

# Catheter Ablation: Pre- and Post-procedure Management

## Pre-procedure role and responsibilities of cardiologist<sup>1</sup>

A series of actions and studies should be performed in advance of AF ablation. The electrophysiologist performing the catheter ablation should be made aware of all required patient information and studies that could help improve the outcome and safety of the procedure. A careful review of all prior anatomic studies is critical prior to bringing the patient to the electrophysiology laboratory.

### PRE-PROCEDURE CHECKLIST<sup>1</sup>

- Electrocardiographic documentation of AF via 12-lead ECG, 24-hour Holter, or 30-day event monitor
- Exclude reversible causes of AF (e.g., hyperthyroidism)
- Exclude and/or treat AF triggers (e.g., accessory pathways, atrioventricular nodal reentry, atrial tachycardia)
- Assess comorbidities and allergies (e.g., sleep apnea, IVC filter)
- Discuss risks, benefits, and alternatives of ablation
- Anticoagulation for 4 weeks unless TEE performed (documentation INR: 2–3)
- Assess left ventricular systolic function
- Assess anatomy, variants, and anomalies of LA, PV, and esophagus (MRI or CT pre-procedure imaging)
- TEE to exclude intracardiac thrombus, if indicated
- Discontinuation of antiarrhythmic drugs for at least 5 half-lives in most cases
- Update and evaluate laboratory data prior to ablation
- Optimize hydration status prior to IV contrast load
- NPO starting at midnight prior to day of procedure

# Post-procedure Management

## Patients who have undergone catheter ablation require ongoing management by their cardiologist to monitor their condition.

The expert consensus guidelines recommend the following post-procedure management:

- Low-molecular-weight heparin or intravenous heparin should be used as a bridge to resumption of systemic anticoagulation following AF ablation<sup>2</sup>
- Oral anticoagulation is recommended for at least 2 months following an AF ablation procedure<sup>2</sup>
- Decisions regarding the use of oral anticoagulation more than 2 months following ablation should be based on the patient's risk factors for stroke and not on the presence or type of AF<sup>2</sup>
- Discontinuation of oral anticoagulation therapy post-ablation is generally not recommended in patients who are at high risk of stroke as estimated by CHADS<sub>2</sub> or CHA<sub>2</sub>DS<sub>2</sub>-VASc<sup>2</sup>
- Patients should be seen in follow-up at a minimum of 3 months following the ablation procedure, then every 6 months for at least 2 years<sup>2</sup>
- An event monitor should be obtained to screen for recurrent AF/flutter/tachycardia in patients who complain of palpitations during follow-up<sup>1</sup>
  - An AF/flutter/tachycardia episode is present if it is documented by ECG and lasts at least 30 seconds
- A blanking period of 3 months should be employed after ablation when reporting efficacy outcomes. Thus, early recurrences of AF/AFL/AT within the first 3 months should not be classified as treatment failure<sup>2</sup>

**References:** 1. Huizar JF, Kaszala K, Wood MA, Ellenbogen KA. Preprocedure preparation. In: Calkins H, Jais P, Steinberg JS, eds. *A Practical Approach to Catheter Ablation of Atrial Fibrillation*. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:37-54. 2. Calkins H, Kuck KH, Cappato R, et al. 2012 HRS/EHRA/ECAS expert consensus statement on catheter and surgical ablation of atrial fibrillation: recommendations for patient selection, procedural techniques, patient management and follow-up, definitions, endpoints, and research trial design: a report of the Heart Rhythm Society (HRS) Task Force on Catheter and Surgical Ablation of Atrial Fibrillation. Developed in partnership with the European Heart Rhythm Association (EHRA), a registered branch of the European Society of Cardiology (ESC) and the European Cardiac Arrhythmia Society (ECAS); and in collaboration with the American College of Cardiology (ACC), American Heart Association (AHA), the Asia Pacific Heart Rhythm Society (APHRS), and the Society of Thoracic Surgeons (STS). Endorsed by the governing bodies of the American College of Cardiology Foundation, the American Heart Association, the European Cardiac Arrhythmia Society, the European Heart Rhythm Association, the Society of Thoracic Surgeons, the Asia Pacific Heart Rhythm Society, and the Heart Rhythm Society. *Heart Rhythm*. 2012;9(4):632-693. e21.

### Biosense Webster, Inc.

3333 Diamond Canyon Road | Diamond Bar, CA 91765, USA  
Tel: 909-839-8500 | Tel: 800-729-9010 | Fax: 909-468-2905 | [www.biosenswebster.com](http://www.biosenswebster.com)

### EU Representative

#### Biosense Webster

A Division of Johnson & Johnson Medical NV/SA  
Leonardo da Vincilaan 15 | 1831 Diegem, Belgium  
Tel: +32-2-7463-401 | Fax: +32-2-7463-403

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