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《中国心脏起搏与心电生理杂志》网络首发论文

题目：《2024 ESC 与欧洲心胸外科协会(EACTS)合作制定的心房颤动管理指南》要点解读

作者：黄鹤，石少波，唐艳红，黄从新

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·指南解读·

《2024 ESC 与欧洲心胸外科协会(EACTS)合作制定的心房颤动管理指南》要点解读

黄鹤　石少波　唐艳红　黄从新

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2024 年 8 月 30 日发布了 2024 年欧洲心脏病学会(ESC)与欧洲心胸外科协会(EACTS)合作制定的心房颤动(简称房颤)管理指南(下文简称 2024 ESC 指南)[1]包含了一系列新的方法和特定治疗建议,以应对全球范围内迅速增长的房颤患者数量。2024 ESC 指南强调共同决策与平等护理、患者参与、共病管理、循证医学和动态再评估。

主要要点:①由于人口老龄化、共病负担增加、意识提高以及新检测技术的出现,预计到 2050 年房颤的患病率将翻倍。②通过遵循新的“AF-CARE”路径可以优化房颤患者的管理。③“AF-CARE”整合了共病和风险因素管理[C,Comorbidity and risk factor management],预防卒中和血栓栓塞[A,Avoid stroke and thromboembolism],通过控制心率和节律减轻症状[R,Reduce symptoms by rate and rhythm control],以及评估和动态再评估[E,Evaluation and dynamic reassessment]。④共享决策,包括患者和多学科团队,以及对患者、家属和医护人员的教育,应成为房颤管理的基石。

1　AF-CARE 管理路径更新

2024 ESC 指南强调了按照新的 AF-CARE 路径进行最佳管理的重要性,该路径旨在确保每一位房颤患者都能从最新的科学进展中受益:[C]共病和风险因素管理;[A]预防卒中和血栓栓塞;[R]通过控制心率和节律减轻症状;以及[E]评估和动态再评估。

作者单位:武汉大学人民医院心内科 武汉大学心血管病研究所 心血管病湖北省重点实验室(湖北武汉 430060)
作者简介:黄鹤(1977－),男(汉族),湖北武汉人,医学博士,教授,博士生导师,专业方向为心律失常和心脏电生理。
通讯作者:黄从新,E-mail:huangcongxin@vip.163.com

2　房颤类型更新

详见表 1。

表 1　推荐:根据时间模式对房颤定义和分类更新

分类	定义
首诊房颤	从未被诊断过的房颤。无论症状状态、发作时间或持续时间如何
阵发性房颤	在7 天内自行终止或通过干预终止的房颤。有证据表明,大多数自发终止的阵发性房颤持续时间少于 48 h[2]
持续性房颤	房颤发作不会自行终止。许多干预试验将 7 天作为定义持续性房颤的界限[3－4]。长期持续性房颤定义为持续至少 12 个月的连续房颤,但在某些患者中,节律控制仍然是一个治疗选择,这使其与永久性房颤有所区别
永久性房颤	在患者和医生共同决定后,计划不再尝试恢复窦性心律的房颤

3　共病管理更新

2024 ESC 指南中的共病章节强调了房颤不能孤立地看待。对共病和风险因素的全面评估和管理对房颤患者的各个管理方面至关重要,这有助于避免房颤的复发和进展,提高治疗成功率,并预防与房颤相关的不良结果。详见表 2。

4　血栓风险评估更新

使用 CHA_2DS_2-VA 评分(不考虑性别)来辅助决策,更广泛地应用适当的抗凝治疗。详见表 3。

女性性别是一个依赖年龄的卒中风险修正因素,而不是一个独立的风险因素[49－51]。性别的纳入使得临床实践对医疗专业人员和患者而言更加复杂[52],也忽略了那些自我认同为非二元性别、跨性别或正在接受性激素治疗的个体。ESC 及全球的先前指南实际上并未使用CHA_2DS_2-VASc评分;

表 2 推荐:房颤患者合并症和风险因素管理的建议

推荐	建议类别	证据级别
将识别和管理风险因素及合并症作为房颤管理的核心部分[5-8]	Ⅰ	B
对合并高血压的房颤患者进行降血压治疗,以减少房颤的复发和进展,并预防不良心血管事件[7-11]	Ⅰ	B
对于合并心力衰竭和充血的房颤患者,建议使用利尿剂,以缓解症状并促进更好的房颤管理	Ⅰ	C
对于合并心力衰竭和左室射血分数(LVEF)受损的房颤患者,建议使用适当的心力衰竭药物治疗,以减轻症状和/或减少心力衰竭住院次数,并预防房颤复发[12-18]	Ⅰ	B
建议对合并心力衰竭和房颤的患者使用钠-葡萄糖共转运蛋白 2(SGLT2)抑制剂,无论 LVEF 如何,以降低心力衰竭住院和心血管死亡的风险[17,19-21]	Ⅰ	A
建议在糖尿病患者和房颤患者中进行有效的血糖控制,作为全面风险因素管理的一部分,以减少房颤负荷、复发和进展	Ⅰ	C
建议在超重和肥胖的房颤患者中进行减重,作为全面风险因素管理的一部分,以减少症状和房颤负荷,目标是体重减少 10%或更多[6-9]	Ⅰ	B
建议为阵发性或持续性房颤患者量身定制运动计划,以改善心肺适能并减少房颤复发[22-27]	Ⅰ	B
建议将酒精摄入量减少到每周不超过 3 份标准饮料(≤30 克酒精),作为全面风险因素管理的一部分,以减少房颤的复发[7-8,28]	Ⅰ	B
对于房颤患者且体重指数(BMI)≥40 kg/m^2*,并计划进行节律控制策略的个体,可以考虑结合生活方式改变和药物治疗进行减重手术,以减少房颤的复发和进展	Ⅱb	C
对于房颤患者,可以考虑将阻塞性睡眠呼吸暂停的管理纳入全面风险因素管理中,以减少房颤的复发和进展[7-9,29-35]	Ⅱb	B
在对房颤患者筛查阻塞性睡眠呼吸暂停时,不推荐仅使用基于症状的问卷调查[36-38]	Ⅲ	B

注:* 或 BMI≥35 kg/m^{2}伴肥胖相关并发症

而是为房颤的女性和男性提供了不同的评分标准来决定是否进行口服抗凝治疗。因此,实际上 CHA_2DS_2-VA(不包括性别)已经在使用中[53]。

表 3 推荐:CHA_2DS_2-VA 评分表

CHA_2DS_2-VA 评分	定义	评分*
C 慢性心力衰竭	心力衰竭的症状和体征[无论 LVEF 如何,包括心力衰竭射血分数保留型(HFpEF)、心力衰竭射血分数中间型(HFmrEF)和心力衰竭射血分数降低型(HFrEF)],或无症状的 LVEF ≤40%[39-41]	1
H 高血压	至少在两个不同时间点的静息血压>140/90 mmHg,或当前正在接受抗高血压治疗。与最低心血管事件风险相关的最佳血压目标是 120~129/70~79 mmHg(或尽可能低的水平)[42-43]	1
A ≥75 岁	年龄是缺血性卒中风险的独立决定因素[44]。年龄相关的风险是一个连续过程,但为了实际操作,年龄≥75 岁给予 2 分	2
D 糖尿病	糖尿病(1 型或 2 型),根据当前接受的标准定义[45],或接受降糖治疗	1
S 既往卒中、短暂性脑缺血发作(TIA)或动脉血栓	既往发生血栓栓塞与复发风险极高相关,因此权重为 2 分	2
V 血管疾病	冠状动脉疾病:包括既往心肌梗死、心绞痛、冠状动脉再血管化史(外科或经皮)及血管造影或心脏影像学显示的显著冠状动脉疾病[46] 外周血管疾病:包括间歇性跛行、既往外周血管再血管化、腹主动脉经皮或外科干预,以及影像学上显示的复杂主动脉斑块(具有活动性、溃疡、蒂状突起或厚度≥4 mm 的特征)[47-48]	1
A 65~74 岁	年龄在 65 至 74 岁之间的患者给予 1 分	1

注:* 除这些因素外,还应考虑改变个体卒中和血栓栓塞风险的其他特征,包括癌症、慢性肾脏疾病、种族(黑人、西班牙裔、亚裔)、生物标志物(肌钙蛋白和脑钠肽),以及特定人群中的心房增大、高脂血症、吸烟和肥胖

2024 ESC 指南工作组建议,在没有其他经过本地验证的替代方案的情况下,临床医生和患者应使用 CHA_2DS_2-VA 评分来协助决定口服抗凝治疗(即不考虑出生性别或性别)。在低风险患者的进一步试验结果(NCT04700826[54], NCT02387229[55])出来之前,对于 CHA_2DS_2-VA 评分为 2 分或以上的患者推荐使用口服抗凝药物,对于 CHA_2DS_2-VA 评分为 1 分的患者应考虑采取以患者为中心的共享管理方法。详见表 4。

表 4 推荐:评估和管理房颤患者血栓栓塞风险的建议

推荐	建议类别	证据级别
建议对临床房颤患者中血栓栓塞风险升高的个体使用口服抗凝药物,以预防缺血性卒中和血栓栓塞[56-57]	Ⅰ	A
推荐 CHA_2DS_2-VA 评分为 2 分或以上作为评估血栓栓塞风险升高的指标,以决定是否开始口服抗凝治疗	Ⅰ	C
对于所有合并肥厚型心肌病或心脏淀粉样变性的房颤患者,无论 CHA_2DS_2-VA 评分如何,建议使用口服抗凝药物,以预防缺血性卒中和血栓栓塞[58-64]	Ⅰ	B
建议定期对房颤患者进行个体化的血栓栓塞风险重新评估,以确保在适当的患者中开始抗凝治疗[65-68]	Ⅰ	B
CHA_2DS_2-VA 评分为 1 分应被视为血栓栓塞风险升高的指标,以决定是否开始口服抗凝治疗	Ⅱa	C
对于无症状的经设备检测到的亚临床房颤且血栓栓塞风险升高的患者,可以考虑直接口服抗凝药物治疗,以预防缺血性卒中和血栓栓塞,但应排除高出血风险的患者[69-70]	Ⅱb	B
在房颤患者中,抗血小板治疗不推荐作为抗凝治疗的替代方案来预防缺血性卒中和血栓栓塞[71-72]	Ⅲ	A
不建议根据房颤的时间模式(阵发性、持续性或永久性)来决定是否需要口服抗凝治疗[73-74]	Ⅲ	B

5 通过控制心率和节律减轻症状更新

详见表 5。

表 5 推荐:房颤患者心率管理更新内容

推荐	建议类别	证据级别
对于房颤患者,建议使用心率控制治疗,作为急性期的初始治疗、节律控制治疗的辅助措施,或作为单独治疗策略来控制心率和减轻症状[75-77]	Ⅰ	B
在LVEF>40%的房颤患者中,建议使用β受体拮抗剂、地尔硫䓬、维拉帕米或地高辛作为首选药物来控制心率和减轻症状[78-80]	Ⅰ	B
对于症状严重的永久性房颤患者,且至少有一次因心力衰竭住院的患者,应该考虑房室结消融联合心脏再同步治疗,以减轻症状、活动受限、反复的心力衰竭住院以及死亡率[81-82]	Ⅱa	B

6 房颤导管消融更新

详见表 6。

表 6 推荐:房颤导管消融更新内容

推荐	建议类别	证据级别
窦房结病变/心动过速-心动过缓综合征 对于有房颤相关心动过缓或在房颤终止时出现窦性停搏的患者,应考虑进行房颤导管消融,以改善症状并避免植入起搏器[83-86]	Ⅱa	C
导管消融后的复发 对于在初次导管消融后出现房颤复发的患者,如果患者在初次肺静脉隔离(PVI)后症状有所改善或初次 PVI 失败,应考虑再次进行房颤导管消融,以减轻症状、复发和房颤的进展[87-89]	Ⅱa	B

导管消融在症状性阵发性或持续性房颤患者中,能够预防房颤复发、减少房颤负荷,并改善生活质量,尤其是对于那些对抗心律失常药物耐受性差或无反应的患者[90-96]。对于因房颤终止后出现长时间停搏而有症状的患者,非随机数据已显示导管消融可以改善症状,并避免起搏器植入[83-86]。

PVI 仍然是导管消融的核心[90,95,97-98],但在非阵发性房颤人群中,最佳消融策略尚未明确[99]。新兴技术如脉冲消融也在不断发展,该技术使用高幅度电脉冲通过电穿孔来消融心肌,具有较高的组织特异性。在一项单盲随机对照试验(RCT)中,607 名患者接受了脉冲消融,其疗效和安全性终点与传统射频或冷冻球囊消融相当[100]。

7 房颤病情的动态再评估

房颤患者需要进行动态评估和再评估,初级和次级管理中的医疗团队需要定期重新评估以调节风险因素。房颤的发展和进展是由基础机制与广泛的临床因素和相关共病的持续相互作用所驱动的。每一个因素的作用随着时间而显著变化,影响其对房颤进展。每位患者的风险概况也远非静态,需采用动态管理模式以确保房颤的最佳管理[101-102]。为了提高整体管理质量,对房颤患者评估治疗,应关注可能减缓或逆转房颤进展、提高生活质量以及预防不良结果等,需根据这种变化的风险状态定期重新评估治疗。及时关注可改变的因素和基础共病有可能减缓或逆转房颤的进展,提高生活质量,并预防心力衰竭、血栓栓塞和重大出血等不良结果。

AF-CARE 中的[E]部分涵盖了医疗专业人员

和患者所需的活动范围，包括：①彻底评估相关共病和风险因素，以指导治疗；②提供动态评估，以确保治疗计划始终适合特定患者。2024 ESC 指南工作组建议采取一种适应性策略，不仅对患者反映的变化作出反应，还主动寻找可能影响患者健康的管理调整点。这一框架还旨在避免不必要和昂贵的随访，通过教育和赋能患者，帮助识别是否需要专业护理或管理升级。以患者为中心的共享决策理念被嵌入其中，以提高管理模式的效率，并满足房颤患者的需求。

合并疾病和任何检查结果应定期重新评估，以应对共病和风险因素的动态变化[103]。这可能会影响治疗决策，例如在患者肾功能改善后恢复全剂量的直接口服抗凝药治疗。AF-CARE 路径的复审时间应根据患者的具体情况进行，通常建议在初次就诊后的 6 个月进行重新评估，然后至少每年进行一次。

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(王晞编辑)