at least 2 months post ablation, and * Long-term continuation of systemic anticoagulation beyond 2 months post ablation is based on the patient’s stroke risk profile and not on the apparent success or failure of the ablation procedure. | I | C | Overgenomen |
| **Postoperative anticoagulation after AF surgery (Chapter 10.2.2.6.3)** | **Class** | **Level** | **Status** |
| Long-term OAC therapy is recommended in patients after AF surgery and appendage closure, based on the patient’s thrombo-embolic risk assessed with the CHA2DS2-VASc score. | I | C | Overgenomen |
| **Long-term antiarrhythmic drugs (Chapter 10.2.2.7)** | **Class** | **Level** | **Status** |
| Amiodarone is recommended for long-term rhythm control in all AF patients, including those with HFrEF. However, owing to its extracardiac toxicity, other AADs should be considered first whenever possible. | I | A | Overgenomen |
| Dronedarone is recommended for long-term rhythm control in AF patients with:   * Normal or mildly impaired (but stable) LV function, or * HFpEF, ischaemic, or VHD. | I | A | Vervallen (dronedarone wordt niet (meer) gebruikt) |
| Flecainide or propafenone is recommended for long-term rhythm control in AF patients with normal LV function and without structural heart disease, including significant LVH and myocardial ischaemia. | I | A | Overgenomen |
| In AF patients treated with sotalol, close monitoring of QT interval, serum potassium levels, CrCl, and other proarrhythmia risk factors is recommended. | I | B | Overgenomen |
| In AF patients treated with flecainide for long-term rhythm control, concomitant use of an atrioventricular nodal-blocking drug (if tolerated) should be considered. | IIa | C | Overgenomen |
| Sotalol may be considered for long-term rhythm control in patients with normal LV function or with ischaemic heart disease if close monitoring of QT interval, serum potassium levels, CrCl, and other proarrhythmia risk factors is provided. | IIb | A | Overgenomen en aangevuld. |
| AAD therapy is not recommended in patients with permanent AF under rate control and in patients with advanced conduction disturbances unless antibradycardia pacing is provided. | III | C | Overgenomen |
| **Lifestyle interventions and management of risk factors and concomitant diseases in patients with AF (Chapter 10.3)** | **Class** | **Level** | **Status** |
| Identification and management of risk factors and concomitant diseases is recommended as an integral part of treatment in AF patients. | I | B | Overgenomen |
| Modification of unhealthy lifestyle and targeted therapy of intercurrent conditions is recommended to reduce AF burden and symptom severity. | I | B | Overgenomen |
| Opportunistic screening for AF is recommended in hypertensive patients. | I | B | Overgenomen |
| Attention to good BP control is recommended in AF patients with hypertension to reduce AF recurrences and risk of stroke and bleeding. | I | B | Overgenomen |
| In obese patients with AF, weight loss together with management of other risk factors should be considered to reduce AF incidence, AF progression, AF recurrences, and symptoms. | IIa | B | Overgenomen |
| Advice and management to avoid alcohol excess should be considered for AF prevention and in AF patients considered for OAC therapy. | IIa | B | Overgenomen |
| Physical activity should be considered to help prevent AF incidence or recurrence, with the exception of excessive endurance exercise, which may promote AF. | IIa | C | Overgenomen |
| Opportunistic screening for AF should be considered in patients with OSA. | IIa | C | Vervallen |
| Optimal management of OSA may be considered, to reduce AF incidence, AF progression, AF recurrences, and symptoms. | IIb | C | Overgenomen (IIa geworden) |
| **Management of AF with haemodynamic instability (Chapter 11.1)** | **Class** | **Level** | **Status** |
| Emergency electrical cardioversion is recommended in AF patients with acute or worsening haemodynamic instability. | I | B | Overgenomen |
| In AF patients with haemodynamic instability, amiodarone may be considered for acute control of heart rate. | IIb | B | Overgenomen (IIa geworden) |
| **Patients with AF and an ACS, PCI, or CCS (Chapter 11.3)** | **Class** | **Level** | **Status** |
| **General recommendations for patients with AF and an indication for concomitant antiplatelet therapy** |  |  |  |
| In AF patients eligible for NOACs, it is recommended to use a NOAC in preference to a VKA in combination with antiplatelet therapy. | I | A | Overgenomen |
| In patients at high bleeding risk (HAS-BLED ≥3), rivaroxaban 15 mg o.d. should be considered in preference to rivaroxaban 20 mg o.d. for the duration of concomitant single or DAPT, to mitigate bleeding risk. | IIa | B | Overgenomen |
| In patients at high bleeding risk (HAS-BLED ≥3), dabigatran 110 mg b.i.d. should be considered in preference to dabigatran 150 mg b.i.d. for the duration of concomitant single or DAPT, to mitigate bleeding risk. | IIa | B | Overgenomen |
|  |  |  | *Extra aanbeveling toegevoegd* |
| In AF patients with an indication for a VKA in combination with antiplatelet therapy, the VKA dosing should be carefully regulated with a target INR of 2.0 - 2.5 and TTR>70% | IIa | B | Overgenomen (I geworden) |
| **AF patients with ACS** |  |  |  |
| In AF patients with ACS undergoing an uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of dual therapy with an OAC and a P2Y12 inhibitor (preferably clopidogrel) for up to 12 months is recommended if the risk of stent thrombosis is low or if concerns about bleeding risk prevail over concerns about risk of stent thrombosis, irrespective of the type of stent used | I | B | Overgenomen |
| Triple therapy with aspirin, clopidogrel, and an OAC for longer than 1 week after an ACS should be considered when risk of stent thrombosis outweighs the bleeding risk, with the total duration (≤1 month) decided according to assessment of these risks, and the treatment plan should be clearly specified at hospital discharge. | IIa | C | Overgenomen |
| **AF patients with a CCS undergoing PCI** |  |  |  |
| After uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of dual therapy with OAC for up to 6 months and clopidogrel is recommended if the risk of stent thrombosis is low or if concerns about bleeding risk prevail over concerns about risk of stent thrombosis, irrespective of the type of stent used. | I | B | Overgenomen |
| Triple therapy with aspirin, clopidogrel, and an OAC for longer than 1 week should be considered when risk of stent thrombosis outweighs the bleeding risk, with the total duration (≤1 month) decided according to assessment of these risks, and the treatment plan should be clearly specified at hospital discharge. | IIa | C | Overgenomen |
| **Search for AF in patients with cryptogenic stroke (Chapter 11.4.2)** | **Class** | **Level** | **Status** |
|  |  |  | Vervallen; wordt verwezen naar de Nederlandse richtlijn Herseninfarct en hersenbloeding |
| **Secondary stroke prevention in AF patients after acute ischaemic stroke (Chapter 11.4.4)** | **Class** | **Level** | **Status** |
|  |  |  | Vervallen; wordt verwezen naar de Nederlandse richtlijn Herseninfarct en hersenbloeding |
| **Stroke prevention in AF patients after intracranial haemorrhage (Chapter 11.4.4)** | **Class** | **Level** | **Status** |
| In AF patients at high risk of ischaemic stroke, (re-)initiation of OAC, with preference for NOACs over VKAs in NOAC-eligible patients, should be considered in consultation with a neurologist/stroke specialist after:   * A trauma-related ICH * Acute spontaneous ICH (which includes subdural, subarachnoid, or intracerebral haemorrhage), after careful consideration of risks and benefits. | IIa | C | Aangepast |
| **Management of active bleeding on OAC (Chapter 11.5)** | **Class** | **Level** | **Status** |
|  |  |  | Niet overgenomen; wordt verwezen naar de richtlijn Antitrombotisch beleid |
| **Patients with valvular heart disease and AF (chapter 11.7)** | **Class** | **Level** | **Status** |
| NOACs are contraindicated in patients with a prosthetic mechanical valve. | III | B | Overgenomen |
| Use of NOACs is not recommended in patients with AF and moderate-to-severe mitral stenosis. | III | C | Overgenomen |
| **Atrial fibrillation and chronic kidney disease (chapter 11.8)** | **Class** | **Level** | **Status** |
| No recommendations |  |  | Aanbevelingen toegevoegd |
| **Management of AF in patients with congenital heart disease (Chapter 11.15)** | **Class** | **Level** | **Status** |
| * Oral anticoagulation should be considered in all adult patients with intracardiac repair, cyanosis, Fontan palliation, or systemic right ventricle and a history of AF, AFL, or intra-atrial re-entrant tachycardia. * In patients with AF and other congenital heart diseases, anticoagulation should be considered in the presence of one or more non-sex stroke risk factor(s). | IIa | C | Aangepast |
| Surgery for AF should be considered in patients:   * Who need surgical closure of an atrial septal defect and who have a history of symptomatic atrial arrhythmia (atrial ablation should be considered at the time of surgical closure). * Cox maze surgery should be considered in patients with symptomatic AF and an indication for corrective repair of congenital heart defects. The surgery should be done in experienced centres. | IIa | C | Aangepast |
| AF catheter ablation of atrial arrhythmias associated with congenital heart defects may be considered when performed in experienced centres. | IIb | C | Aangepast (IIa geworden) |
| In patients with congenital heart disease, TOE may be considered together with 3-week anticoagulation therapy before cardioversion. | IIb | C | Vervallen |
| **Management of AF during pregnancy (Chapter 11.17)** | **Class** | **Level** | **Status** |
| **Acute management** |  |  |  |
| Immediate electrical cardioversion is recommended in case of haemodynamic instability or pre-excited AF. | I | C | Overgenomen |
| In pregnant women with HCM, cardioversion should be considered for persistent AF. | IIa | C | Overgenomen |
| Ibutilide or flecainide i.v. may be considered for termination of AF in stable patients with structurally normal hearts. | IIb | C | Overgenomen |
| **Long-term management (oral administration of drugs)** |  |  |  |
| Therapeutic anticoagulation with heparin or VKA according to the stage of pregnancy is recommended for patients with AF. | I | C | Vervallen; wordt verwezen naar de richtlijn Antitrombotisch beleid |
| Beta-selective blockers are recommended for rate control in AF. | I | C | Overgenomen |
| Flecainide, propafenone, or sotalol should be considered to prevent AF if atrioventricular nodal-blocking drugs fail. | IIa | C | Overgenomen |
| Digoxin or verapamil should be considered for rate control if beta-blockers fail. | IIa | C | Overgenomen |
| **Sports activity in patients with AF (Chapter 11.18)** | **Class** | **Level** | **Status** |
| It is recommended to counsel professional athletes that long-lasting intense sports participation may promote AF, while moderate physical activity is recommended to prevent AF. | I | B | Overgenomen |
| **Postoperative AF (Chapter 11.19)** | **Class** | **Level** | **Status** |
| Perioperative amiodarone or beta blocker therapy is recommended for the prevention of postoperative AF after cardiac surgery. | I | A | Overgenomen |
| Long-term OAC therapy to prevent thromboembolic events should be considered in patients at risk for stroke with postoperative AF after non-cardiac surgery, considering the anticipated net clinical benefit of OAC therapy and informed patient preferences. | IIa | B | Overgenomen |
| Long-term OAC therapy to prevent thromboembolic events may be considered in patients at risk for stroke with postoperative AF after cardiac surgery, considering the anticipated net clinical benefit of OAC therapy and informed patient preferences. | IIb | B | Overgenomen |
| Beta-blockers should not be used routinely for the prevention of postoperative AF in patients undergoing non-cardiac surgery. | III | B | Overgenomen |
| **Sex-related differences in AF (Chapter 13)** | **Class** | **Level** | **Status** |
| It is recommended that women and men with AF are equally offered diagnostic assessment and therapies to prevent stroke and other AF-related complications. | I | A | Overgenomen |
| Women with symptomatic paroxysmal or persistent AF should be offered timely access to rhythm control therapies, including AF catheter ablation, when appropriate for medical reasons. | IIa | B | Overgenomen |
| **Quality measures in patients with AF (Chapter 15)** | **Class** | **Level** | **Status** |
|  |  |  | Vervallen |
| **Management of patients with AHRE (Chapter 16)** | **Class** | **Level** | **Status** |
| In patients with AHRE/subclinical AF detected by CIED or insertable cardiac monitor, it is recommended to conduct:   * Complete cardiovascular evaluation with ECG recording, clinical risk factors/comorbidity evaluation, and thrombo-embolic risk assessment using the CHA2DS2-VASc score. * Continued patient follow-up and monitoring (preferably with the support of remote monitoring) to detect progression to clinical AF, monitor the AHRE/subclinical AF burden (especially transition to ≥24 h), and detect changes in underlying clinical conditions. | I | B | Overgenomen |
|  |  |  | *Extra aanbeveling toegevoegd* |