**Abstract:**

**Introduction:** An integral aspect of atrial fibrillation (AF) management involves better symptom control, incorporating a rate control, rhythm control or a combination strategy. The 2020 ESC Guidelines suggest that rhythm control strategy should be recommended for symptomatic patients, to mitigate their symptoms and improve the quality of life. However, adequately powered randomised control trials and prospective ‘real world’ registries are needed to fully assess the impact of early rhythm control strategies on clinical outcomes in patients with AF.

**Objective:** In this narrative review, we discuss clinical outcomes following rhythm management approach among patients with AF, considering the effectiveness of an early intervention strategy.

**Expert Opinion:** Patients involvement and shared decision making are crucial when deciding the optimal management strategy among patients with AF. For those with newly diagnosed symptomatic AF, an early invasive approach such as catheter ablation may have a role in preventing AF progression and subsequent pathophysiological changes.

**Key words:** atrial fibrillation, cardioversion, catheter ablation, heart failure, rate control, rhythm control

**Article highlights:**

* Highly individualised therapy and shared decision making are crucial when deciding the optimal management strategy among patients with AF.
* Rhythm control strategy should be considered for symptomatic patients, to mitigate the symptoms and improve quality of life.
* Early rhythm control strategy, incorporated into holistic AF care, may prevent AF progression and improve outcomes among selected patients with newly diagnosed AF.
* Further randomised control trials and ‘real world’ registries are needed to assess the impact of early rhythm control strategy on long-term clinical outcomes in patients with AF.

1. **INTRODUCTION**

Patients with atrial fibrillation (AF) have an increased risk of morbidity in terms of ischaemic stroke and heart failure, and mortality compared to the general population1. AF is the most common sustained arrhythmia, with a predicted prevalence of 17.9 million in European adults by 20602. A new approach, incorporated in the latest 2020 European Society of Cardiology (ESC) guidelines on AF3 – the Atrial fibrillation Better Care (ABC) pathway4, was introduced to improve the outcomes of these patients5,6. In this pathway, ‘B’ focuses on better symptom control in patients with AF by utilising either a rhythm or rate control strategy4.

In general, a rhythm control strategy is reserved to mitigate symptoms and improve the quality of life3. Nonetheless, among a subset of patients with newly diagnosed AF (Table 1), an early intervention approach using catheter ablation may prevent further electrical and structural remodelling associated with disease progression. This is important as restoration of sinus rhythm becomes increasingly more challenging with advanced disease states3,7. In this regard, a rate control strategy has not been shown to be beneficial to halt disease progression6. Therefore, there may be an argument for pursuing a rhythm control strategy in the first instance in patients with newly diagnosed AF. However, adequately powered randomised control trials (RCTs) and prospective ‘real-world’ registries are needed to fully assess the impact of early *vs.* late rhythm control strategies on clinical outcomes in patients with AF3.

Due to the complexities of AF and variety of treatment options available8, adopting a highly individualised approach and shared decision-making process are crucial when optimising the treatment of patients with AF (Table 2)3,9,10. Recently, new tools were developed to improve further AF management and research3,11,12. The 4S-AF scheme (Stroke risk, Symptom severity, Severity of AF burden, and Substrate for AF) provides a novel approach toward a pathophysiology-based characterisation of patients with AF4. This model is applicable in daily clinical practice to support decision-making on stroke prevention, choice of rate or rhythm control, and management of comorbidities and risk factors3,11. Quality indicators have also been proposed to improve the quality of care in patients with AF12.

In this narrative review, we provide an overview of the rhythm vs rate control strategies, different therapeutic options for rhythm control and benefits of an early rhythm control approach.

1. **Rhythm *vs.* rate control strategy**

Rhythm control in AF involves the restoration of sinus rhythm using ablation techniques, cardioversion or long-term treatment with anti-arrhythmic drugs; whereas rate control is aimed at allowing AF to persist but with well-controlled ventricular rates (Figure 1)3,9,10. In spite of decades of research, it has still not been demonstrated conclusively that rhythm control strategies are more effective than rate control in improving patients’ survival and clinical outcomes13,14.

In the AFFIRM study15, which was a RCT comparing rhythm and rate control strategies among 4060 patients with AF, it was found that the rhythm-control strategy offered no survival advantage (mortality at five years: 23.8% *vs.* 21.3% with rate control; P=0.08) and was related to more adverse drug effects15. The study, published in 2002, predated the advent of catheter ablation, and warfarin discontinuation rates were particularly high in the rhythm control arm. Indeed, a sub-analysis of the trial16 showed that the presence of sinus rhythm and the use of warfarin was associated with a lower risk of death16.

The EORP-AF Pilot Registry17 was conducted in nine European countries to assess contemporary management of patients with AF. The influence of a rate *vs.* rhythm control strategy in 3119 real-world patients over a 1-year follow-up was reported. It was found that 1036 (33.2%) patients were managed with rate control only and 355 (11.4%) patients with rhythm control only. The most commonly used drug for rate control was beta-blockers, while amiodarone was the most frequent anti-arrhythmic drug. Patients assigned to a rhythm control strategy were younger and more likely to be male. The authors demonstrated that a rhythm control strategy was independently related to a lower risk of adverse events and all-cause mortality at 1-year follow-up17. Likewise, the results of Get With The Guidelines-Heart Failure registry which included patients with AF and heart failure with preserved left ventricular function showed a lower rate of all‐cause death at one year in the rhythm control group, as compared with the rate control group (30.8% *vs*. 37.5%, P<0.01; HR: 0.86; 95% CI: 0.75–0.98)18. A meta-analysis of 10 RCTs indicated that among young AF patients (aged < 65 years), rhythm control may be preferable strategy, resulting in a higher rate of restoration of sinus rhythm, and a lower risk of all-cause mortality and worsening heart failure as compared to rate control strategy19.

However, an RCT among patients with a recurrence of persistent AF showed that rate control was not inferior to rhythm control for the prevention of cardiovascular-related morbidity and all-cause death20. Likewise, the ORBIT-AF Registry, consisting of 9749 patients with AF found that rhythm control was not superior to rate control strategy, but was related to a higher risk of cardiovascular hospitalisations (HR: 1.24; 95% CI: 1.10-1.39)21.

Nonetheless, major limitations of the studies described above are that they relied primarily on the use of anti-arrhythmic drugs which are known to perform poorly in maintaining long-term sinus rhythm and are often associated with significant side effects. Therefore, it begs the question as to whether the results would have been different if we analysed only the subgroup of patients with successful anti-arrhythmic treatment or if we utilised a different approach such as AF ablation which has been shown to have better success rates than drugs.

1. **Medical therapy *vs*. AF ablation**

Over the past two decades, the field of AF ablation has received much attention. At present, the cornerstone of AF catheter ablation is electrical isolation of the pulmonary veins (PVI)22. This has been associated with good long-term outcomes in maintaining sinus rhythm with low rates of procedural complications23,24.

**3.1** **General AF population**

The CABANA trial25 was a recently published RCT, including 2204 patients with paroxysmal or persistent AF with a median age of 68 years, comparing outcomes of catheter ablation *vs.* antiarrhythmic drug therapy. Patients had a median time since AF onset of 1.1 years, and more than half the patients had non-paroxysmal AF. Over a median follow-up of 48.5 months, the use of catheter ablation did not significantly reduce the combined primary endpoint of death, disabling ischaemic stroke, major bleeding, or cardiac arrest (8.0% vs 9.2%; HR: 0.86; 95% CI: 0.65-1.15). The risk of death or cardiovascular hospitalisation (HR: 0.83; 95% CI: 0.74-0.93) and the risk of AF recurrence (HR: 0.52; 95% CI: 0.45-0.60) was significantly lower in the ablation group as compared to the drug therapy group25. However, almost 10% patients randomised to the catheter ablation group did not undergo the procedure, whereas 27.5% of patients assigned to the drug therapy group received catheter ablation. Such significant cross-over may have introduced bias to the results and in fact, the ‘as-treated’ analysis demonstrated catheter ablation to be superior to medical therapy. Indeed, a subsequent ‘real-world’ study26 revealed that catheter ablation was related to a reduction in the composite endpoint of death, disabling ischaemic stroke, major bleeding, or cardiac arrest (HR: 0.75; 95% CI: 0.70-0.81); and that the benefit was more significant in the CABANA-eligible patients (HR 0.70, 95% CI 0.63-0.77) compared with the medical therapy group26.

Notably, a meta-analysis27 of nine studies assessed the long-term outcomes of catheter ablation *vs.* medical therapy alone in a general AF population (n=241,372). During a follow‐up of 3.5 years, catheter ablation significantly reduced the risk of death (HR: 0.62; 95% CI: 0.54‐0.72), stroke (HR: 0.63; 95% CI: 0.56‐0.70), and hospitalisation (HR: 0.64; 95% CI: 0.51‐0.80) as compared to the medical therapy27.

Likewise, a study28 of 2,720 patients with AF who underwent an ablation, assessed the impact of the procedure on recurrent hospitalisations. AF ablation was related to a 35% decline in all-cause hospitalisations (from 1,669 hospitalisations in the year pre-ablation to 1,034 hospitalisations in the year post-ablation), which was driven by a reduction in hospitalisations for AF and heart failure (a reduction of 56% and 43%, respectively)28. The independent predictors for decreased AF hospitalisation were age <55 years, history of obstructive sleep apnoea and heart failure28. Furthermore, catheter ablation significantly increased the time to first recurrence of atrial arrhythmias among patients with paroxysmal and persistent AF, during the 12-year follow-up period in comparison to anti-arrhythmic drugs29.

Another study30 assessed the risk of ischaemic stroke and intracranial haemorrhage among patients with AF, depending on the treatment strategy. At 51 months of follow-up, 35.8% of patients with catheter ablation had an AF recurrence, and 29.7% of these patients underwent a repeat procedure. It was found that the risk of ischaemic stroke was significantly higher in the group treated with medical therapy as compared to the catheter ablation group and the non-AF group (Incidence Rate Ratio [IRR]: 1.09% vs 0.30% vs 0.34%; respectively). Of note, among those remaining in sinus rhythm after ablation, the risk of stroke was lower than in patients with post-ablation AF recurrences (IRR: 0.87% vs 0.24%). Curiously, the authors reported that the risk of intracranial bleeding was lower in the ablation group than in the medical therapy group (IRR: 0.06% *vs.* 0.17%); and that the risk of intracranial bleeding did not differ between the ablation group and the non-AF group30. In this regard, it seems implausible that catheter AF ablation would directly influence the risk of ICH, suggesting that there may be potential bias in the study31. A separate analysis using the same database of patients with AF showed that catheter ablation was related to a lower incidence and risk of dementia, including Alzheimer's disease and vascular dementia (HR: 0.73; 95% CI: 0.58-0.93) compared with patients with medical therapy during a follow-up of 52 months32.

**3.2 Patients with atrial fibrillation and heart failure**

CASTLE-AF33 was a RCT assessing the outcomes among patients with symptomatic paroxysmal or persistent AF and symptomatic heart failure (left ventricular ejection fraction ≤ 35%) with an implanted cardioverter-defibrillator, and a history of unsuccessful [or unwillingness to take] antiarrhythmic drug therapy. Patients were randomised to catheter ablation or standard medical therapy. A significantly lower rate of a composite endpoint of all-cause death or hospitalisation for worsening heart failure was observed among those in the ablation group as compared to the drug therapy group (28.5% vs 44.6%; HR: 0.62; 95% CI: 0.43-0.87); catheter ablation was also related to a lower burden of AF, increased the 6-minutes walking distance, and improved the left ventricular ejection fraction33. However, only a minority of patients who were initially screened for the trial were found to be eligible. Indeed, a study34 assessing the generalisability of CASTLE-AF showed that only 7.8% of patients in routine practice would have met the inclusion criteria for the CASTLE-AF. Nonetheless, this study found that patients in the catheter ablation group had a lower risk of the primary outcome as compared to standard medical therapy (HR: 0.81; 95% CI: 0.76-0.87)34.

A meta-analysis of seven RCTs among patients with AF and heart failure showed that catheter ablation was associated with a significant reduction in mortality (risk ratio [RR]: 0.50; 95% CI: 0.34-0.74) and hospitalisations for heart failure (RR: 0.56; 95% CI: 0.44-0.71); and led to improvements in left ventricular ejection fraction (weighted mean difference: 7.48; 95% CI: 3.71-11.26) as compared to medical therapy35. Nonetheless, it is important to note that the inclusion and exclusion criteria differed between the analysed studies.

Overall, a rhythm control strategy with anti-arrhythmic drugs is not superior to rate control in terms of mortality and clinical outcomes15. However, catheter AF ablation may have a positive effect on all-cause mortality, risk of stroke, re-hospitalisation, cognitive function and quality of life among patients with paroxysmal and persistent AF as compared to medical therapy, especially in specific subgroups29,30,32,36. Patients with ‘long-standing persistent’ AF (>3 years continuously in AF prior to ablation) are less likely to restore and maintain the sinus rhythm post ablation than those with paroxysmal AF37. Of note, time since first AF episode and heart failure are associated with higher, whereas absence of structural heart disease, with lower AF recurrences after catheter ablation38. A 10-year post AF ablation follow-up of 255 patients showed that greater LA anteroposterior diameter, hypertension, higher BMI and increased fasting blood glucose were independently associated with AF recurrences39.

Given the current literature, patient selection and preferences are important aspects of treatment, including the benefit-risk assessment of ablation in order to identify an optimal individualised strategy40. Further studies are needed to determine whether there are additional subgroups who may benefit from AF ablation in terms of reducing long-term complications and improving survival.

1. **Early rhythm control**

Early intervention in the “natural history” of AF may prevent its progression and AF-related pathophysiological changes41. New management strategies are proposed to maintain sinus rhythm in the “early-stage” AF and improve clinical outcomes in patients with AF42.

The recently published EAST-AFNET 4 trial43 included 2789 patients with AF diagnosed up to one year prior to enrolment; which was symptomatic in around 70% of patients. Patients were randomised to early rhythm control (treatment with antiarrhythmic drugs or AF ablation) or usual care (rhythm control was limited to the symptomatic patients). The primary composite outcome was cardiovascular-related death, stroke, or cardiovascular-related hospitalisation; and the primary composite safety outcome was death, stroke, or serious adverse events related to rhythm control therapy. The trial was discontinued after a median of 5.1 years of follow-up due to the demonstration at the third interim analysis that early rhythm control therapy was related to a lower risk of adverse cardiovascular outcomes than usual care. The first-primary-outcome event rate was 3.9 per 100 person-years in the early rhythm control group vs 5.0 per 100 person-years in the usual care group (HR: 0.79; 96% CI: 0.66-0.94), while the primary safety outcome did not differ significantly between the groups. The use of oral anticoagulation (OAC) was continued during the follow-up (although data on quality of anticoagulation were not reported), and the incidence of ischaemic stroke was low in both groups (0.6% in the early rhythm control group and 0.9% in the usual care group). Of note, sinus rhythm at 24 months was maintained in 82% of the patients assigned to early rhythm control and 60% of patients in the usual care group43. It is important to note that only around 1 in 5 patients in the rhythm control arm underwent catheter ablation during the study period, with antiarrhythmic drugs being the predominant mode of rhythm control. 14.6% of patients in the usual care group too received the rhythm control therapy to mitigate their symptoms. Given that patients in the early rhythm control group underwent an intense, structured follow-up, the positive results may have been influenced by better treatment of risk factor and comorbidities in the intervention arm33. As shown in Table 4, there are important differences between the AFFIRM and EAST-AFNET4 trials, which may explain the different headline results. In particular, the success rate of the rhythm control strategy was significantly higher in EAST-AFNET4, and the OAC discontinuation rates significantly lower than in AFFIRM. In summary, EAST-AFNET 4 suggests that early rhythm control is a reasonable consideration as part of a holistic approach to AF care3,34.

A decade ago, the MANTRA-PAF study46 was performed to evaluate the outcomes of radiofrequency ablation as first-line therapy for patients with paroxysmal AF. Patients were randomised to receive radiofrequency catheter ablation or treatment with anti-arrhythmic drugs. Primary end points were the cumulative and per-visit burden of atrial fibrillation assessed in 7-day Holter-ECG (at 3, 6, 12, 18, and 24 months). Although there was no significant difference between groups in the cumulative burden of AF, the AF burden at 24 months, was significantly lower in the ablation group than in the AAD group (9% vs. 18%; P=0.007); and more patients in the ablation group were free from symptomatic AF (93% vs. 84%; P=0.01)46.

Results of two RCTs, evaluating cryoballoon AF ablation as a first-line strategy compared with anti-arrhythmic drug therapy: the STOP-AF FIRST47 and the EARLY-AF 48 have been recently published. The trials comprised of patients with symptomatic, paroxysmal AF untreated previously with rhythm-control strategy, and without severe left atrial enlargement (diameter <5cm)47,48. Both studies showed that cryoballoon ablation had a superior efficacy as first-line therapy as compared to antiarrhythmic drugs (class I or III agents) during 12 months of follow-up 47,48. The primary efficacy outcome of the STOP-AF FIRST47 was defined as the freedom from efficacy failure, i.e, acute procedural failure, any subsequent AF surgery or ablation, atrial arrhythmias or cardioversion (and antiarrhythmic drug therapy in the ablation group) after the 90-day blanking period. It occurred in 75% of patients from the cryoballoon ablation group and in 45% of those from the antiarrhythmic drug therapy group47. Limitations of the study include arrhythmia assessment with intermittent electrocardiography monitoring, possibly inadequate drug dosing in the drug therapy arm (the drug failures were observed mostly among patients taking very low doses), and a 15% rate of crossover from drug therapy arm to the ablation group which counted as a component of the primary efficacy outcome47.On the other hand, EARLY-AF study was methodologically more sound, in that there was no crossover from the drug therapy to the ablation group, and there was continuous rhythm monitoring with an implantable loop recorder. As such, the results of EARLY-AF study48 may be more representative of the true benefits of catheter ablation: atrial tachyarrhythmia occurred in 43% of patients in the ablation group and in 68% of those from the antiarrhythmic drug therapy (HR: 0.48; 95% CI: 0.35-0.66). 11% of patients in the ablation arm had symptomatic post-ablation atrial tachyarrhythmia *vs.* 26.2% of those from the antiarrhythmic drug therapy (HR: 0.39; 95% CI: 0.22-0.68), and this was associated with better QOL improvements and lower incidence of hospitalization on follow up48.

The recently presented Cryo-FIRST Cryoballoon Ablation Trial (NCT01803438)49 among naïve patients with AF similarly showed a higher arrhythmia-free survival rate among patients after cryoballoon ablation as compared to the anti-arrhythmic drugs therapy group (82.2% *vs.* 67.6%) during 12 months of follow-up50. In addition, an improvement in the quality of life was observed in the catheter ablation group; and 86.5% of the these patients were symptom-free *vs.* 70.4% of patients in the anti-arrhythmic drug group51. Of note, the results of ATTEST trial52 support the notion of increased benefit with AF catheter ablation as compared to AAD therapy. The study assessed the AF progression among patients with paroxysmal AF, randomised to radiofrequency ablation or AAD treatment. At 3 years, the rate of persistent AF/atrial tachycardia was significantly lower in the ablation group compared with the AAD therapy group (2.4% vs 17.5%; P = 0.0009). It was found that patients aged ≥65 years were more likely to progress to persistent arrhythmia than those < 65 years (HR: 3.87; 95% CI: 0.88–17.00)52.

A recent European multicentre registry53 showed that cryoballoon ablation may be useful as a first-line option even for patients with persistent AF. At 24 months, the arrhythmia-free survival rate was 64% of patients with persistent AF and 57% of those with long-standing persistent AF. Repeat procedures were required in 20% of those with persistent AF and in 32% of subjects with long-standing persistent AF.

A study54 among 1241 patients showed that the time interval between AF diagnosis and ablation was associated with procedural outcomes. It found that the shorter diagnosis-to-ablation time of less than 1 year was related to a lower rate of AF recurrence, and a reduction in atrial remodelling biomarkers, i.e. B-type natriuretic peptide, C-reactive protein, and left atrial size as compared to those with the longer diagnosis-to-ablation time54. Thus, early ablation‐based rhythm control may prevent cardiac remodelling, thereby translating to physiological and symptomatic improvement, in particular among patients with AF and tachycardia-mediated cardiomyopathy55.

Given the significant upfront costs of catheter ablation, the cost-effectiveness of using it as first line therapy needs to be evaluated. A subanalysis56 of the MANTRA-PAF trial was performed to estimate the cost-effectiveness of radiofrequency catheter ablation for paroxysmal AF as first-line treatment, compared with antiarrhythmic drugs during the 2-year follow-up. Radiofrequency catheter ablation was found to be a cost-effective strategy in younger patients (€3434/ quality-adjusted life years [QALY] in ≤50-year-old patients *vs.* €108 937/QALY in >50-year-old patients)56. It should be noted that in the MANTRA-PAF trial, almost half the patients in the ablation arm required repeat procedures, whereas the corresponding figure in the recent cryoballoon trials was around 1 in 10. This, along with the much shorter procedure times with Cryoballoon as compared to radiofrequency ablation57, means that cost-effectiveness of cryoballoon PVI as first-line treatment can be expected to be even higher.

The use of an early rhythm control strategy may reduce AF-related adverse clinical outcomes among patients with recently diagnosed AF. For this purpose, catheter ablation as first-line treatment may be a safe and effective approach, with superior results compared to anti-arrhythmic drugs. However, the long-term impact on heart failure and mortality has not been studied; and prognostic implications of this strategy require further confirmation in RCTs and ‘real-world’ studies.

1. **Factors adversely affecting outcomes of catheter ablation**

Several scores, stratifying the risk of adverse outcomes or AF recurrence among patients undergoing AF catheter ablation, have been developed. (Table 4)3,58–60. The validity of these scores requires further confirmation in large cohort studies; and the use of biomarkers or cardiovascular imaging may improve their predictive value. Besides the evaluation of the predictors of AF recurrence, the personalised approach, including the patient’s preferences, should be adjusted3,61.

Left atrial volume was shown to be the most important independent predictor of AF recurrence post-ablation62. A pooled meta-analysis63 of 7217 patients who underwent AF ablation showed a 31.2 % AF recurrence rate during a follow up of 22 months. Patients with persistent AF had a greater risk of arrhythmia recurrence after the first ablation (OR 1.78; 99% CI: 1.14-2.77) than these with paroxysmal AF. In the overall population, the strongest predictors of AF ablation failure were an early (> 30-days) AF recurrence (OR: 4.30; 95% CI: 2.00-10.80), a left atrial diameter > 50mm (OR: 5.10; 95% CI: 2.00-12.90), and valvular AF (OR: 5.20; 95% CI: 2.22–9.50)63.

1. **Conclusions**

The management of AF should be individualised with a shared decision-making process in order to determine the optimal rhythm or rate control strategy to pursue. The benefit of anti-arrhythmic *drugs* compared to rate control options remains unproven. However, there is emerging evidence that catheter AF ablation may be more effective than rate control alone in improving the patients’ QOL, and clinical outcomes. As such, an early rhythm control strategy using catheter ablation may be a promising approach among patients with newly diagnosed paroxysmal AF when recommended as part of holistic care.

1. **Expert Opinion on the Future of AF Management**

Rhythm control involves AF ablation, cardioversion or long-term treatment with anti-arrhythmic drugs to maintain sinus rhythm; which should be recommended for symptom relief and to improve quality of life3.

Historically, acute peri-procedural complications occurred in 4.8-7.8% of patients undergoing AF ablation, including tamponade, stroke, or transient ischaemic attack, and death (<0.1%)25,64–66. During long-term follow-up, re-ablation was required in 20-50% of patients, 67,68. However, more recent studies have not only shown a much lower risk of major complications (<2%), but also a significantly lower need for repeat procedures (<20%)25,47,48. Also, a small subset of patients with persistent and long standing AF may benefit from a hybrid approach, integrating the strengths of both surgical and catheter ablation69,70. There are also limited data regarding AF ablation and left atrial appendage occlusion performed as a single procedure; to integrate the ‘cure’ for AF and prevent stroke complications, in order to avoid the risk associated with repeated procedures71–73.

Given the current evidence-base, rhythm control may be the preferred option among patients with AF and acute heart failure; and for unstable patients, an urgent cardioversion should be considered74. In this setting, all anti-arrhythmic agents apart from amiodarone, are contraindicated. Therefore, electrical cardioversion should be considered as it restores sinus rhythm faster and also more effectively than pharmacological cardioversion with amiodarone74. It is important that thromboembolic risk should be assessed and an OAC initiated prior to the procedure. In those at increased risk of stroke, the OAC should be continued life-long75. A study among 5625 patients with AF and acute heart failure showed that successful restoration of sinus rhythm was related to a significantly lower rate of all-cause mortality (HR: 0.68; 95% CI: 0.49-0.93), heart failure re-hospitalisation (HR: 0.66; 95% CI: 0.45-0.97) as compared to persistent AF, during 2.6 years of follow-up76. Notably, most patients with recent-onset AF will convert spontaneously within 48 hours, and a wait-and-see approach may be reasonable in stable patients75,77.

First and foremost, it is crucial to assess and treat comorbidities. A position paper on the prevention of AF78 highlighted that avoidable or modifiable risk factors are related to lifestyle choices, e.g. diet modification, quitting smoking and alcohol, regular physical activity. Hence, as clinicians, we should direct our focus toward specific at-risk groups such as adolescents who, paradoxically, are at increased cardiac risk due to the epidemics of obesity, inadequate nutrition, smoking and alcohol abuse78,79. Of note, obesity [and male gender] were independent predictors of failed cardioversion80, whereas weight-loss was related to maintenance of sinus rhythm81. Likewise, the RACE 382 was a RCT of 245 patients with early persistent AF and mild-to-moderate heart failure randomised to the targeted therapy of underlying conditions or conventional therapy. Both groups received standard treatment of AF and heart failure, and rhythm control therapy. At one year follow-up, the improvement in blood pressure, lipid profile, weight and heart failure was observed in the intervention group. Besides, sinus rhythm was present in 75% of patients with targeted therapy *vs.* 63% in the conventional group (odds ratio [OR]: 1.76; 95% CI: 1.02-3.05)82.

Likewise, impressive progress in the field of the electrophysiology has led to improvements of existing techniques and tools, and new ones are constantly emerging, increasing the efficacy and safety of catheter AF ablation83,84. Of note, the randomised trials (e.g. CIRCA-DOSE, FIRE and ICE) directly comparing cryoballoon vs radiofrequency ablation did not find one energy source superior to the other85,86. In addition, the point-by-point radiofrequency ablation developed significantly during last decade (introduction of contact force catheters, ablation indexes). It is expected that single-shot PVI ablation will enable quicker and more durable ablation lesion sets84,87. Moreover, the advances in electroanatomical mapping technologies have provided a better understanding of the triggers for AF, outside of the pulmonary veins88. With the integration of these AF mapping systems, specific targets for ablation may be identified, resulting in better AF control beyond PVI alone84,89. Lately, the most promising new technology in catheter AF ablation is pulsed-field ablation (PFA)90. This technique is used to create micropores at the cell membranes to ablate myocardium without tissue heating91. The IMPULSE (NCT03700385) and the PEFCAT (NCT03714178) were the first human trials on PFA, presenting excellent efficacy and safety data. PFA was reported to be an ‘ultrafast’ procedure with a 100% efficacy in terms of 3-month durability of PVI92. On top, early studies with electroporation show very promising high success rate and low complication rate. Thus, catheter ablation is a procedure that comprises different approaches, which are continuously evolving.

Complementary data on the identification and monitoring of AF can be seen in the use wearable technology and implantable loop recorders to detect and record AF episodes93–97. Indeed, smartwatches may be used for long-term AF screening in large populations, especially in high-risk patients. Early AF detection and implementation of proper therapy may reduce the risk of AF-related complications98. A recent study99 showed that patients with pre-ablation AF episodes lasting less than 24 hours (continuously) had a significantly lower incidence of arrhythmia recurrence following AF ablation compared to those with AF pre-ablation episodes of between two and seven days, and those with episodes for more than seven days (0% *vs*. 0.1% *vs*. 1.0%; respectively)99. Thus, wearable technology may be a useful tool to assess the burden of AF for risk stratification pre-ablation. Furthermore, it can be used to monitor for AF recurrences during long-term follow-up. Regular post-ablation follow-up is crucial to implement appropriate and effective rhythm control therapy, assess symptoms, and detect and optimise treatment of concomitant risk factors and comorbidities98,100–105. Overall, the wearable technology may assist in integrated care, optimising the holistic approach among patients with AF106.

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