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How Do I Improve the Ability to Screen, Interpret, and Diagnose Elderly Patients With Atrial Fibrillation?

Announcer:
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Dr. Patel:
Hi, my name is Manesh Patel. I'm at Duke. I'm a Cardiologist here, and I'm joined by a friend and a colleague, also a Cardiologist here at Duke, Sean Pokorney, and we're going to talk today about how to – how do we improve how we screen, diagnose, and understand atrial fibrillation in our elderly patients. Sean, thanks for joining me.

Dr. Pokorney:
Yeah, thanks so much, Manesh, for having me. I'm really glad to be here.

Dr. Patel:
Talk about a common and important question. And first atrial fibrillation, it's obviously growing in prevalence and growing in our, thankfully, aging population. But you know, how to best understand its relevance and how to screen for it is really important. And I guess, you know, anybody in clinic these days with patients that have Apple Watches or all kinds of devices are often faced with these questions of, should we be using them? How do we interpret the data? So let me ask you, first, just about the evidence of, I'll call it, three big types of devices we might have, whether it's a watch or a band - I'll call that the Apple Watch as a generic way of thinking about that - the second are people with implantable defibrillators or pacemakers where we might identify atrial fibrillation, and the third are sometimes we put patches or things on people to identify if they have AFib. What's the top-line sort of evidence on those three things?

Dr. Pokorney:
Yeah, no, I think it's a great question. And again, it's something that we're facing more and more challenges within our clinical practice as more patients are wearing consumer wearables. And I think across the spectrum that you mentioned, I think that there's some benefits for each of those individual categories. I think that when you look at the consumer mobile devices, one of the benefits is that you can get almost indefinite monitoring in these patients as they constantly recharge their devices and monitor themselves over time. And one of the drawbacks to that relative to an implanted cardiac device, like a loop implanted loop recorder, or a pacemaker defibrillator is that you get more continuous monitoring with those because they don't require recharging. And then that's different yet still to the patch monitors, which really, are only meant to be worn for 2 weeks, to maybe as long as 4 weeks where we get continuous data over those different segments.

And I think that there's a couple of studies that have looked at these. You – we have trials like REHEARSE-AF that looked at the AliveCor device where you can take single lead strips. We have also the Apple Watch study, which also looked at – at using wearable – or consumer wearable devices to screen patients. And basically, both of those studies showed that we're able to identify these patients that have atrial fibrillation, but when you look across a very broad population, the number of patients that we identify is relatively small.

And that shifts a little bit when you think about some of the monitoring studies that have been done with patch monitors like mSToPS, where they really found a highly enriched patient population. And they had those patients wear a monitor for a briefer period of time, and they identified atrial fibrillation in a – in a higher percentage of those patients, again, by really coming up with a very, extremely enriched population.

And then I think that the final study to talk about which relates to the implanted devices is the ARTESIA trial, which was just recently presented, and, again, highlighted the fact that if we identify patients, even with shorter episodes of atrial fibrillation with these continuous monitors, that we can decrease the risk of stroke when we treat those patients with anticoagulation.

Dr. Patel:
Yeah, really helpful. And maybe one of the greatest ways to enrich the population is thinking about our elderly patients over 75, who might be at greater risk for stroke and systemic embolism, as we know, especially when they have AFib.

So, I guess, you know, it brings me to my second question for this episode, which is, of course, we could use any of the things you've talked about, some are easier, because maybe they've already got a device in or they already have an Apple Watch. But who should we screen? Or what is that population of risk? And then how much AFib is enough to treat if you will?

Dr. Pokorney:
Yeah, I think again, another great question. And I think there's a lot to unpack even in that – even in that sort of two-part question. I think in terms of who we should screen, you know, there are some differences here between the U.S. guideline recommendations and the European guideline recommendations.

The European Society of Cardiology, for their AFib guidelines, really recommends opportunistic screening in patients greater than 65 years of age that do have increased risk factors, and certainly doing systemic ECG screening in the patients that you mentioned, which is patients greater than 75 years of age.

The U.S. Preventive Task Force does not necessarily generate that same recommendation. And I think that as we approach these patients in clinical practice, I think that we certainly want to make sure that we're doing opportunistic screening. And we want to take advantage of the patients that do have these consumer devices that are able to follow themselves over time remotely. And I think that certainly we should be looking in patients that are 75 years of age or older, we should be looking at all those patients when they come into clinic and doing pulse checks and making sure that we're spot checking for AFib, particularly in patients that are at higher risk, like those with sleep apnea and obesity. Certainly, if you know that their left atrium is enlarged, those are patients that we may see that on echocardiogram and may choose to follow those patients more closely.

I think that in terms of the question of how much is enough AFib? You know again, there's still – this is a hotly debated topic as you know, it'd be great to get your perspective on this, as well. Certainly, if we capture an EKG of a patient in atrial fibrillation, certainly that's enough to treat them for atrial fibrillation. If they describe symptoms and we identify it on a monitor, even if we identify it on a wearable device that would be enough to label that patient as having clinical AFib. And then ARTESIA showed that – that even in device detected subclinical atrial fibrillation or asymptomatic atrial fibrillation, that really 6 minutes may be enough to – in – in particularly high-risk patients; and I would say for me, particularly in patients that have a history of stroke.

Dr. Patel:
Yeah, I think you're right. I mean, I guess my take from the available data first is that it's dependent on the patient's risk, right? So, the first big driver is symptoms. People that have symptoms, they're going to keep having symptoms, and that's a different type of atrial fibrillation, then I'll call it screening for subclinical, but certainly, symptomatic patients I'm looking for it with a good exam and the kinds of things you describe.

And then, for asymptomatic people, it's going to be what's easy. Those that have a device in or are already wearing a watch, what do we find? And if we find enough of it, and it's starting to look like it can be anywhere from 6 minutes to a couple hours, then yeah, in that range, depending on the risk, then it's a shared decision conversation about treatment.

But listen, this has been great. We know that our elderly patients are at highest risk, there are a lot of ways to screen or detect atrial fibrillation. We've gotten a lot better at it. I'm sure with AI and other things, we're only going to get even more better at this. But thank you for joining me, Sean, on this episode of: how do I improve detecting atrial fibrillation and diagnosing it in my elderly patients, thinking about all the kinds of tools we have today?

Dr. Pokorney:
Great. Thanks for having me.

Announcer:

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