Letter to the Editor Response

Dear Dr. Dural and colleges,

Thank you for your comments. In fact, Healy et al reported an incidence of 10.1% of Atrial High Rate Episodes (AHRE), considering a cut-off of 5 minutes with available electrogram (EGM),[1] which is similar to our study (9.3%).[2] Paul Ziegler et al did not examine the intracardiac EGM and considered episodes lasting more than 5 minutes. Since EGM was not available, some of these episodes could be false positives results, increasing the incidence of "AHRE" in their study (30%).[3]

We are in agreement with you in what concerns antiarrhythmic drugs since they may affect the incidence of AHRE. However we did not have information about the use of drugs in all of our patients, so we did not include the results in basal characteristics. We do know beta-blockers were used in some of our patients (24% of those who had that information) (mostly due to hypertension and coronary heart disease) and it did not statistically differ between the groups with and without AHRE.

According to experts, the minimum duration of AHRE which confers increased thromboembolic risk is not precisely defined, and varies from minutes to several hours, several but may be as brief as several minutes to several hours. It is recommended to consider more than 5.5 hour, but it was also stated that data suggest risk is similarly increased by a mere 5 minutes episode.[4] As we stated in our article, the currently accepted "minimal duration" of AHREs, 5-6 minutes, is based on technicalities related to the adequate diagnosis of true AHREs and their distinction from artifacts and other arrhythmias, rather than on biological processes.[2] Thus, we informed the patient's physician about the detection of AHRE and left to him the decision of oral anticoagulation (OAC) initiation, according to patient's characteristics, embolic risk, and hemorrhagic risk. Although CHADSVASc score was higher in patients who initiated OAC, the difference was not statistically significant. Also AHRE duration was not statistically different in patients who initiate or did not initiate OAC. We admit some limitations in our study and agree that randomized studies will give valuable information to this issue.

R. Marinheiro, MD,*
L. Parreira, MD
Centro Hospitalar de Setúbal, Rua Camilo, castelo Branco 2910-446 Setubal Portugal
E-mail address: ritamarinheiro@gmail.com

https://doi.org/10.1016/j.jstrokecerebrovasdis.2019.05.012

References

1. Healey JS, Connolly SJ, Gold MR, et al. Subclinical atrial fibrillation and the risk of stroke. N Eng J Med 2012; 366:120-129.
2. Marinheiro R, Parreira L, Amador P, et al. Clinical Impact of oral anticoagulation in patients with atrial high-rate episodes. J Stroke Cerebrovasc Dis 2019;4:971-979.
3. Ziegler PD, Glotzer TV, Daoud EG, et al. Detection of previously undiagnosed atrial fibrillation in patients with stroke risk factors and usefulness of continuous monitoring in primary stroke prevention. Am J Cardiol 2012; 110:1309-1314.
4. Gorenek BC, Bax J, Boriani G, et al. Device-detected subclinical atrial tachyarrhythmias: definition, implications and management-an European Heart Rhythm Association (EHRA) consensus document, endorsed by Heart Rhythm Society (HRS), Asia Pacific Heart Rhythm Society (APHRS) and Sociedad Latinoamericana de Estimulacion Cardiaca y Electrofisiologia (SOLEACE). Europace 2017; 19:1556-1578.

DOI of original article: http://dx.doi.org/10.1016/j.jstrokecerebrovasdis.2019.05.011.
1052-3057/$ - see front matter