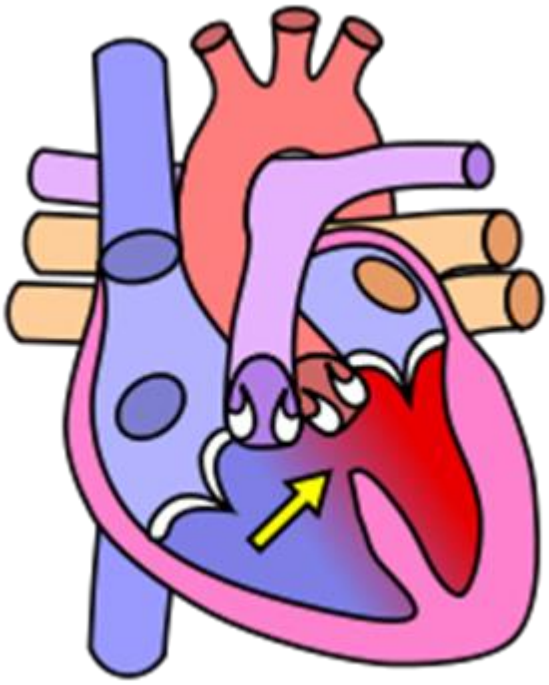
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Cardiology
Current Awareness Newsletter
February 2016



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3: Latest relevant Systematic Reviews from the Cochrane Library

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6: Current Awareness database articles

Tables of Contents from relevant journals

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Journal of the American College of Cardiology

Circulation

European Heart Journal

New Nice Guidance

Quality Standard	**In development** Chronic heart failure in adults

Latest relevant Systematic Reviews from the Cochrane Library

Dietary fibre for the primary prevention of cardiovascular disease

Louise Hartley, Michael D May, Emma Loveman, Jill L Colquitt, Karen Rees

Online Publication Date: January 2016

Exercise-based cardiac rehabilitation for coronary heart disease

Lindsey Anderson, David R Thompson, Neil Oldridge, Ann-Dorthe Zwisler, Karen Rees, Nicole Martin, Rod S Taylor

Online Publication Date: January 2016

Yoga for improving functional capacity, quality of life and cardiovascular outcomes in people with heart failure

Mahalaqua N Khatib, Richard Kirubakaran, Shilpa Gaidhane, Anuraj Shankar, Zahiruddin Quazi Syed

Online Publication Date: January 2016

Recent Research from Research Gate

Click here Bristol Heart Institute

UptoDate

What's new in cardiovascular medicine

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Conflict of interest policy

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: Dec 2015. | **This topic last updated:** Jan 28, 2016.

The following represent additions to UpToDate from the past six months that were considered by the editors and authors to be of particular interest. The most recent What's New entries are at the top of each subsection.

ARRHYTHMIAS

"Warning" symptoms preceding sudden cardiac arrest (January 2016)

"Warning" symptoms may precede sudden cardiac arrest (SCA) in many patients, but symptoms are often unrecognized or minimized. In a community-based study of patients with SCA in whom symptom assessment could be ascertained (either from the surviving patient or from family members, witnesses at the scene of the event, or medical records from the four weeks leading up to the event), more than half of patients had warning symptoms within four weeks preceding SCA [1]. Chest pain and dyspnea were the most common symptoms, with chest pain being more common in men and dyspnea in women. Patients with symptoms concerning for cardiac disease, particularly new or unstable symptoms, should seek prompt medical care for potentially life-saving evaluation and treatment. (See "Overview of sudden cardiac arrest and sudden cardiac death", section on 'Warning symptoms'.)

Reversal agent for factor Xa inhibitors (November 2015)

Lack of reversal agents for the direct oral anticoagulants has been a concern. Andexanet alfa is a recombinant protein designed to reverse factor Xa inhibitors by binding to the drugs and sequestering them away from endogenous factor Xa. In a randomized trial in healthy volunteers, an andexanet bolus reduced anti-factor Xa activity by 94 percent and 92 percent for volunteers taking apixaban or rivaroxaban, respectively, compared with reductions of 21 and 18 percent for a placebo bolus [2]. A study evaluating andexanet efficacy in patients with factor Xa inhibitor-associated bleeding is ongoing. (See "Management of bleeding in patients receiving direct oral anticoagulants", section on 'Antidotes under development'.)

Leadless cardiac pacing for single ventricle VVI pacing (September 2015, Modified November 2015)

Currently available transvenous and epicardial permanent cardiac pacemaker systems are associated with both early and long-term complications. Many of the complications, including infection, venous thrombosis, and lead malfunction resulting in device failure, relate to the presence of indwelling transvenous leads or the need to surgically place epicardial leads.

- In LEADLESS II, a prospective nonrandomized multicenter study of a miniaturized self-contained leadless pacemaker, both the primary efficacy endpoint (acceptable pacing capture threshold and sensing amplitude) and the primary safety endpoint (freedom from device-related adverse events) were achieved at six-month follow-up [3].
- Similarly, in the Micra Transcatheter Pacing Study, a prospective, nonrandomized multicenter study of a different miniaturized self-contained leadless pacemaker, both the primary efficacy endpoint (acceptable pacing capture threshold and sensing amplitude) and the primary safety endpoint (freedom from device-related adverse events) were achieved at six-month follow-up [4].

Leadless cardiac pacing holds promise as an option for patients requiring long-term single ventricle (right ventricle only, VVI) pacing. However, leadless pacing systems remain investigational and longer-term follow-up is needed to assess the safety and efficacy of these devices along with the potential for any long-term deleterious effects of RV-only pacing. (See "Permanent cardiac pacing: Overview of devices and indications", section on 'Leadless systems'.)

Dabigatran reversal agent approved (October 2015)

The lack of a specific reversal agent for the direct thrombin inhibitor dabigatran has been a persistent concern in its use for patients with atrial fibrillation or venous thromboembolism. Idarucizumab (Praxbind) is a reversal agent for dabigatran that was approved by the US Food and Drug Administration in October 2015 to reverse dabigatran effect in the setting of life-threatening or uncontrolled bleeding or emergency surgery [5,6]. Approval was based on studies in healthy volunteers and an interim analysis of the RE-VERSE AD trial, which included a cohort of 90 older adult patients who had clinically significant bleeding or the need for an urgent invasive procedure while taking dabigatran for atrial fibrillation [7]. Idarucizumab produced rapid normalization of clotting times and/or surgical hemostasis; there were five thrombotic events and 18 deaths. Without a control group it is unclear how these outcomes would compare with similar patients who did not receive idarucizumab. For patients with life-threatening bleeding, we would use idarucizumab, if available, along with other measures to decrease bleeding risk, but we would not combine idarucizumab with procoagulant products such as an activated prothrombin complex concentrate (aPCC). Idarucizumab is an antibody-based therapy and does not have known activity against direct factor Xa inhibitors or other anticoagulants. (See "Management of bleeding in patients receiving direct oral anticoagulants", section on 'Dabigatran reversal'.)

Radiofrequency catheter ablation for atrial fibrillation (September 2015)

Up to 50 percent of patients with atrial fibrillation (AF) who undergo radiofrequency catheter ablation (CA) require a second procedure to treat recurrent symptoms. A contact force (CF)-sensing catheter improves the efficacy of energy delivery and thus may reduce the recurrence of symptomatic episodes. The TOCCASTAR study randomly assigned 300 patients with paroxysmal AF to radiofrequency CA with a CF-sensing catheter or a non-CF catheter [8]. There was no significant difference in the primary end point of freedom from recurrent symptomatic atrial arrhythmia off antiarrhythmic drug therapy or the need for a second ablation procedure at 12 months (67.8 and 69.4 percent, respectively). In a post hoc analysis, the primary outcome was significantly improved (75.9 versus 58.1 percent) in patients who received a higher force (≥10 grams) with the CF catheter. Based on TOCCASTAR, we suggest using a CF-sensing catheter with force ≥10 grams in most patients with paroxysmal AF undergoing radiofrequency CA. However, additional evidence from a prospective study supporting the use of this catheter is needed before we recommend using it in all patients. (See "Catheter ablation to prevent recurrent atrial fibrillation: Technical considerations", section on 'Circumferential pulmonary vein isolation'.)

Modified Valsalva maneuver for treatment of hemodynamically stable supraventricular tachycardia (September 2015)

For both diagnostic and therapeutic purposes, the Valsalva maneuver is commonly used in patients with suspected supraventricular tachycardia (SVT). In a randomized trial of vagal maneuvers for the treatment of hemodynamically stable SVT, patients were assigned to perform the standard Valsalva maneuver (strain generating 40 mmHg pressure for 15 seconds while in a semirecumbent position) with or without supine repositioning and passive leg raise for 15 seconds following the strain phase [9]. Patients performing the modified Valsalva maneuver with supine repositioning and passive leg raise were significantly more likely to have restoration of sinus rhythm at one minute. For patients with hemodynamically stable SVT who are able to effectively perform the maneuver, we recommend the modified Valsalva maneuver as the initial treatment. (See "Atrioventricular nodal reentrant tachycardia", section on 'Vagal maneuvers'.)

Adenosine-guided pulmonary vein isolation for patients with AF (July 2015)

In patients with paroxysmal atrial fibrillation (AF) who undergo catheter ablation (CA) for symptom control, AF reoccurs in up to 50 percent at one year. Studies have shown that the intravenous administration of adenosine (within 20 minutes of ablation) can unmask dormant conduction in patients who are otherwise felt to have had a successful procedure. In the ADVICE study, 534 patients with paroxysmal AF underwent standard catheter ablation using radiofrequency energy followed by the administration of intravenous adenosine [10]. The 284 patients with unmasked conduction were randomly assigned to additional ablation or to no additional ablation. Freedom from symptomatic atrial tachycardia at one year occurred more often with adenosine-guided additional ablation (69 versus 42 percent). Based on the ADVICE study, we suggest that most patients with paroxysmal AF undergoing radiofrequency CA receive adenosine to provoke dormant AF. (See "Catheter ablation to prevent recurrent atrial fibrillation: Clinical applications", section on 'Use of adenosine-guided pulmonary vein isolation'.)

CORONARY ARTERY BYPASS GRAFT SURGERY

Prophylactic glucocorticoid not beneficial at the time of cardiopulmonary bypass (September 2015)

Cardiopulmonary bypass used at the time of cardiac surgery leads to a systemic inflammatory state. The SIRS trial randomly assigned 7507 patients to receive high-dose

methylprednisolone or placebo and found no difference in the risk of death or a combined end point of death and major morbidity at 30 days [11]. We do not recommend the use of prophylactic glucocorticoids to lower the risk of clinically important outcomes at the time of cardiac surgery with cardiopulmonary bypass. (See "Medical therapy to prevent complications after coronary artery bypass graft surgery", section on 'Glucocorticoid therapy'.)

CORONARY HEART DISEASE, ACUTE

Outcomes worse with morphine use in patients with acute MI (January 2016)

In patients with acute myocardial infarction (MI), several small studies have suggested that morphine may worsen outcomes. In the IMPRESSION trial, 70 acute MI patients treated with ticagrelor were randomly assigned to receive intravenous morphine (5 mg) or placebo [12]. Morphine lowered ticagrelor plasma concentration and impaired its antiplatelet effect.
We reserve morphine use for patients who have an unacceptable level of chest pain. (See "Overview of the acute management of ST elevation myocardial infarction", section on 'Morphine'.)

Cyclosporine not effective in improving outcomes after acute STEMI (September 2015, Modified January 2016)

Ischemic reperfusion injury accounts for a significant percent of final infarct size in patients with acute ST-elevation myocardial infarction (STEMI). In one early study, cyclosporine reduced infarct size, perhaps by reducing reperfusion injury. However, two randomized trials of STEMI patients undergoing primary percutaneous coronary intervention (PCI) have not found clinical benefit:

- The CIRCUS trial randomly assigned 970 patients to intravenous cyclosporine or placebo prior to primary PCI [13]. There was no difference between the groups in the primary composite clinical outcome.
- The CYCLE trial randomly assigned 410 patients to intravenous cyclosporine or placebo prior to primary PCI [14]. There was no difference in the rate of the primary end point of ≥70 percent resolution of ST-segment elevation on the electrocardiogram 60 minutes after establishment of Thrombolysis In Myocardial Infarction flow grade 3.

Despite the absence of benefit in these studies, research directed at reducing reperfusion injury is ongoing and includes studies with cyclosporine. (See "Reperfusion injury of the heart", section on 'Cyclosporine'

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