***EDITORIAL***

***Atrial fibrillation diagnosed following stroke:***

***Dealing with a new clinical entity or just a matter of definition?***

Stephanie L Harrison1,2, Benjamin Buckley1,2, Riccardo Proietti1, Gregory Y. H. Lip1,2,3

1Liverpool Centre for Cardiovascular Science, University of Liverpool and Liverpool Heart & Chest Hospital, Liverpool, United Kingdom; 2Department of Cardiovascular and Metabolic Medicine, University of Liverpool, Liverpool, United Kingdom; 3Aalborg Thrombosis Research Unit, Department of Clinical Medicine, Aalborg University, Aalborg, Denmark

Short Title: Atrial fibrillation diagnosed following stroke

Word count: 1127

References: 16

Corresponding author:

Prof Gregory Y. H. Lip.   
Liverpool Centre for Cardiovascular Science,

University of Liverpool,

William Henry Duncan Building,

Liverpool, L7 8TX United Kingdom

[gregory.lip@liverpool.ac.uk](mailto:gregory.lip@liverpool.ac.uk)

Keywords: acute ischemic stroke, atrial fibrillation, atrial flutter, risk factors for stroke, risk stratification

**Text**

Detection of atrial fibrillation (AF) is critical to ensure an appropriate management plan is initiated, which may include the use of oral anticoagulants (OACs) to reduce the risk of stroke and mortality. OACs are usually indicated for individuals with AF and one or more additional stroke risk factor for example, in clinical risk scores, such as the CHA2DS2-VASc. Of note, type of AF (paroxysmal, persistent, permanent) or burden of arrhythmia has not established sufficient clinical evidence to be included in the indication for OAC, especially since we are dealing with a dynamic arrhythmia where the number of paroxysms and burden change over time.

Clinically, AF can also be differentiated into symptomatic or asymptomatic forms; of which the latter often remains undetected. Observational evidence suggests that the risk of stroke with asymptomatic AF is not significantly less than the risk with symptomatic AF [1]. Similarly, observational evidence also suggests that the risks of stroke and mortality in individuals with asymptomatic AF may be significantly reduced with the use of OACs [2]. OACs have even been shown to reduce the risk of stroke in patients with single time-point electrocardiogram (ECG) screen-detected AF, using handheld single-lead ECGs [3].

The bottom line is that AF detection is improved if we *“look longer, look harder and look with more sophisticated methods...”.* Advances in technologies to support opportunistic screening for AF include the use of photoplethysmographic (PPG) technologies. PPG signals are used in many smart watches and the use of automated algorithms have the potential to detect suspected AF, which could have benefits such as widespread opportunistic AF screening at relatively low-cost [4,5]. The applicability of the use of smartwear technologies to detect suspected AF for people following a stroke is currently unknown.

For patients with embolic stroke of undetermined source (ESUS), the use of implantable loop recorders may be beneficial to detect AF; however, randomised controlled trials have not shown a benefit of OACs in all patients with ESUS compared to the use of antiplatelets, and have also suggested a higher rate of bleeding with OACs [6]. This highlights the need to identify if certain ESUS patients may benefit from OACs, specifically those with undetected AF. In a study of 123 patients with ESUS, continuous cardiac monitoring with an implantable loop recorder detected AF in 24% of patients at ~1-year, and 41% over a 3-year period [7,8]. It remains unclear, however, if there is a benefit of OACs compared to antiplatelets for stroke risk reduction in patients with ESUS and asymptomatic AF detected with implantable loop recorders.

The European Society of Cardiology (ESC) guidelines for the management of AF recommend short-term ECG recording followed by continuous ECG monitoring for at least 72 hours for all patients after an ischaemic stroke or transient ischaemic attack (TIA) [9]. Determining if there are clinical differences between patients with AF detected after stroke (AFDAS) and AF known before stroke (KAF) could have important implications for patient management.

In the latest issue of *Cerebrovascular Diseases*, Fridman et al., performed a systematic review to synthesise evidence comparing the characteristics and outcomes of AFDAS and KAF [10]. The authors screened over 33,000 articles to identify 21 studies (14 cross-sectional studies, 6 cohort studies and one case-control study). The results of meta-analyses demonstrated the prevalence of co-morbidities (hypertension, dyslipidaemia, coronary artery disease, prior myocardial infarction, congestive heart failure, peripheral artery disease and previous stroke or TIA) were significantly lower in patients with AFDAS compared to KAF. Patients with AFDAS also had lower CHA2DS2-VASc scores, smaller mean left atrial diameter, larger left ventricular ejection fraction, and lower odds of recurrent stroke (odds ratio (OR) 0.74 [95% confidence interval 0.58-0.95]; 3 studies; I2=0%), compared to patients with KAF. It is also interesting to consider whether AFDAS is an early phase of KAF, that is diagnosed due to more intense cardiac monitoring, or AF that is caused by stroke through neurogenic mechanisms, and whether this disparity in mechanism has any impact on treatment outcomes. Future research is needed to answer such questions.

The observational nature of the evidence should be considered when interpreting the findings particularly with regard to the potential for residual confounding factors. As many of the studies were cross-sectional or retrospective cohort studies, and only three studies were identified to compare stroke recurrence in AFDAS and KAF, further evidence from prospective longitudinal cohort studies is warranted.

It is unknown whether the efficacy of OAC therapy to reduce recurrent stroke risk differs by whether patients have KAF or AFDAS. Randomised controlled trials for patients with AFDAS to receive OACs or antiplatelets could be considered for asymptomatic patients, but this may not be ethical given the known benefits of OACs in patients with AF to reduce risk of stroke. Current guidance does not distinguish between AFDAS and KAF in how treatment should be approached for patients following stroke. As all patients with AF following stroke would have a CHA2DS2-VASc score of ≥2, OAC therapy would be indicated in the majority, irrespective of whether AF was known before or detected after stroke. This should be conducted as part of an integrated care or holistic management pathway such as the Atrial Fibrillation Better Care (ABC) pathway to: (A) Avoid stroke with oral anticoagulants; (B) Better symptom management and (C) Cardiovascular and other co-morbidities risk reduction [11], given that adherence with the ABC pathway has been clearly associated with an improvement in clinical outcomes[12,13].

Identification of AF is important, not only to initiate OACs to reduce stroke and mortality risks, but initiation of OACs may also reduce risk of dementia for people with AF independent of the risk of stroke. One observational study of over 15,000 individuals with AF suggested OACs were associated with a lower risk of incident dementia even after censoring incident stroke and TIA [14]. In a registry study of almost 10,000 patients with first-ever ischaemic stroke aged ≥65 years, AFDAS and KAF were also associated with higher risk of dementia compared to patients with no AF [15]. Furthermore, the use of OACs was associated with lower risk of dementia among patients with AFDAS.

In conclusion, increasing evidence demonstrates that the use of OACs are beneficial to reduce risk of stroke for patients with asymptomatic AF. There appears to be some differences in the clinical characteristics of patients with AFDAS and KAF. Perhaps in the future there will be sufficient evidence to inform more granular anticoagulation guidelines dependent on patient characteristics and AF subtype. Until then, there is insufficient evidence to warrant that these two groups of patients with AF should be managed differently. Advancements in technologies may assist with improving the detection of AF following stroke, and methods of AF detection should be optimised in order to initiate appropriate management pathways following stroke, ideally in an integrated or holistic manner [16].

**Statements**

**Conflict of Interest Statement**

SLH: received funding from Bristol Myers Squibb (BMS) outside of the submitted work. BJRB: received funding from BMS/Pfizer outside of the submitted work. GYHL: consultant for Bayer/Janssen, BMS/Pfizer, Medtronic, Boehringer Ingelheim, Novartis, Verseon and Daiichi-Sankyo and speaker for Bayer, BMS/Pfizer, Medtronic, Boehringer Ingelheim, and Daiichi-Sankyo. No fees are directly received to GYHL personally. RP: no conflicts of interest to declare.

**Funding Sources**

None

**Author Contributions**

All authors contributed to the drafting and critical revisions of the manuscript.

**References**

1 Wallenhorst C, Martinez C, Freedman B: Risk of Ischemic Stroke in Asymptomatic Atrial Fibrillation Incidentally Detected in Primary Care Compared with Other Clinical Presentations. Thromb Haemost 2021

2 Martinez C, Katholing A, Freedman SB: Adverse prognosis of incidentally detected ambulatory atrial fibrillation. A cohort study. Thromb Haemost 2014;112:276-286.

3 Sun W, Freedman B, Martinez C, Wallenhorst C, Yan BP: Atrial Fibrillation Detected by Single Time-Point Handheld Electrocardiogram Screening and the Risk of Ischemic Stroke. Thromb Haemost 2021

4 Perez MV, Mahaffey KW, Hedlin H, Rumsfeld JS, Garcia A, Ferris T, Balasubramanian V, Russo AM, Rajmane A, Cheung L, Hung G, Lee J, Kowey P, Talati N, Nag D, Gummidipundi SE, Beatty A, Hills MT, Desai S, Granger CB, Desai M, Turakhia MP: Large-Scale Assessment of a Smartwatch to Identify Atrial Fibrillation. New England Journal of Medicine 2019;381:1909-1917.

5 Guo Y, Wang H, Zhang H, Liu T, Liang Z, Xia Y, Yan L, Xing Y, Shi H, Li S, Liu Y, Liu F, Feng M, Chen Y, Lip GYH: Mobile Photoplethysmographic Technology to Detect Atrial Fibrillation. J Am Coll Cardiol 2019;74:2365-2375.

6 Hart RG, Sharma M, Mundl H, Kasner SE, Bangdiwala SI, Berkowitz SD, Swaminathan B, Lavados P, Wang Y, Wang Y, Davalos A, Shamalov N, Mikulik R, Cunha L, Lindgren A, Arauz A, Lang W, Czlonkowska A, Eckstein J, Gagliardi RJ, Amarenco P, Ameriso SF, Tatlisumak T, Veltkamp R, Hankey GJ, Toni D, Bereczki D, Uchiyama S, Ntaios G, Yoon BW, Brouns R, Endres M, Muir KW, Bornstein N, Ozturk S, O'Donnell MJ, De Vries Basson MM, Pare G, Pater C, Kirsch B, Sheridan P, Peters G, Weitz JI, Peacock WF, Shoamanesh A, Benavente OR, Joyner C, Themeles E, Connolly SJ: Rivaroxaban for Stroke Prevention after Embolic Stroke of Undetermined Source. N Engl J Med 2018;378:2191-2201.

7 Kitsiou A, Rogalewski A, Kalyani M, Deelawar S, Tribunyan S, Greeve I, Minnerup J, Israel C, Schäbitz WR: Atrial Fibrillation in Patients with Embolic Stroke of Undetermined Source during 3 Years of Prolonged Monitoring with an Implantable Loop Recorder. Thromb Haemost 2021;121:826-833.

8 Israel C, Kitsiou A, Kalyani M, Deelawar S, Ejangue LE, Rogalewski A, Hagemeister C, Minnerup J, Schäbitz WR: Detection of atrial fibrillation in patients with embolic stroke of undetermined source by prolonged monitoring with implantable loop recorders. Thromb Haemost 2017;117:1962-1969.

9 Hindricks G, Potpara T, Dagres N, Arbelo E, Bax JJ, Blomström-Lundqvist C, Boriani G, Castella M, Dan GA, Dilaveris PE, Fauchier L, Filippatos G, Kalman JM, La Meir M, Lane DA, Lebeau JP, Lettino M, Lip GYH, Pinto FJ, Thomas GN, Valgimigli M, Van Gelder IC, Van Putte BP, Watkins CL: 2020 ESC Guidelines for the diagnosis and management of atrial fibrillation developed in collaboration with the European Association for Cardio-Thoracic Surgery (EACTS): The Task Force for the diagnosis and management of atrial fibrillation of the European Society of Cardiology (ESC) Developed with the special contribution of the European Heart Rhythm Association (EHRA) of the ESC. Eur Heart J 2021;42:373-498.

10 Fridman S, Jimenez-Ruiz A, Vargas-Gonzalez JC, Sposato LA: Differences between Atrial Fibrillation detected before and after Stroke and TIA: A Systematic Review & Meta-Analysis Cerebrovascular Diseases 2021

11 Lip GYH: The ABC pathway: an integrated approach to improve AF management. Nature Reviews Cardiology 2017;14:627-628.

12 Yoon M, Yang PS, Jang E, Yu HT, Kim TH, Uhm JS, Kim JY, Sung JH, Pak HN, Lee MH, Joung B, Lip GYH: Improved Population-Based Clinical Outcomes of Patients with Atrial Fibrillation by Compliance with the Simple ABC (Atrial Fibrillation Better Care) Pathway for Integrated Care Management: A Nationwide Cohort Study. Thrombosis and haemostasis 2019;119:1695-1703.

13 Romiti GF, Pastori D, Rivera-Caravaca JM, Ding WY, Gue YX, Menichelli D, Gumprecht J, Koziel M, Yang PS, Guo Y, Lip GY, Proietti M: Adherence to the 'Atrial Fibrillation Better Care' (ABC) Pathway in Patients with Atrial Fibrillation. Thrombosis and haemostasis 2021

14 Field TS, Weijs B, Curcio A, Giustozzi M, Sudikas S, Katholing A, Wallenhorst C, Weitz JI, Cohen AT, Martinez C: Incident Atrial Fibrillation, Dementia and the Role of Anticoagulation: A Population-Based Cohort Study. Thromb Haemost 2019;119:981-991.

15 Krawczyk M, Fridman S, Cheng Y, Fang J, Saposnik G, Sposato LA: Atrial fibrillation diagnosed after stroke and dementia risk: cohort study of first-ever ischaemic stroke patients aged 65 or older. Europace 2019;21:1793-1801.

16 Lip GY, Ntaios G: Integrated Care for Stroke Management: Easy as ABC. Thrombosis and haemostasis 2021