



6 Congrès des SAMU.URGENCES DES OUTRE-MER

UFR SANTÉ // SAINT-PIERRE - LA RÉUNION

19-20-21 NOVEMBRE 2025



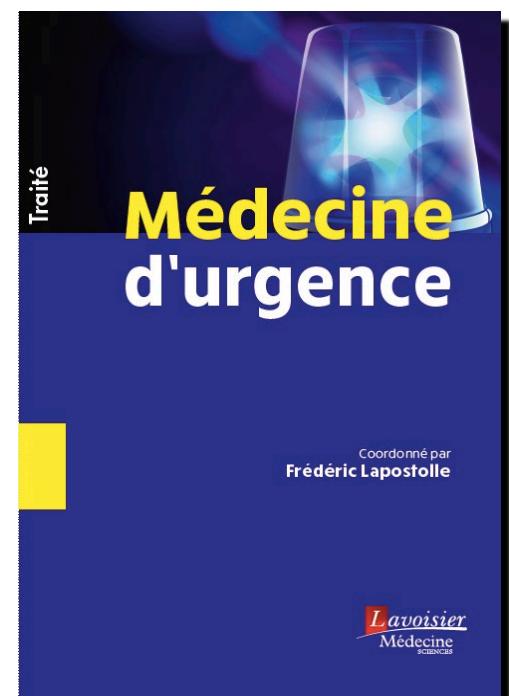
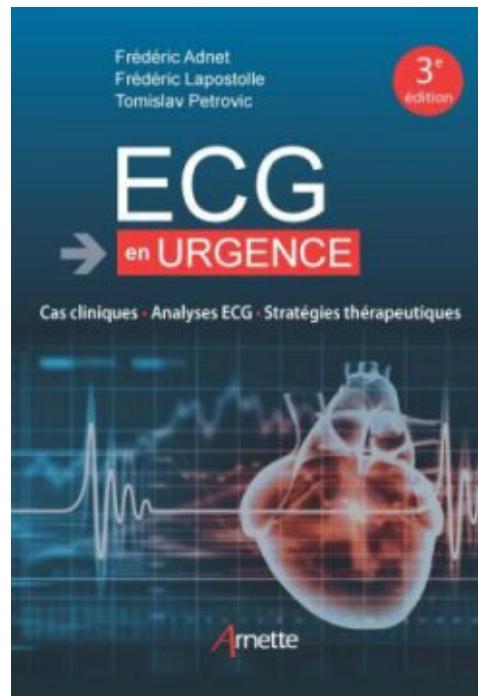


6 Congrès des SAMU.URGENCES DES OUTRE-MER

Fibrillation atriale
A-t-on toujours besoin du cardiologue ?

Disclosures

Partenariat recherche : Mundipharma, Serb, Teleflex



URGENCES

PORTE COUPE-FEU
NE METTEZ PAS D'INTENSITE
A LA FAUCETTE

 URGENCES
ENTREE
STRICTEMENT RESERVEE
POUR LES PATIENTS
DES URGENCES

ACCUEIL



NE PAS
TOUCHER

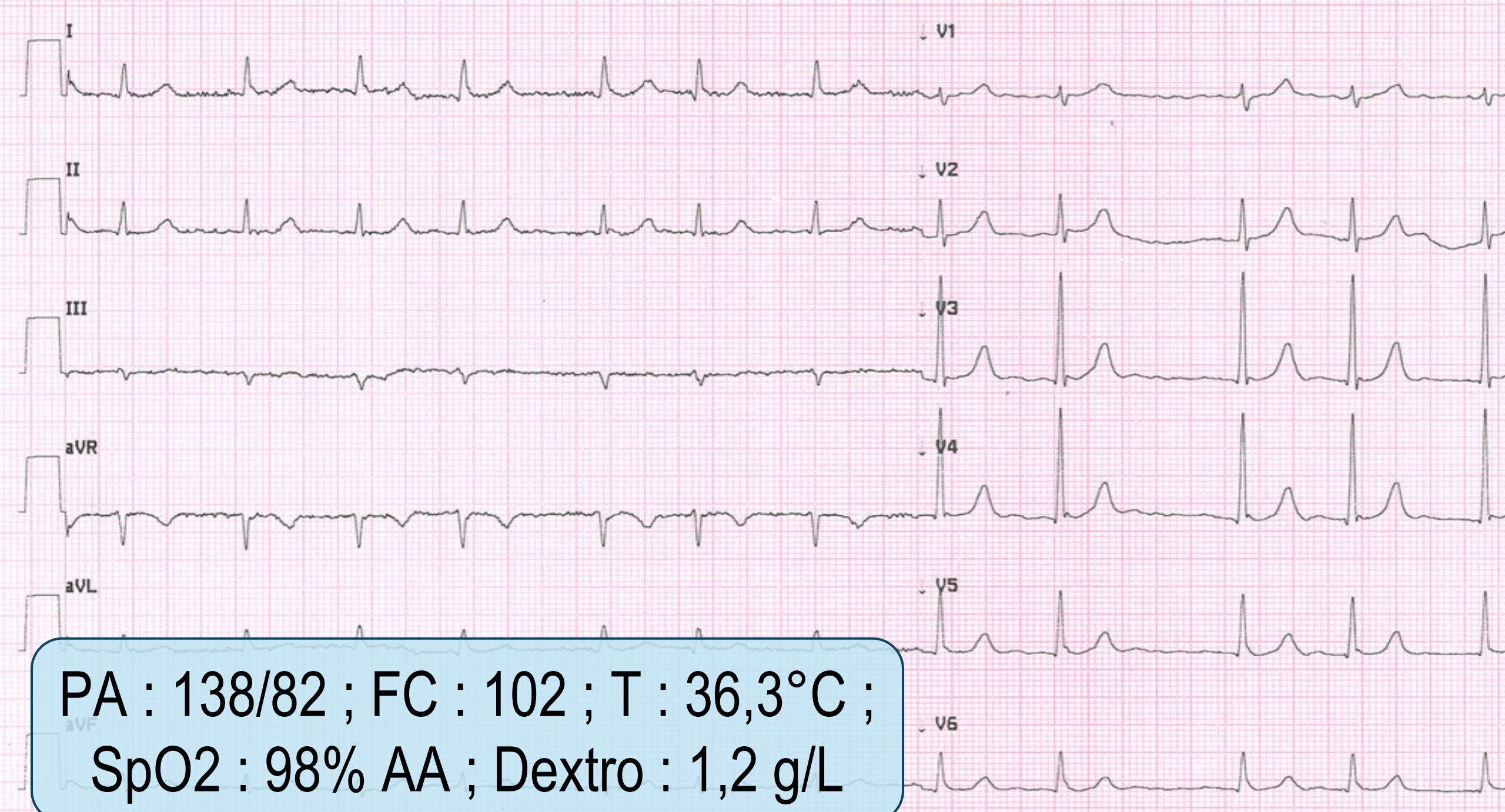


65 ans – HTA, UGD

Consultation samedi matin :
palpitations, malaise, faiblesse générale

*« Il a pris une cuite la veille,
comme tous les week-ends »*

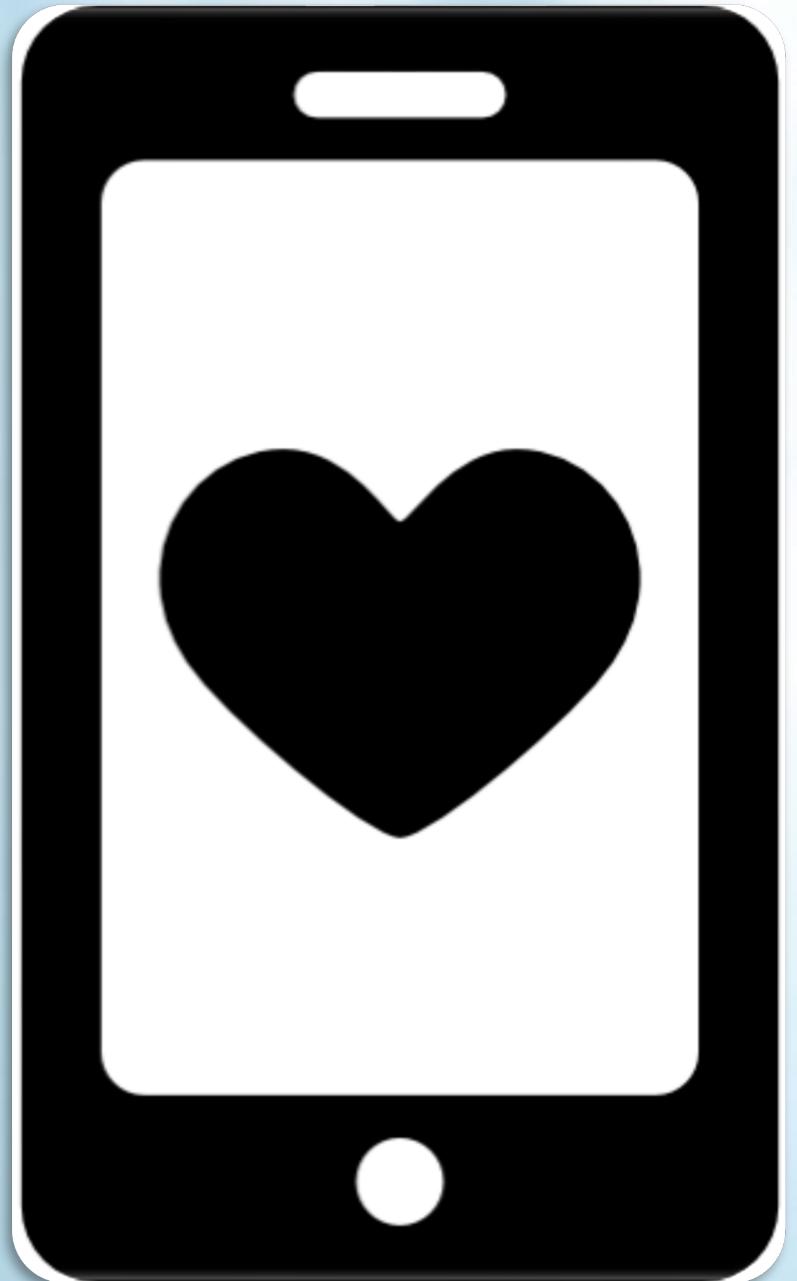


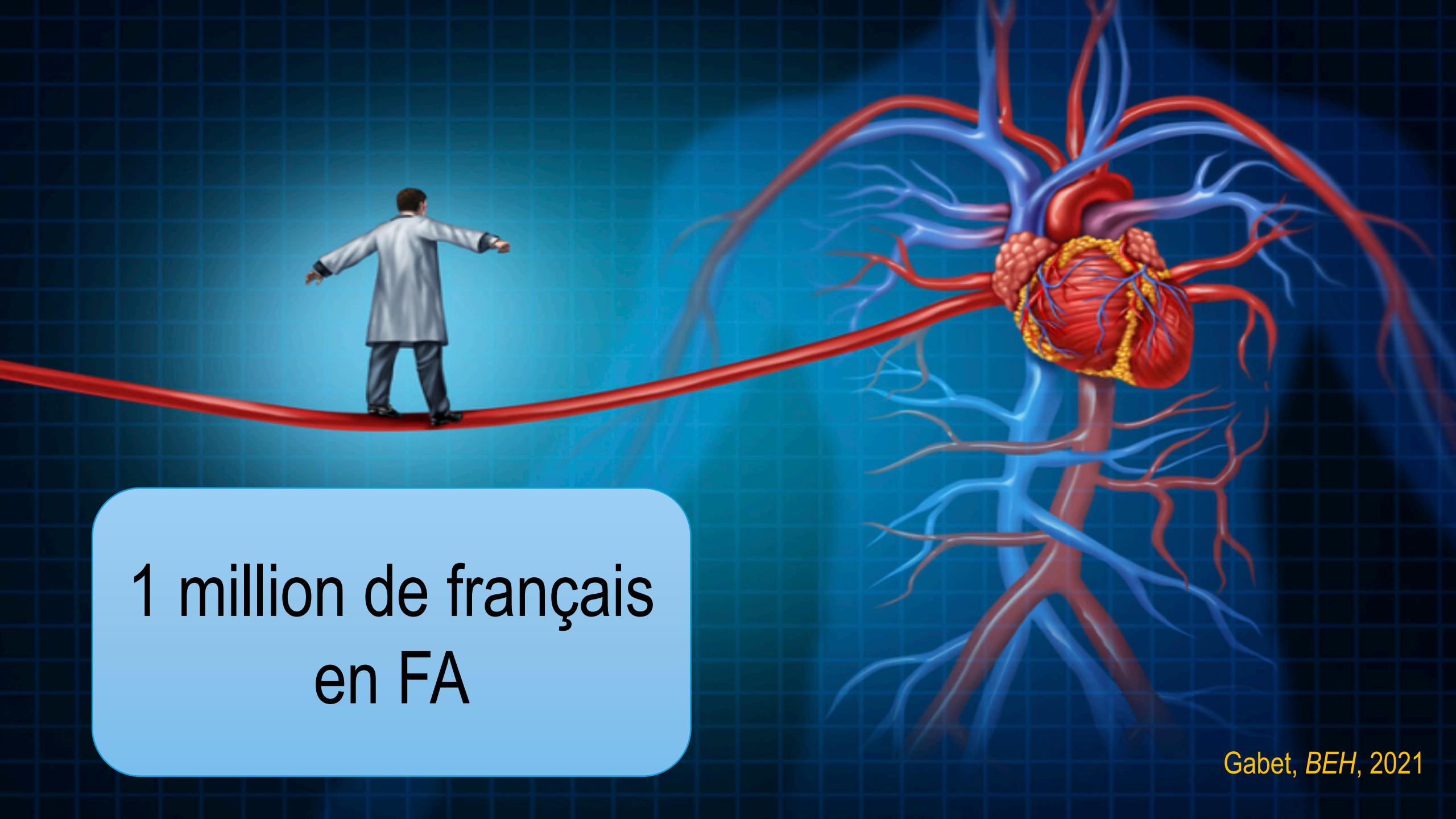


Est-ce que qu'appeler le cardiologue est réaliste ?

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*« Il a pris une cuite la veille,
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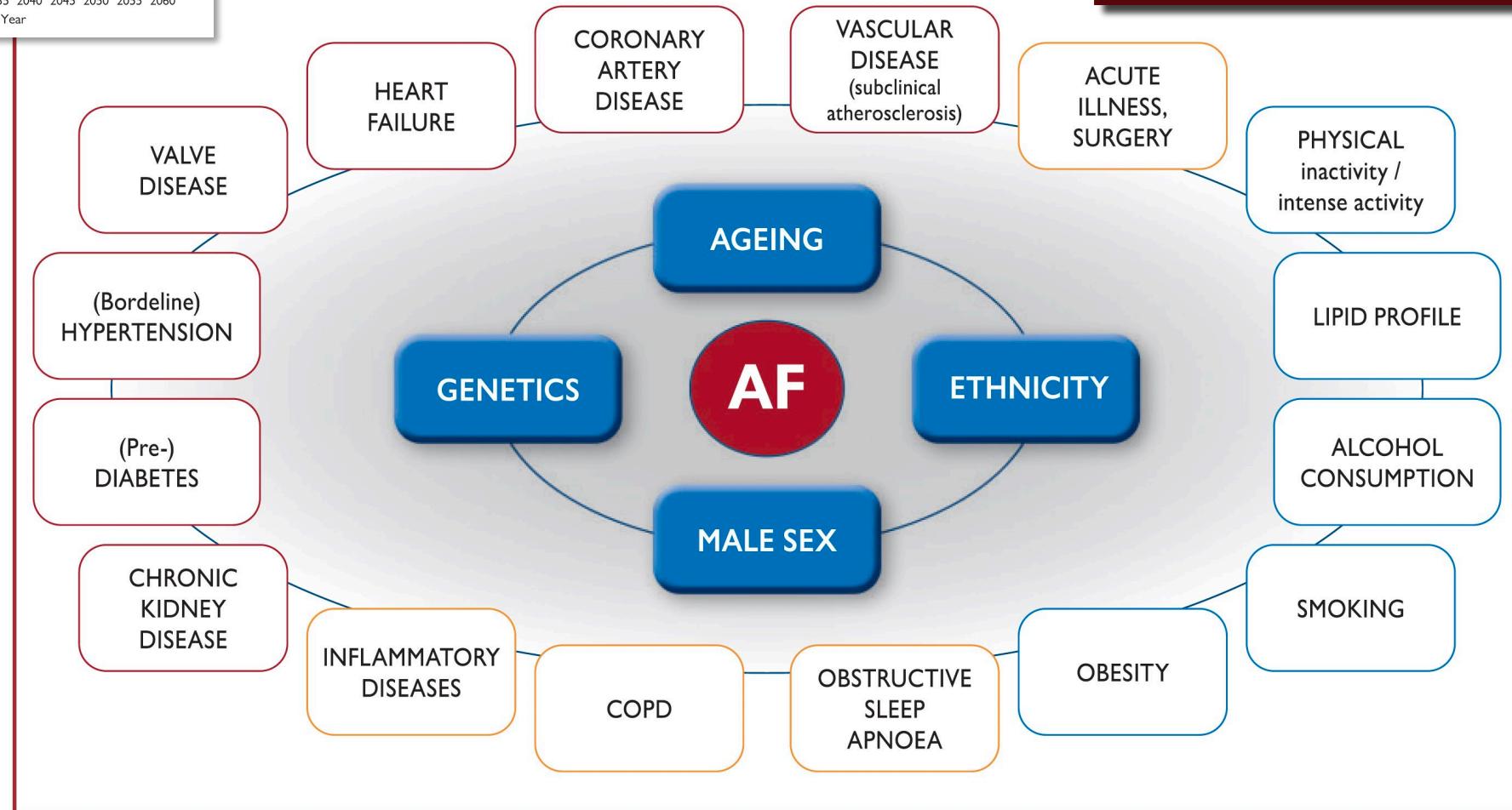
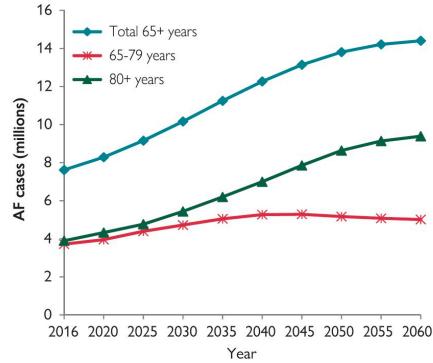






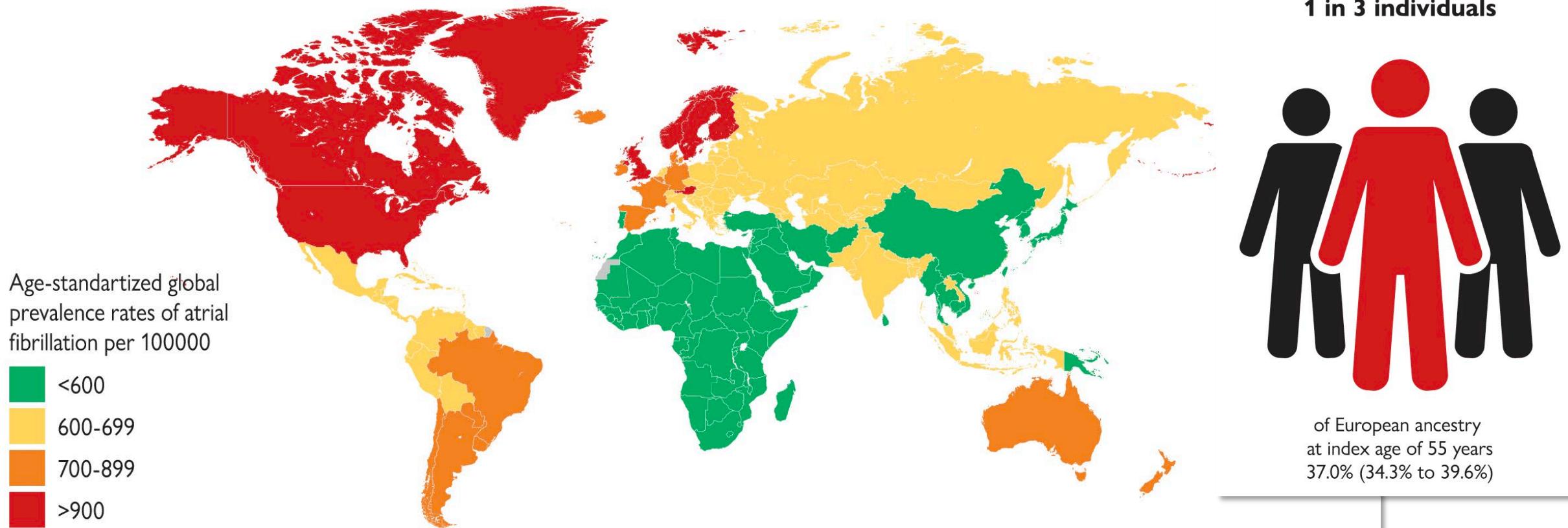
1 million de français
en FA

**Projected increase in AF prevalence
among elderly in EU 2016-2060**



GLOBAL PREVALENCE OF AF

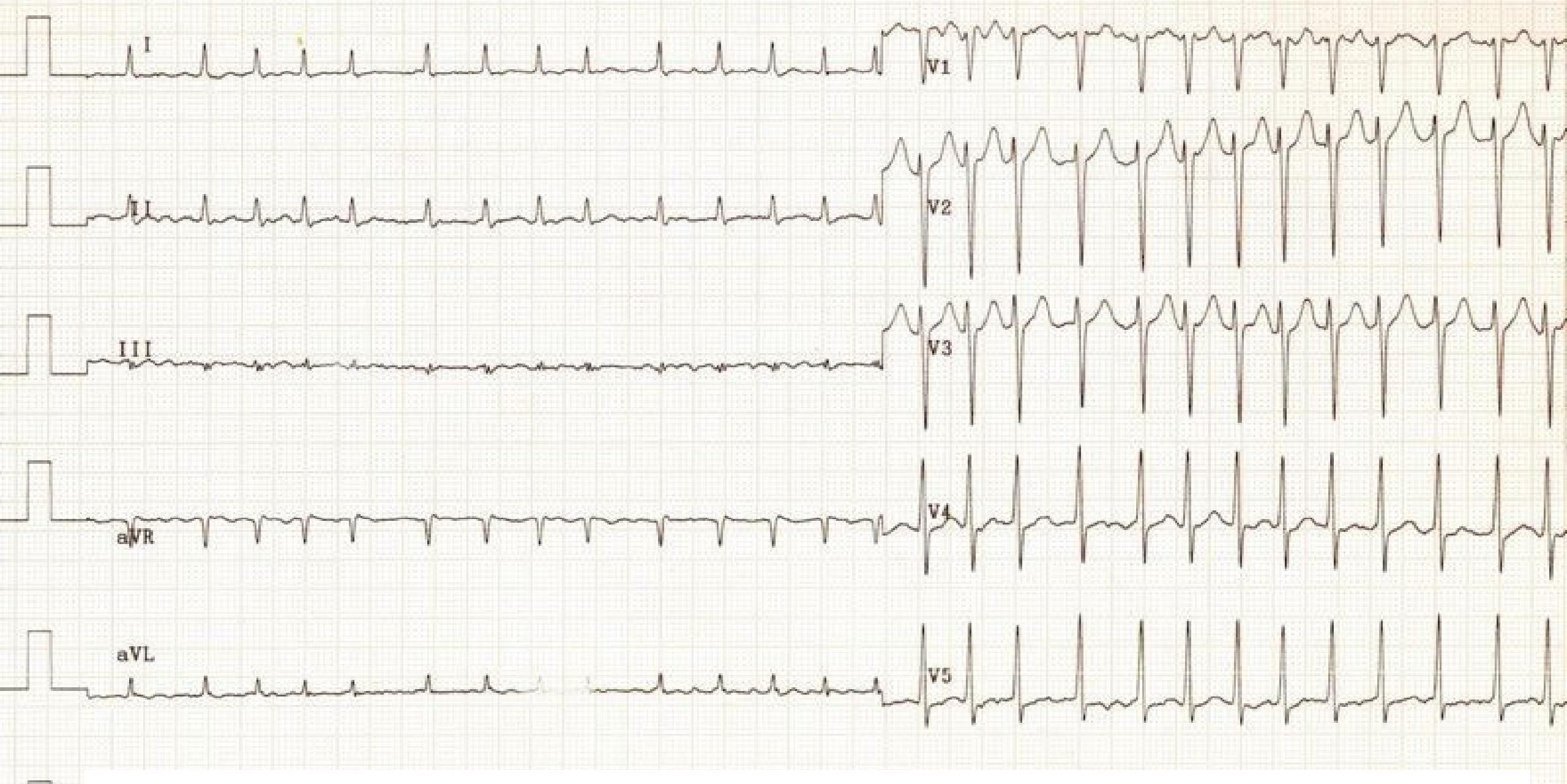
(globally, 43.6 million individuals had prevalent AF/AFL in 2016)



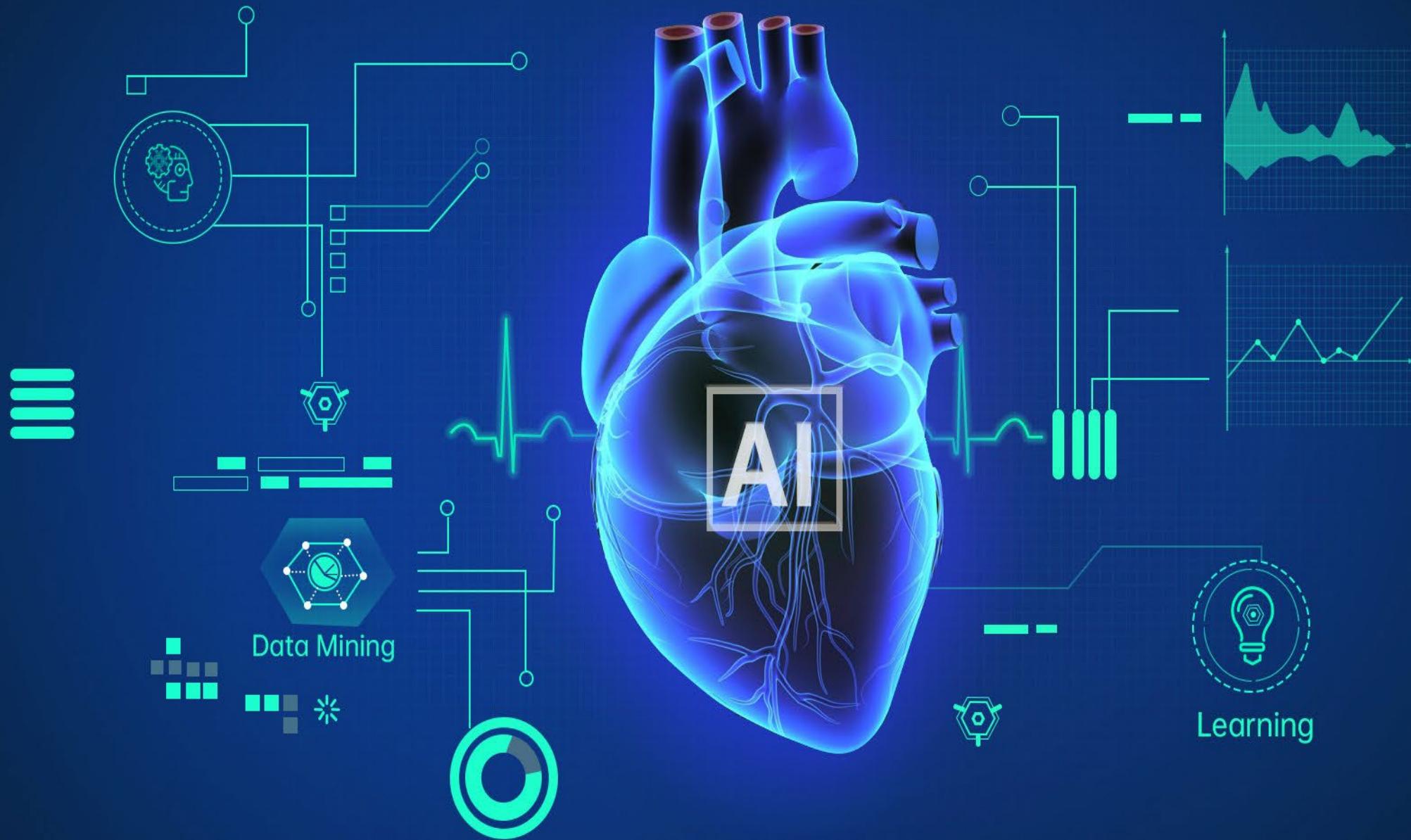


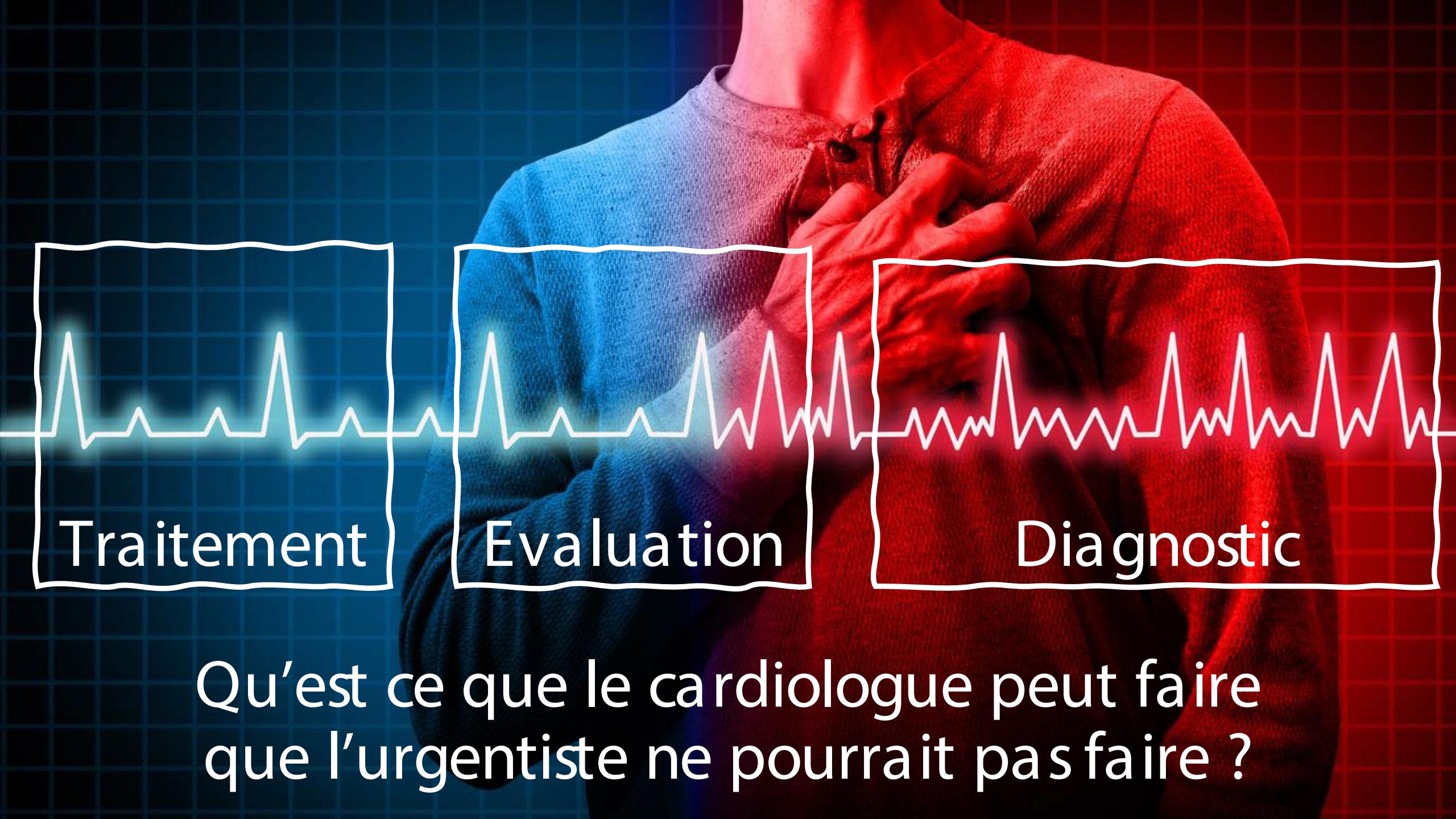
F k i pqu'e

Qu'est ce que le cardiologue peut faire
que l'urgentiste ne pourrait pas faire ?



Tachycardie irrégulière à QRS (le plus souvent) fins





Traitement

Evaluation

Diagnostic

Qu'est ce que le cardiologue peut faire
que l'urgentiste ne pourrait pas faire ?



ESC

European Society
of Cardiology

European Heart Journal (2024) **00**, 1–101

<https://doi.org/10.1093/eurheartj/ehae176>

ESC GUIDELINES

2024 ESC Guidelines for the management of atrial fibrillation developed in collaboration with the European Association for Cardio-Thoracic Surgery (EACTS)

EJ C₄F U₄/XCUe

EJ C₄F U₄/XC

A

Avoid stroke and thromboembolism

Risk of thrombo-embolism

Use locally-validated risk score or CHA₂DS₂-VA

Start oral anticoagulation (Class I)

Temporal pattern of AF not relevant (Class III)

Antiplatelet therapy not an alternative (Class III)

OAC if CHA₂DS₂-VA score = 2 or more (Class I)

OAC if CHA₂DS₂-VA score = 1 (Class IIa)

Choice of anticoagulant

Use DOAC, except mechanical valve or mitral stenosis (Class I)

If VKA:
Target INR 2.0–3.0; (Class I)
>70% INR range; (Class IIa)
or switch to DOAC (Class I)

Assess bleeding risk

Assess and manage all modifiable risk factors for bleeding (Class I)

Do not use risk scores to withhold anticoagulation (Class III)

Prevent bleeding

Do not combine antiplatelets and OAC for stroke prevention (Class III)

Avoid antiplatelets beyond 12 months in OAC treated CCS/PVD (Class III)

Ue"ugzg"ec vgi qt{



Step 2

Consider stroke prevention (ie. OAC) in all AF patients with $\text{CHA}_2\text{DS}_2\text{-VASc} \geq 1$ (male) or ≥ 2 (female)

Address modifiable bleeding risk factors in all AF patients.

Calculate the HAS-BLED score.

If HAS-BLED ≥ 3 , address the modifiable bleeding risk factors and 'flag up' patient for regular review and follow-up.

High bleeding risk scores should not be used as a reason to withhold OAC.

CHA₂DS₂-VASc

=1 (male) or =2 (female)



OAC should be considered
(Class IIa)

≥ 2 (male) or ≥ 3 (female)



OAC is recommended
(Class IA)

Step 3 Begin NOAC (or VKA with high time in therapeutic range^a)

NOACs generally recommended as first line therapy for OAC

Femme=1

CHADS2 – VASc Score		
C	Congestive Heart Failure	1
H	Hypertension ($>140/90$ mmHg)	1
A	Age ≥ 75	2
D	Diabetes Mellitus	1
S₂	Prior TIA or stroke	2
V	Vascular disease (MI, aortic plaque etc)	1
A	Age 65-74	1
Sc	Sex category (Female = 1 pt)	1

2020 ESC Guidelines for the diagnosis and management of atrial fibrillation developed in collaboration with the European Association of Cardio-Thoracic Surgery (EACTS)



2024 ESC Guidelines for the management of atrial fibrillation developed in collaboration with the European Association for Cardio-Thoracic Surgery (EACTS)

Recommendations in 2020 version	Class ^a	Level ^b	Recommendations in 2024 version	Class ^a	Level ^b
<p>Section 6.7—Bleeding risk</p> <p>For a formal risk-score-based assessment of bleeding risk, the HAS-BLED score should be considered to help address modifiable bleeding risk factors, and to identify patients at high risk of bleeding (HAS-BLED score ≥ 3) for early and more frequent clinical review and follow-up.</p>	IIa	B	<p>Assessment and management of modifiable bleeding risk factors is recommended in all patients eligible for oral anticoagulation, as part of shared decision-making to ensure safety and prevent bleeding.</p>	I	B

Step 2

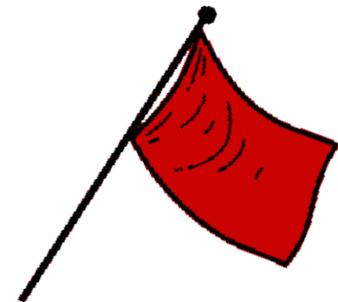
Consider stroke prevention (ie. OAC) in all AF patients with CHA₂DS₂-VASc ≥ 1 (male) or ≥ 2 (female)

Address modifiable bleeding risk factors in all AF patients.

Calculate the HAS-BLED score.

If HAS-BLED ≥ 3 , address the modifiable bleeding risk factors and 'flag up' patient for regular review and follow-up.

High bleeding risk scores should not be used as a reason to withhold OAC.



CHA₂DS₂-VASc

=1 (male) or =2 (female)

≥ 2 (male) or ≥ 3 (female)

OAC should be considered
(Class IIa)

OAC is recommended
(Class IA)

Step 3 Begin NOAC (or VKA with high time in therapeutic range^a)
NOACs generally recommended as first line therapy for OAC



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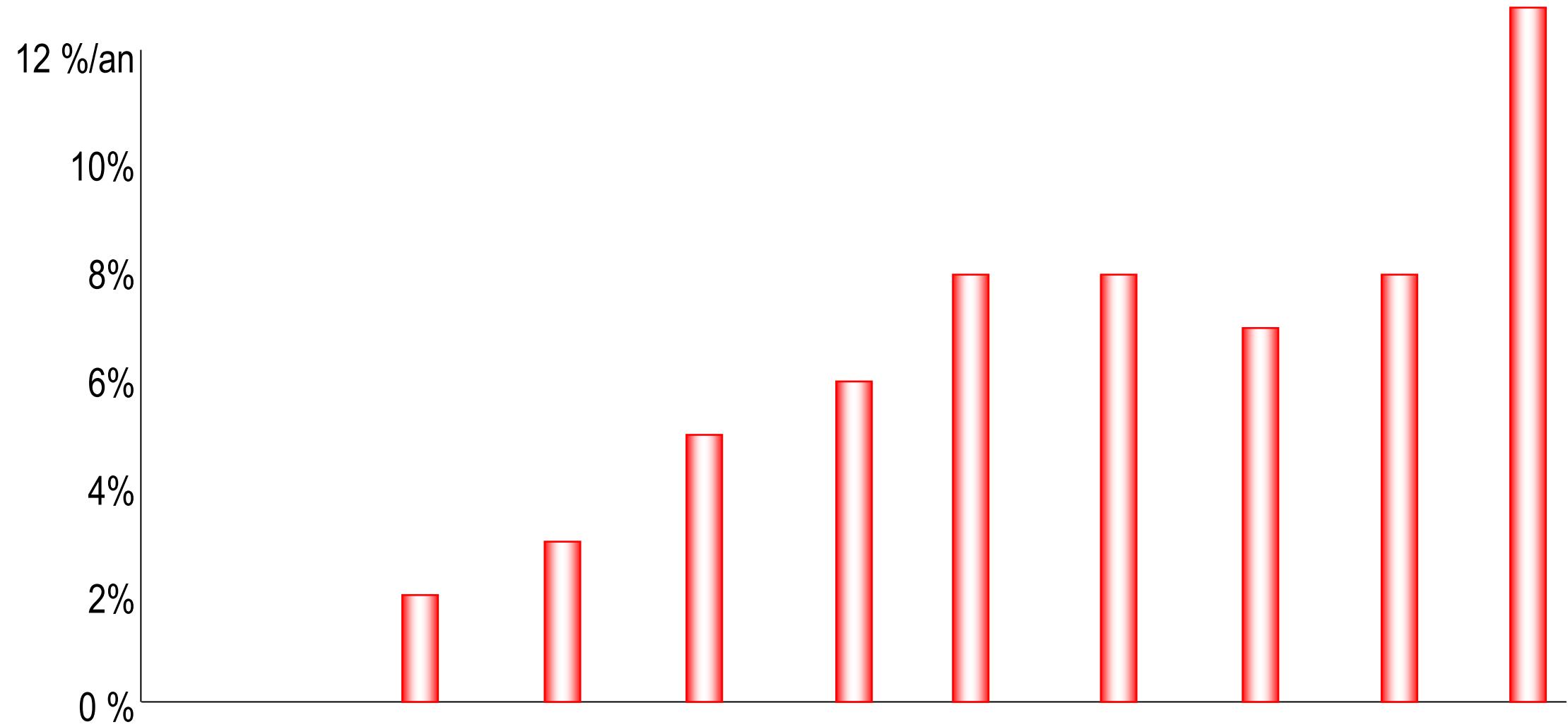
CHA₂DS₂-VASc	Score	HAS-BLED	Score
<u>Congestive heart failure/LV dysfunction</u>	1	Hypertension i.e. uncontrolled BP	1
<u>Hypertension</u>	1	Abnormal renal/liver function	1 or 2
<u>Aged ≥75 years</u>	2	Stroke	1
<u>Diabetes mellitus</u>	1	Bleeding tendency or predisposition	1
<u>Stroke/TIA/TE</u>	2	Labile INR	1
<u>Vascular disease [prior MI, PAD, or aortic plaque]</u>	1	Age (e.g. >65)	1
<u>Aged 65-74 years</u>	1	Drugs (e.g. concomitant aspirin or NSAIDSS) or alcohol	1
<u>Sex category [i.e. female gender]</u>	1		
Maximum score	9		9

2

3

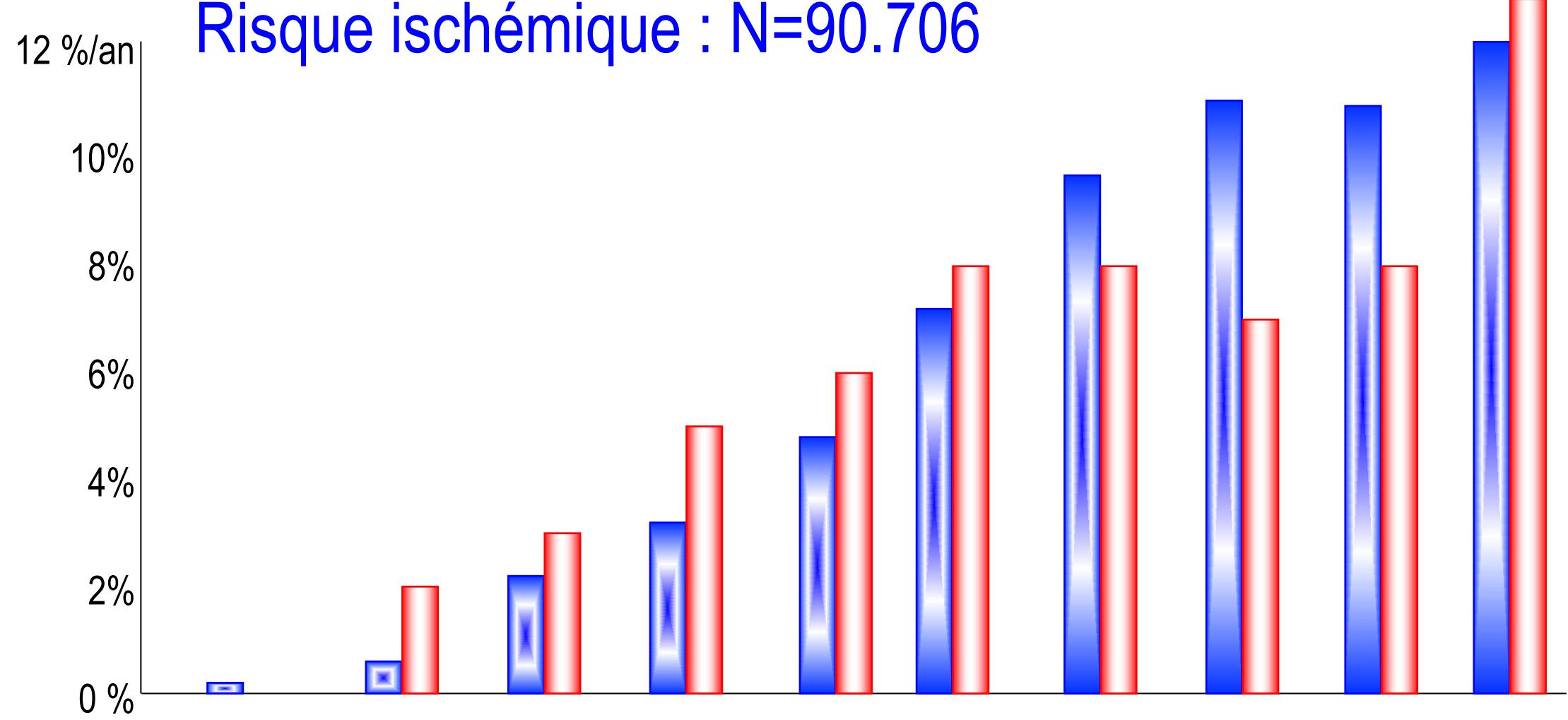


Risque hémorragique : N=68.306

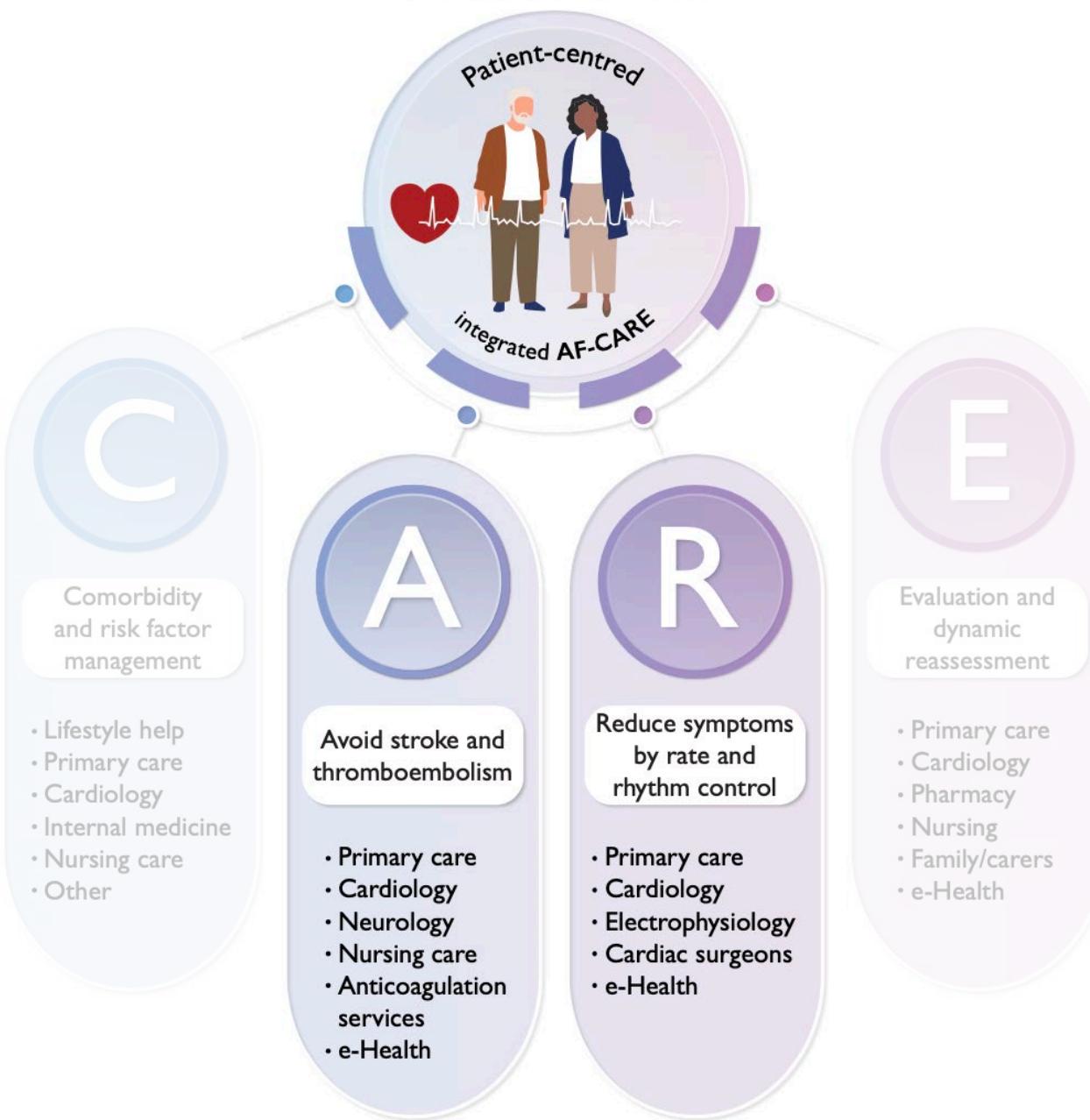


Risque hémorragique : N=68.306

Risque ischémique : N=90.706



Atrial fibrillation



REGULATIONS



RULES



STANDARDS



POLICIES



LAW



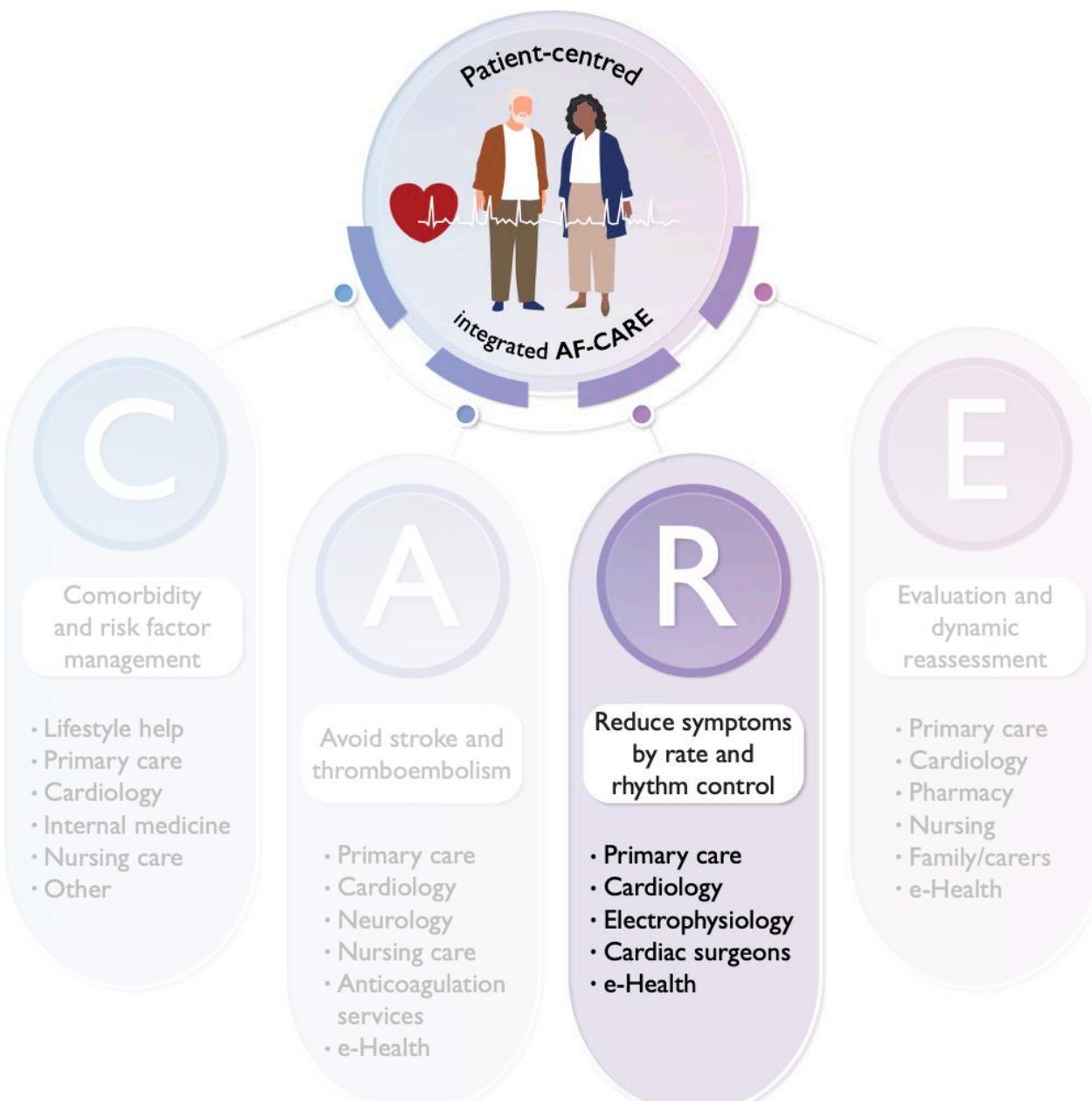
REQUIREMENTS



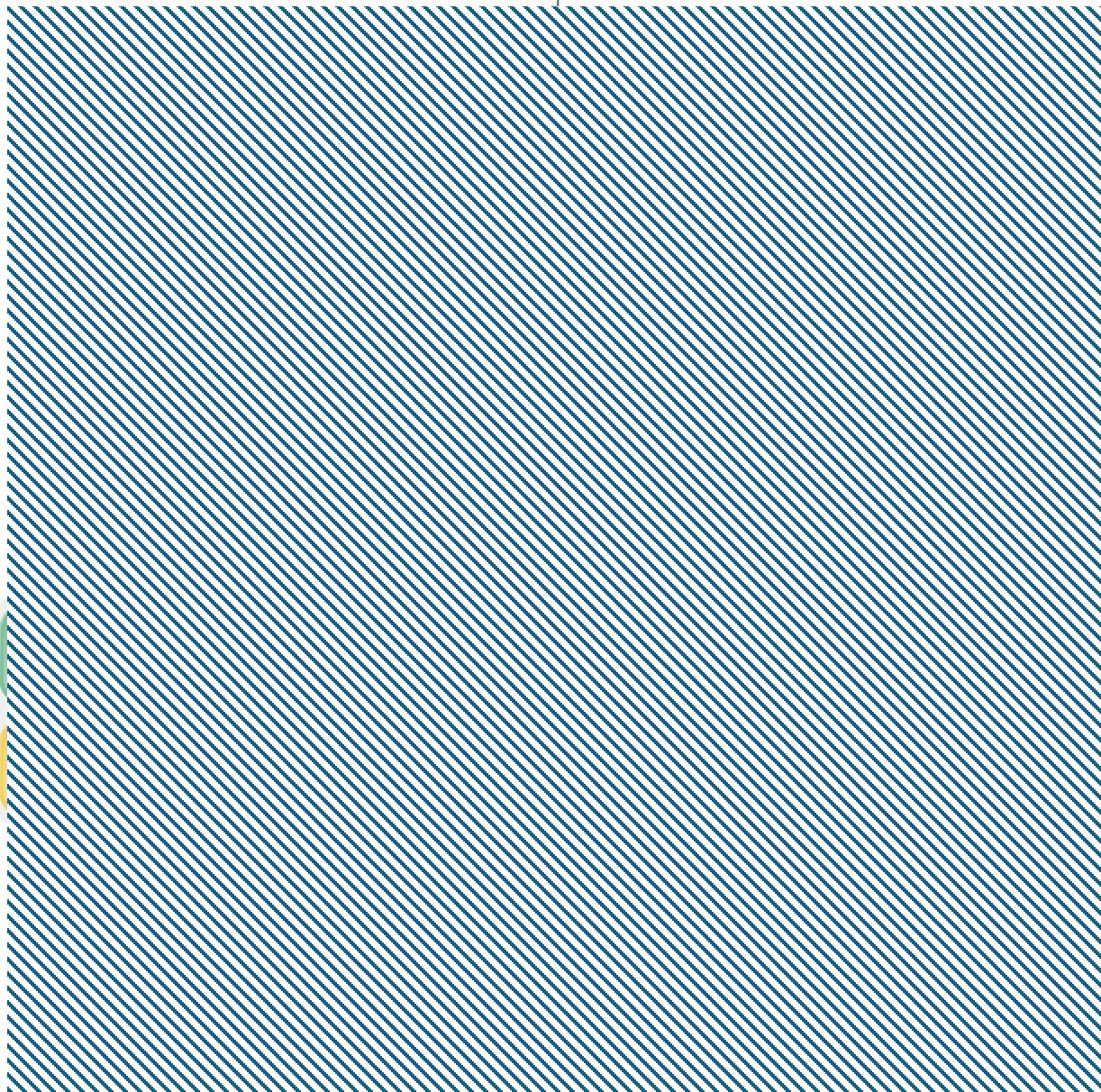
COMPLIANCE



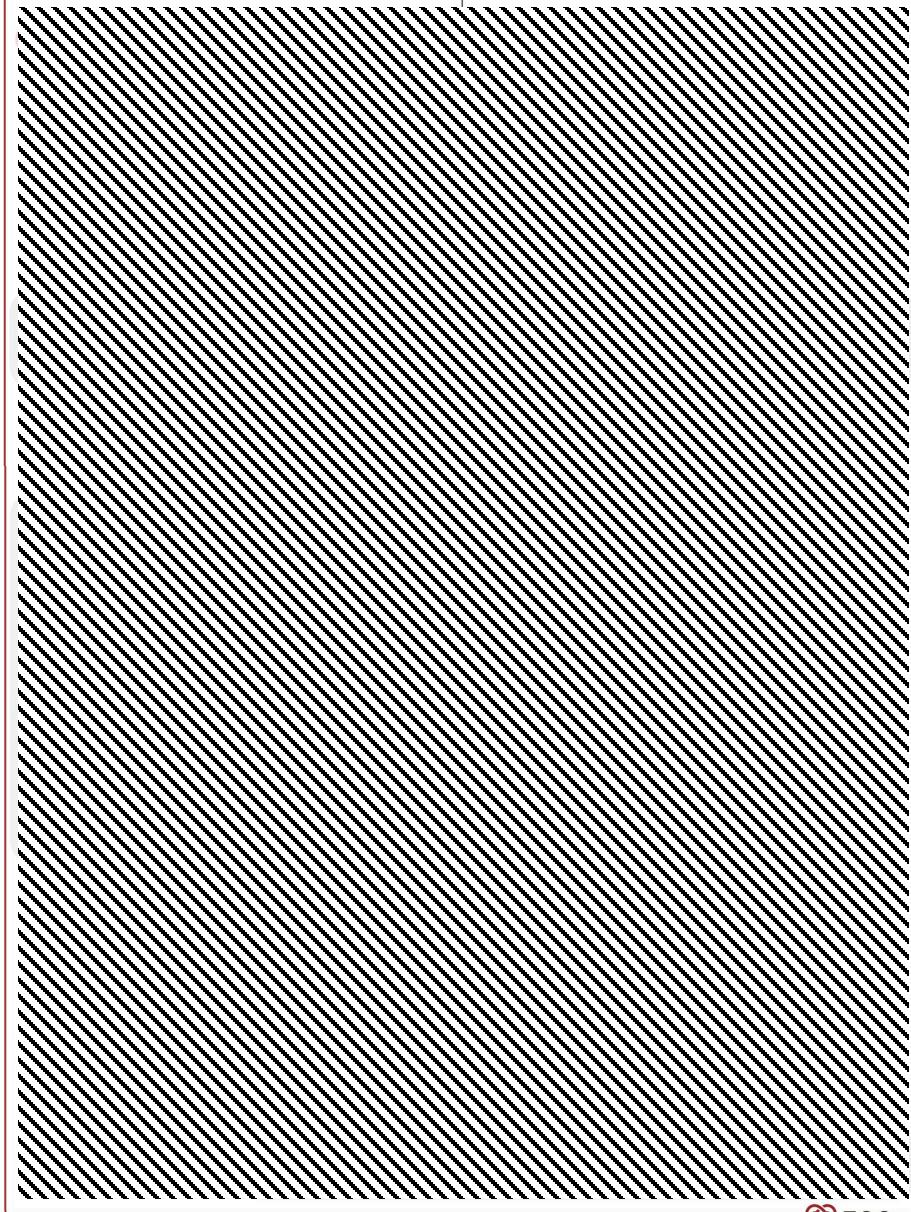
Atrial fibrillation



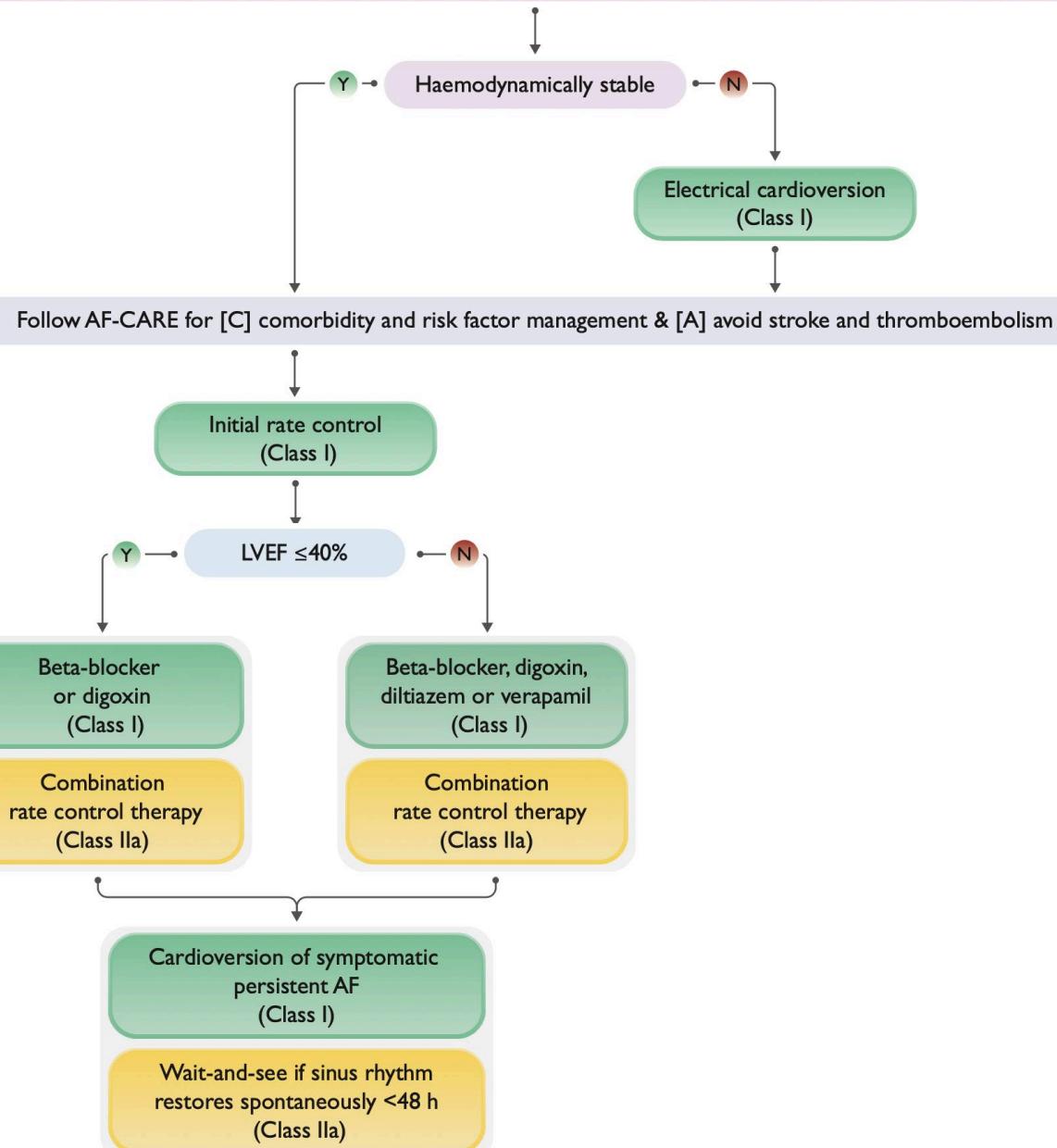
Patient with first-diagnosed AF



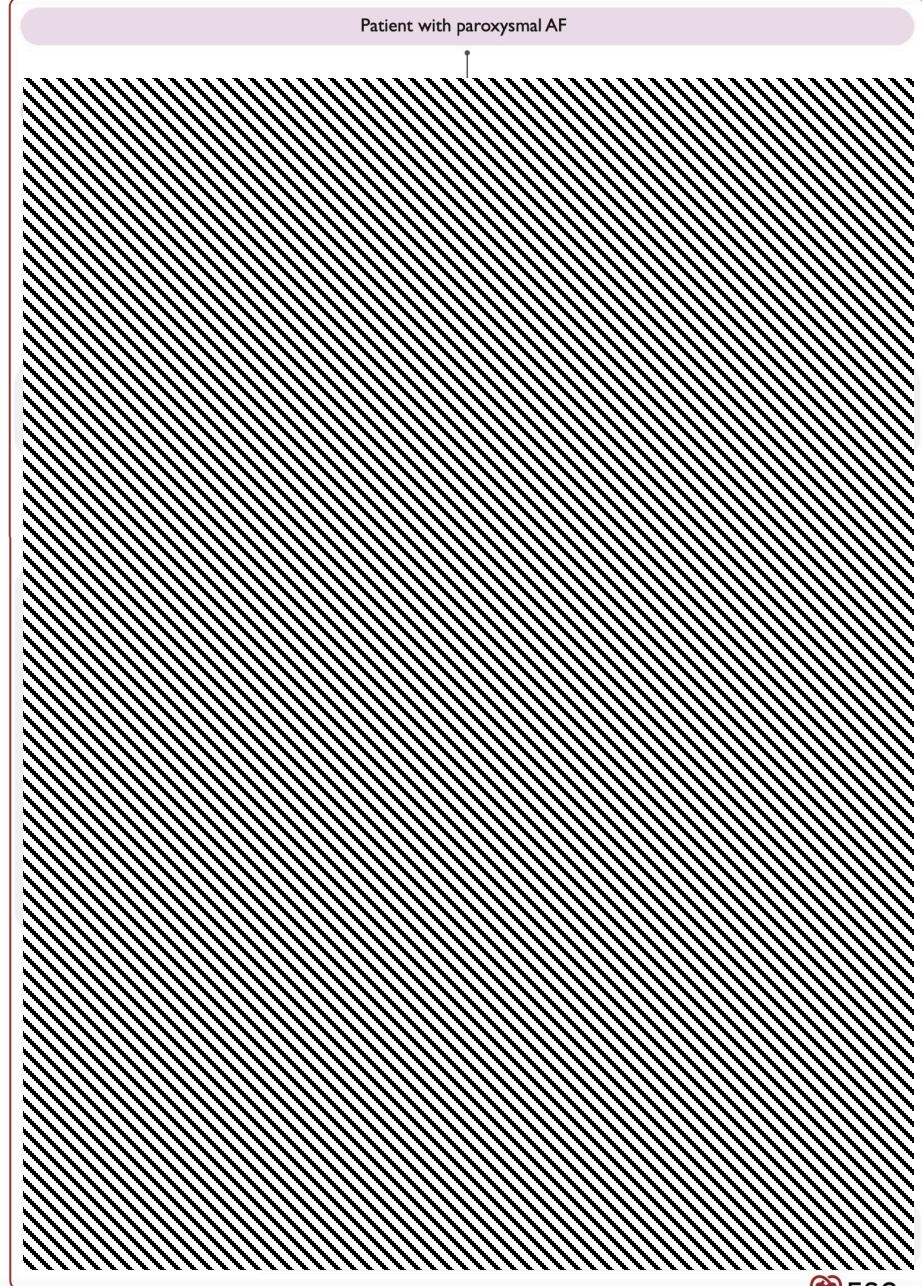
Patient with paroxysmal AF



Patient with first-diagnosed AF



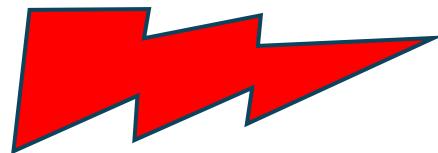
Patient with paroxysmal AF



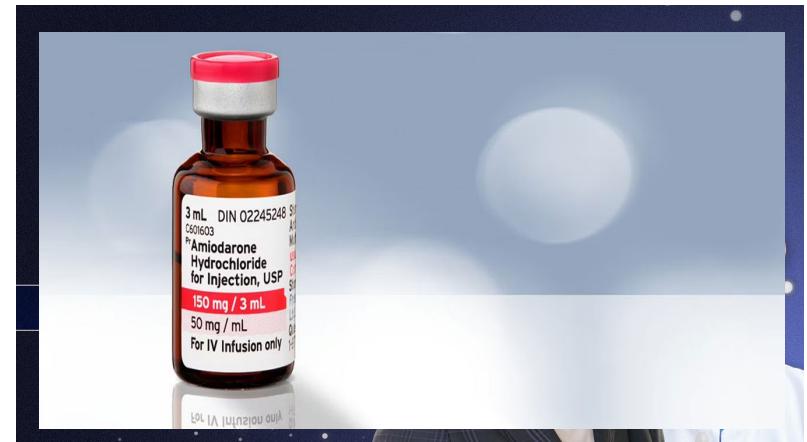
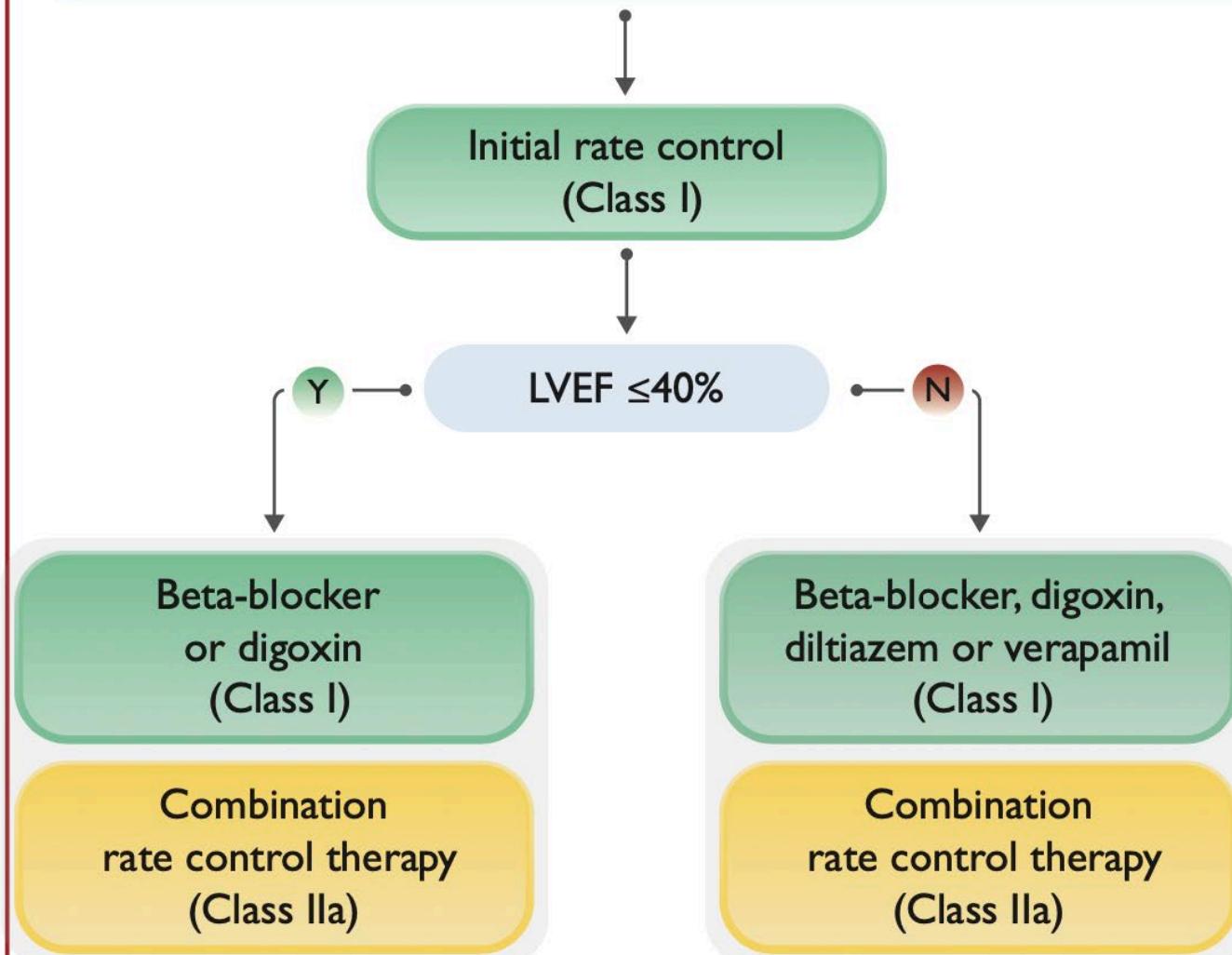
Patient with first-diagnosed AF



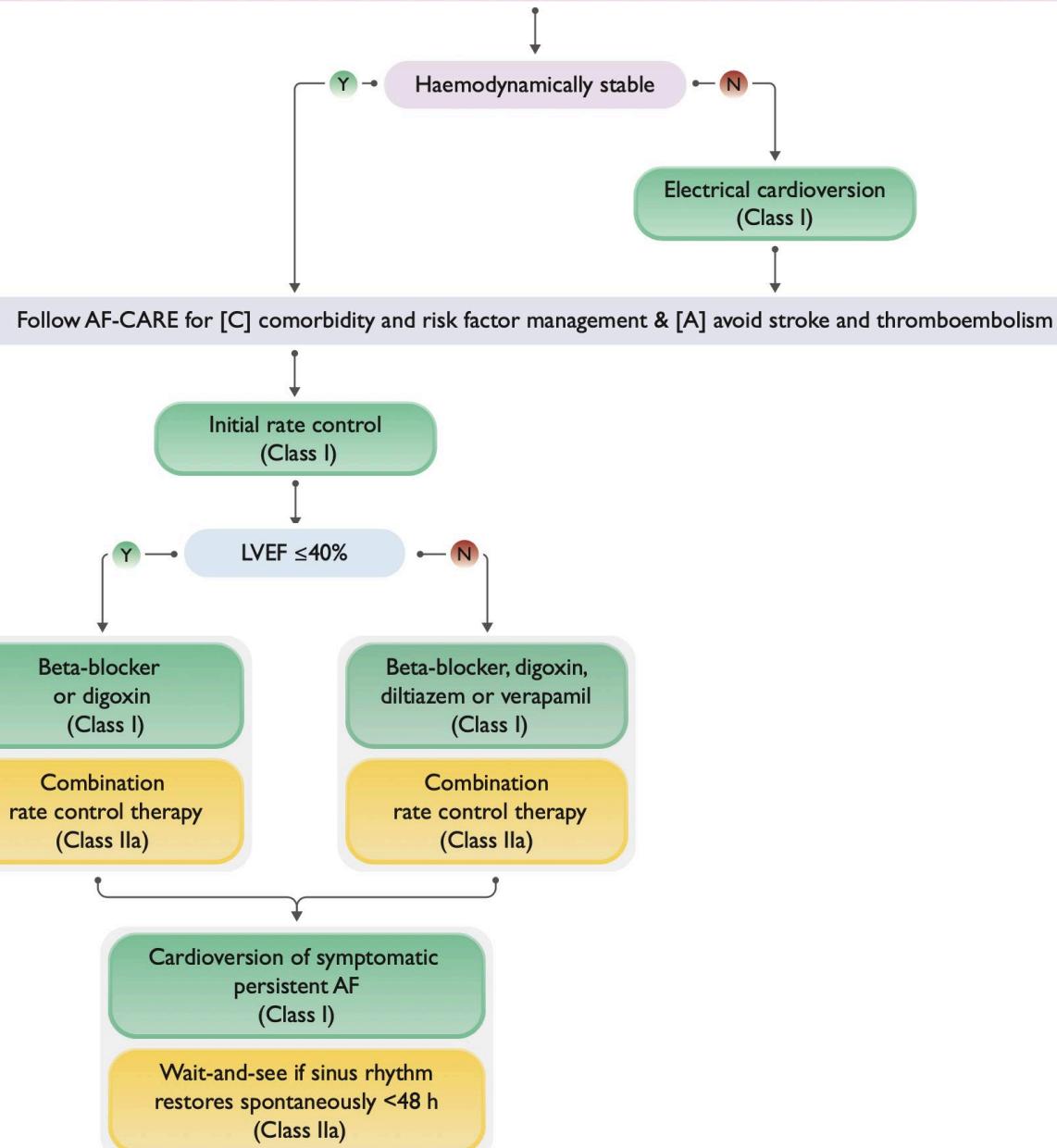
Haemodynamically stable



Follow AF-CARE for [C] comorbidity and risk factor management & [A] avoid stroke and thromboembolism

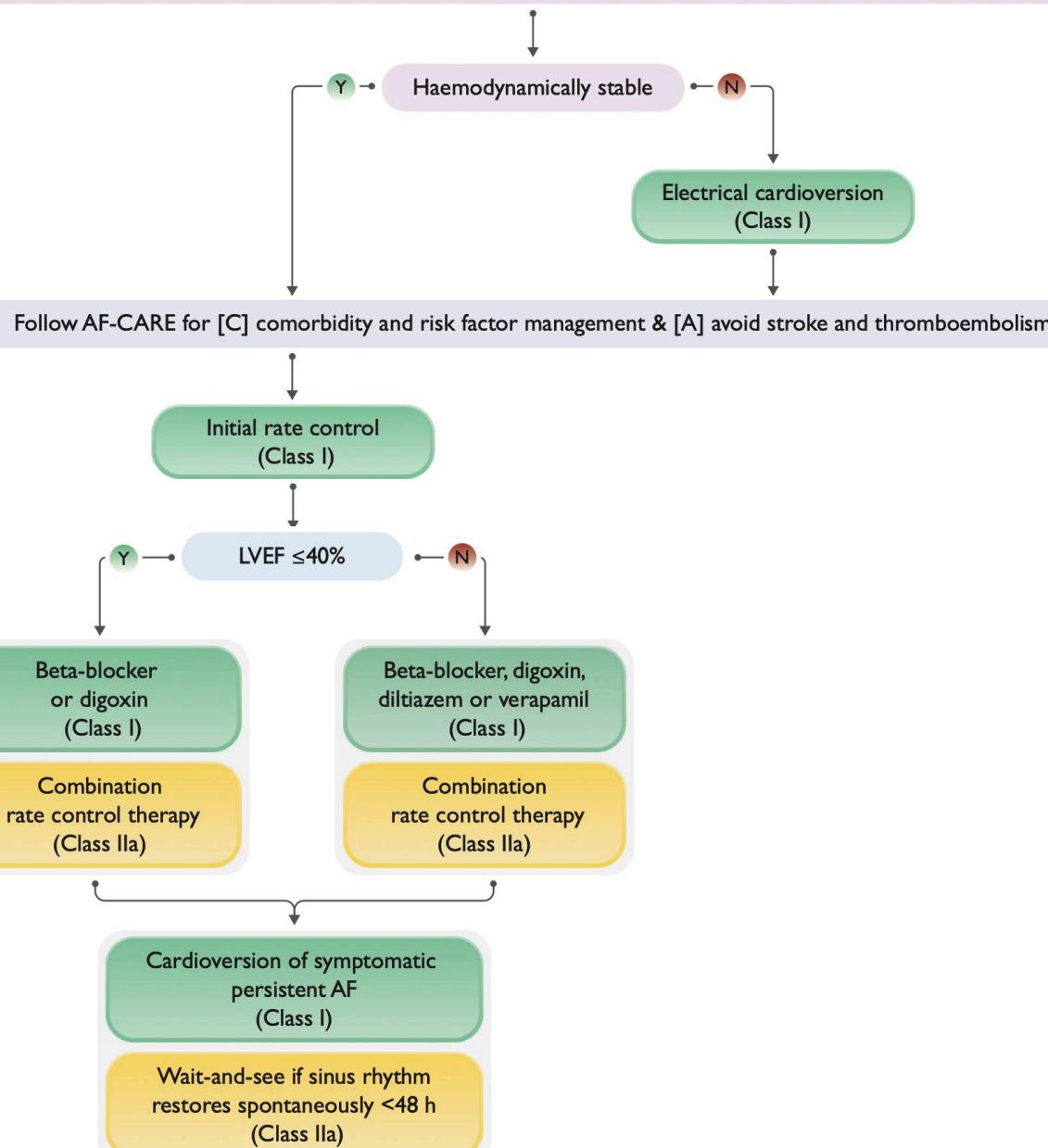


Patient with first-diagnosed AF

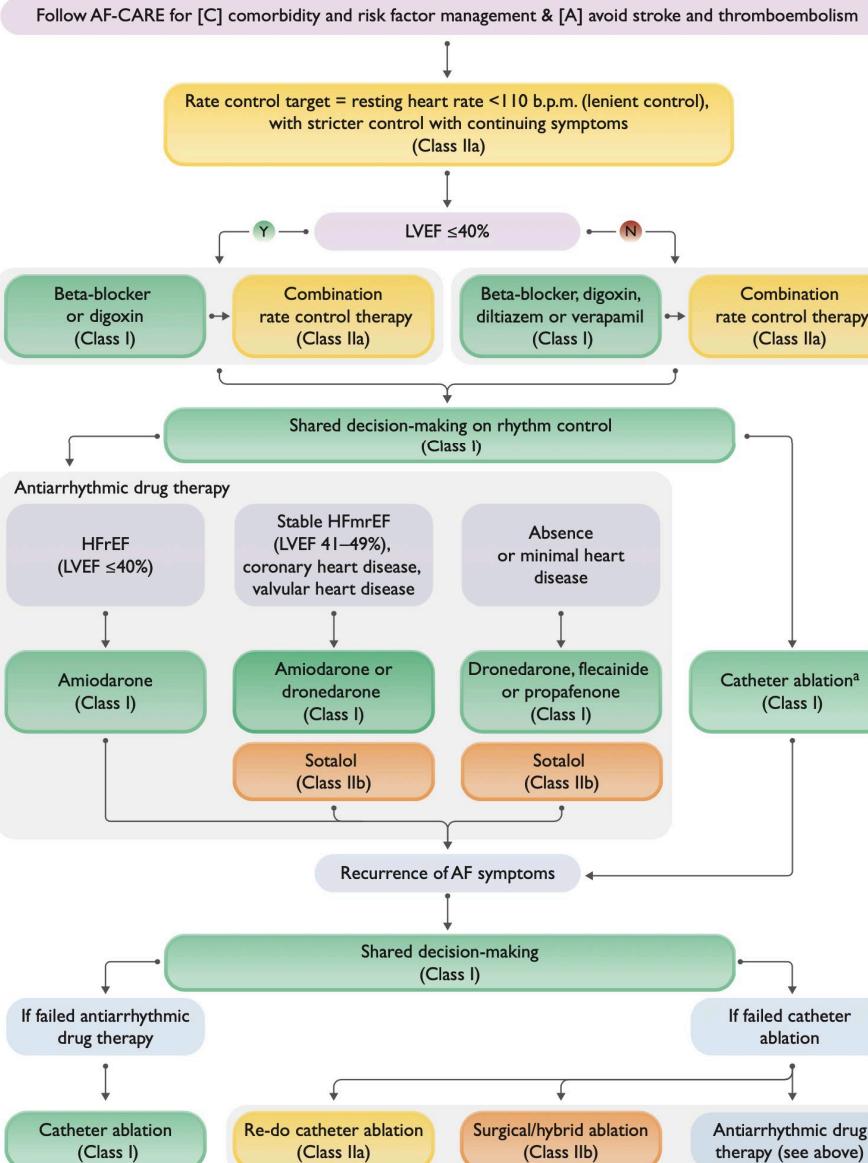


Patient with paroxysmal AF

Patient with first-diagnosed AF



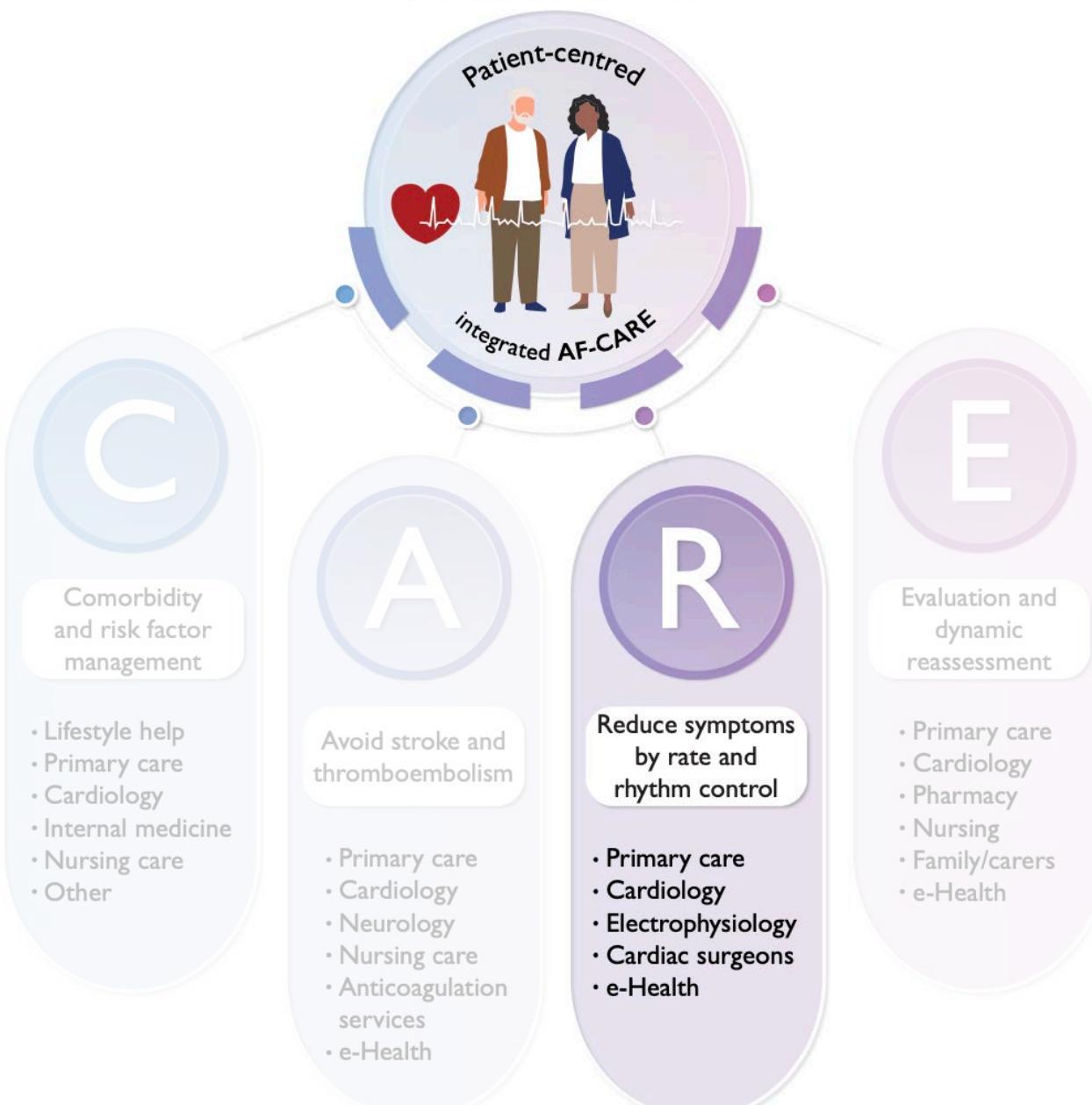
Patient with paroxysmal AF



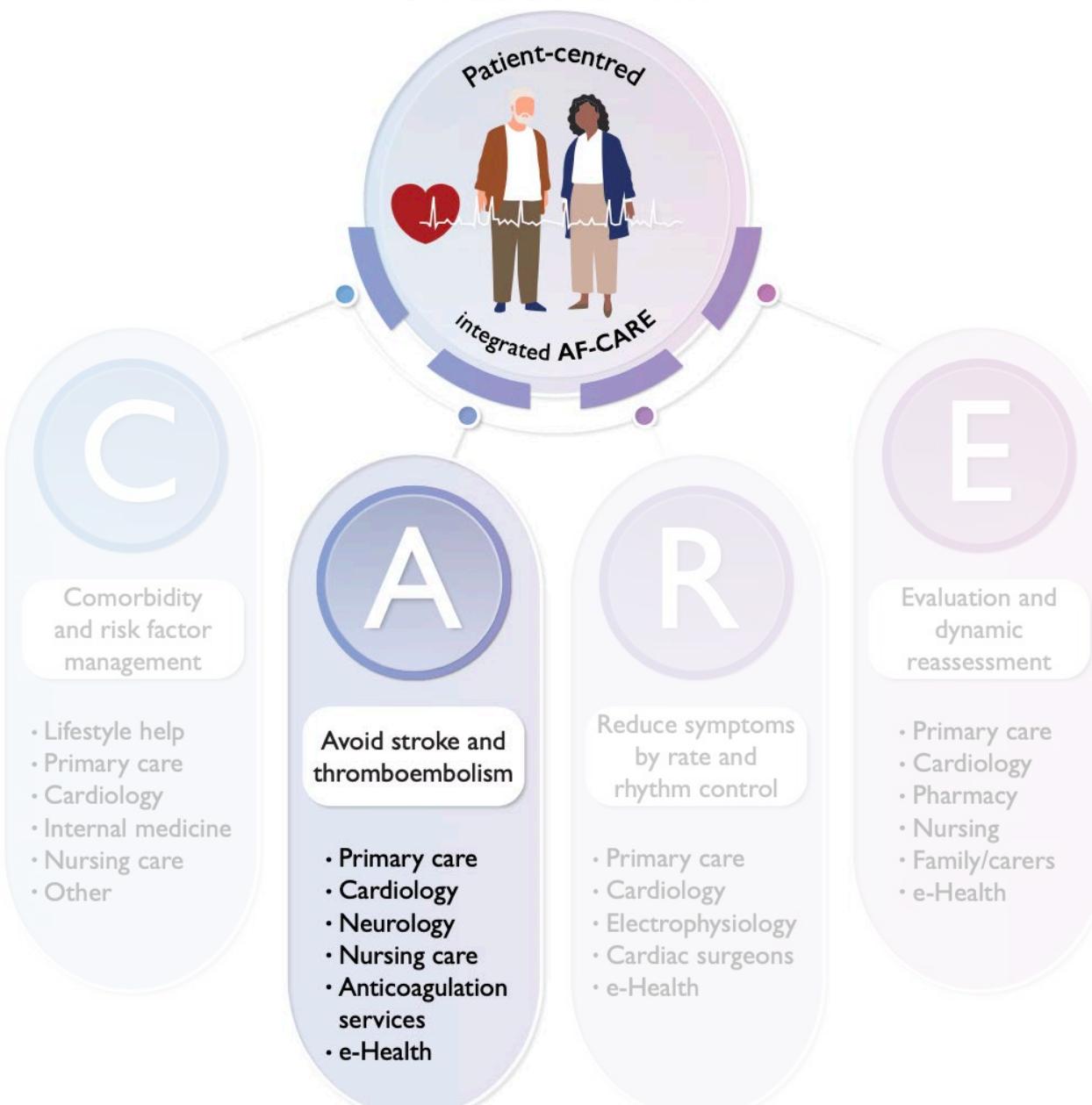
Amiodarone



Atrial fibrillation



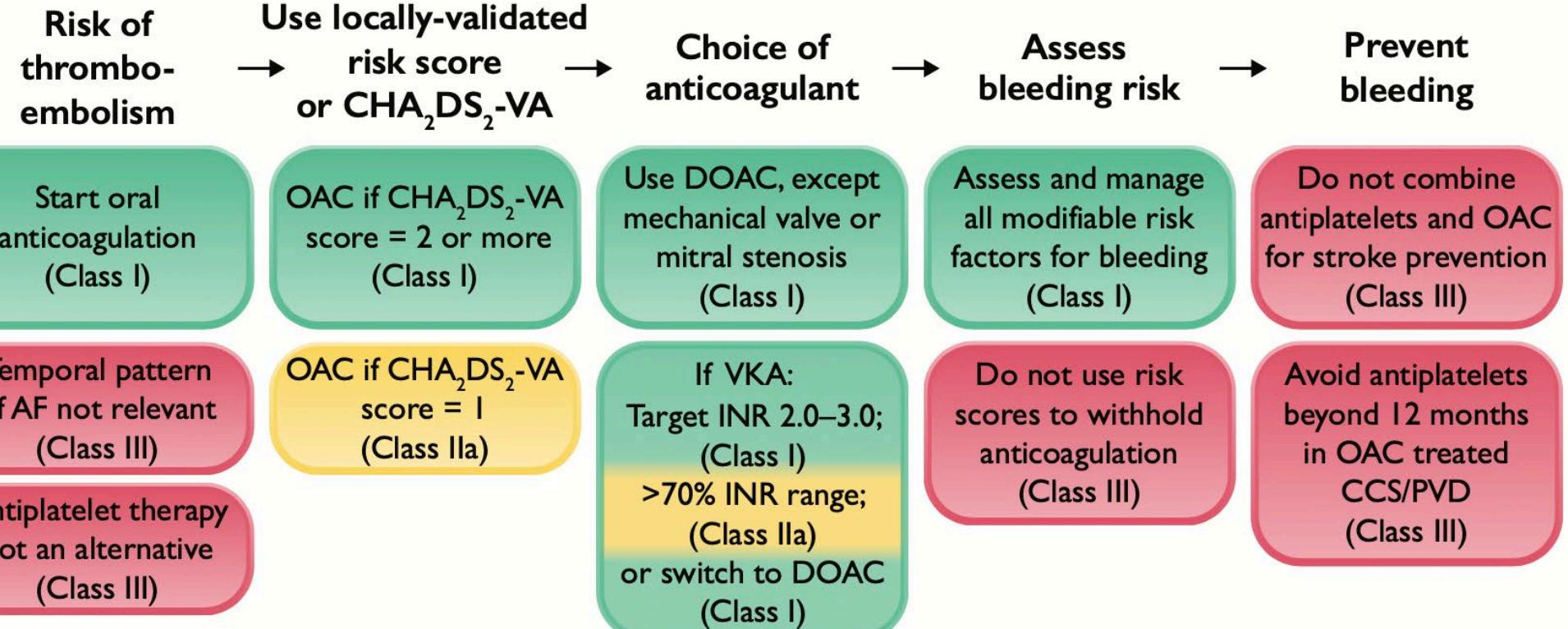
Atrial fibrillation





A

Avoid stroke and thromboembolism



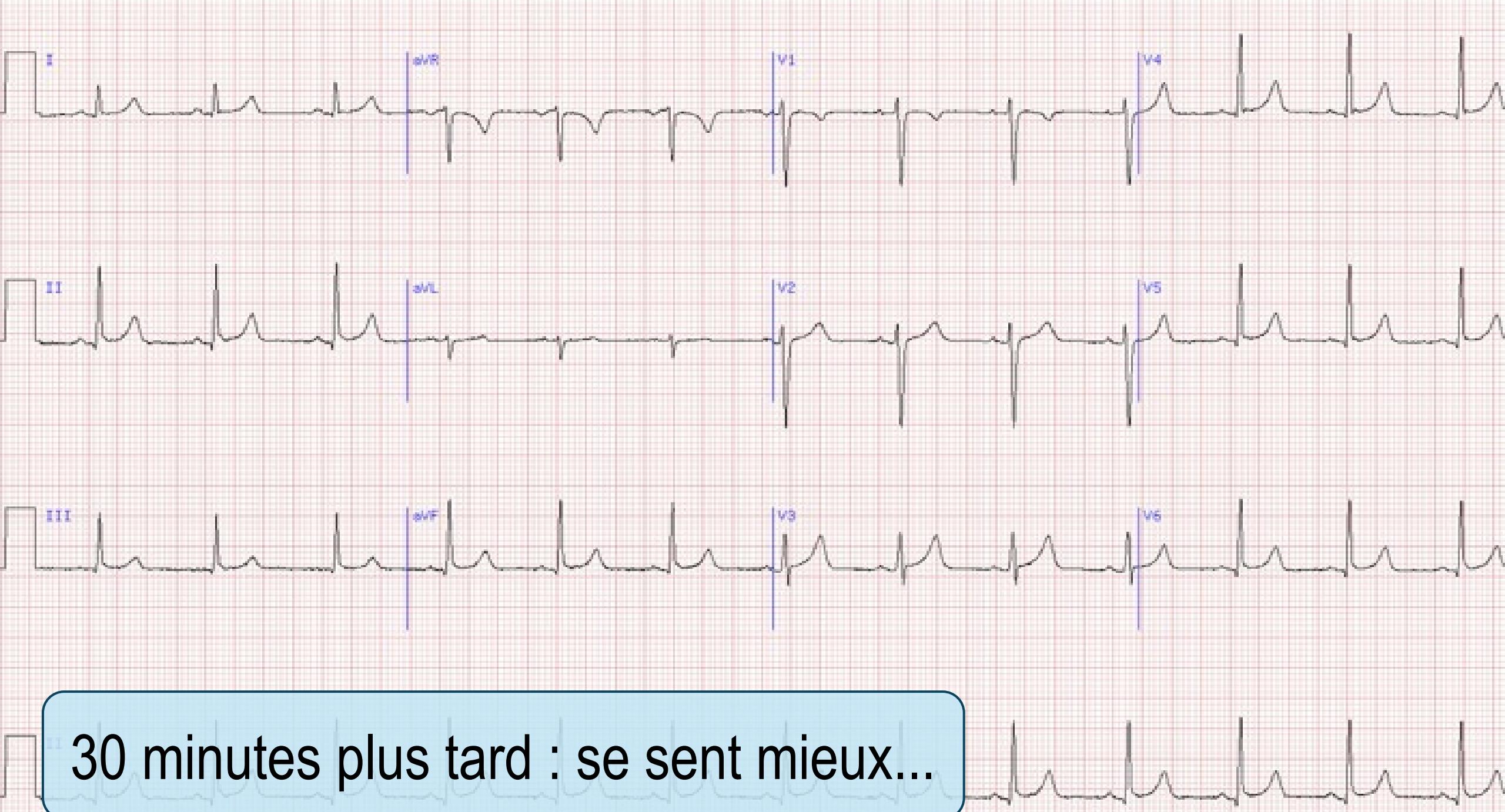


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Consultation samedi matin :
palpitations, malaise, faiblesse générale

*« Il a pris une cuite hier,
comme tous les week-ends »*





30 minutes plus tard : se sent mieux...

Antiagrégant plaquetttaire



Anticoagulant



Gestion risque hémorragique



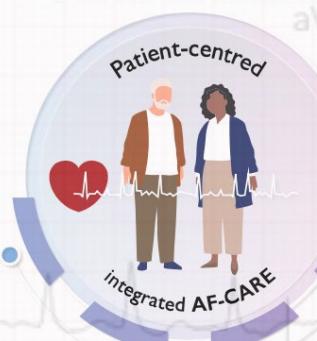
Anti-arythmique



Filière cardiologie



Atrial fibrillation



C

Comorbidity
and risk factor
management

- Lifestyle help
- Primary care
- Cardiology
- Internal medicine
- Nursing care
- Other

A

Avoid stroke and
thromboembolism

- Primary care
- Cardiology
- Neurology
- Nursing care
- Anticoagulation services
- e-Health

R

Reduce symptoms
by rate and
rhythm control

- Primary care
- Cardiology
- Electrophysiology
- Cardiac surgeons
- e-Health

E

Evaluation and
dynamic
reassessment

- Primary care
- Cardiology
- Pharmacy
- Nursing
- Family/carers
- e-Health

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Setting individual
targets for
comorbidities
and risk factors



Shared
decision-making



Behavioural
change

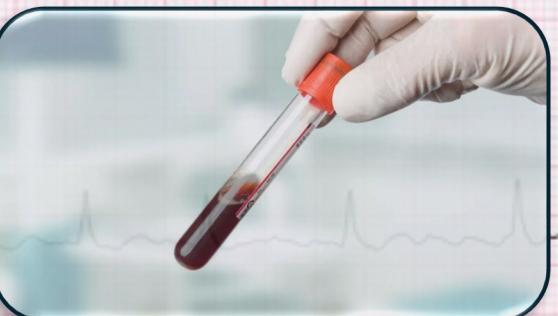
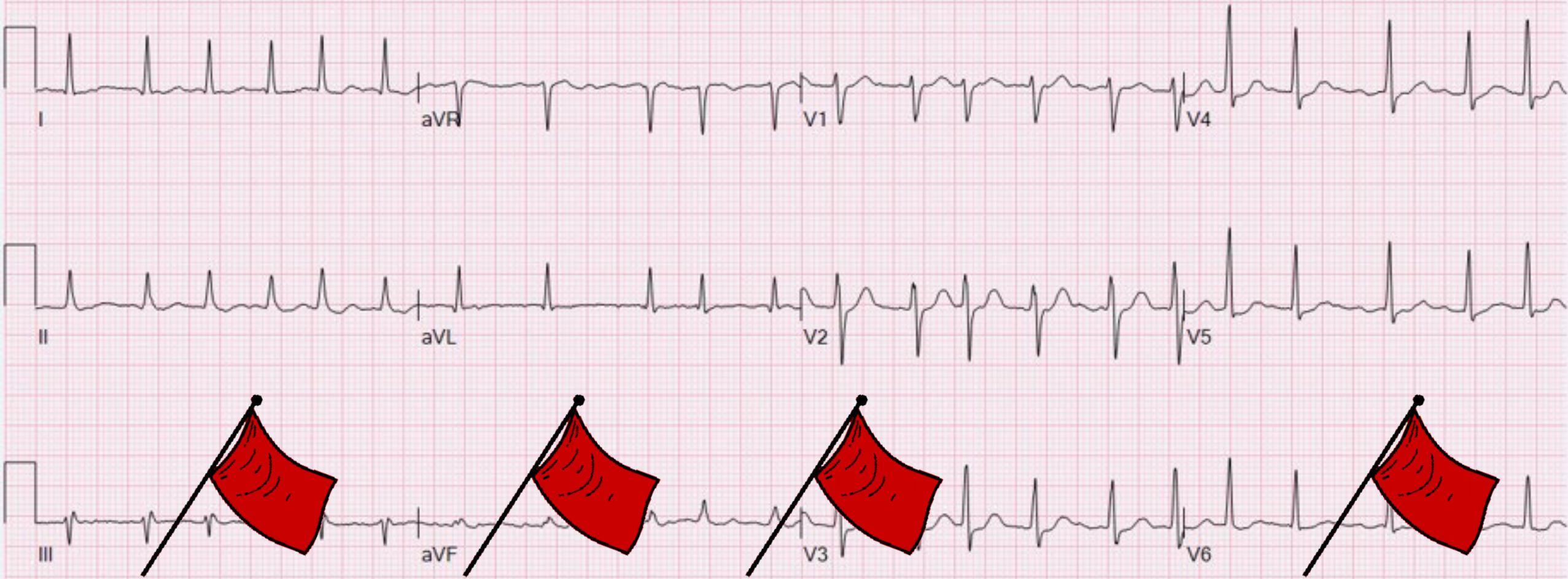


Achievable
targets



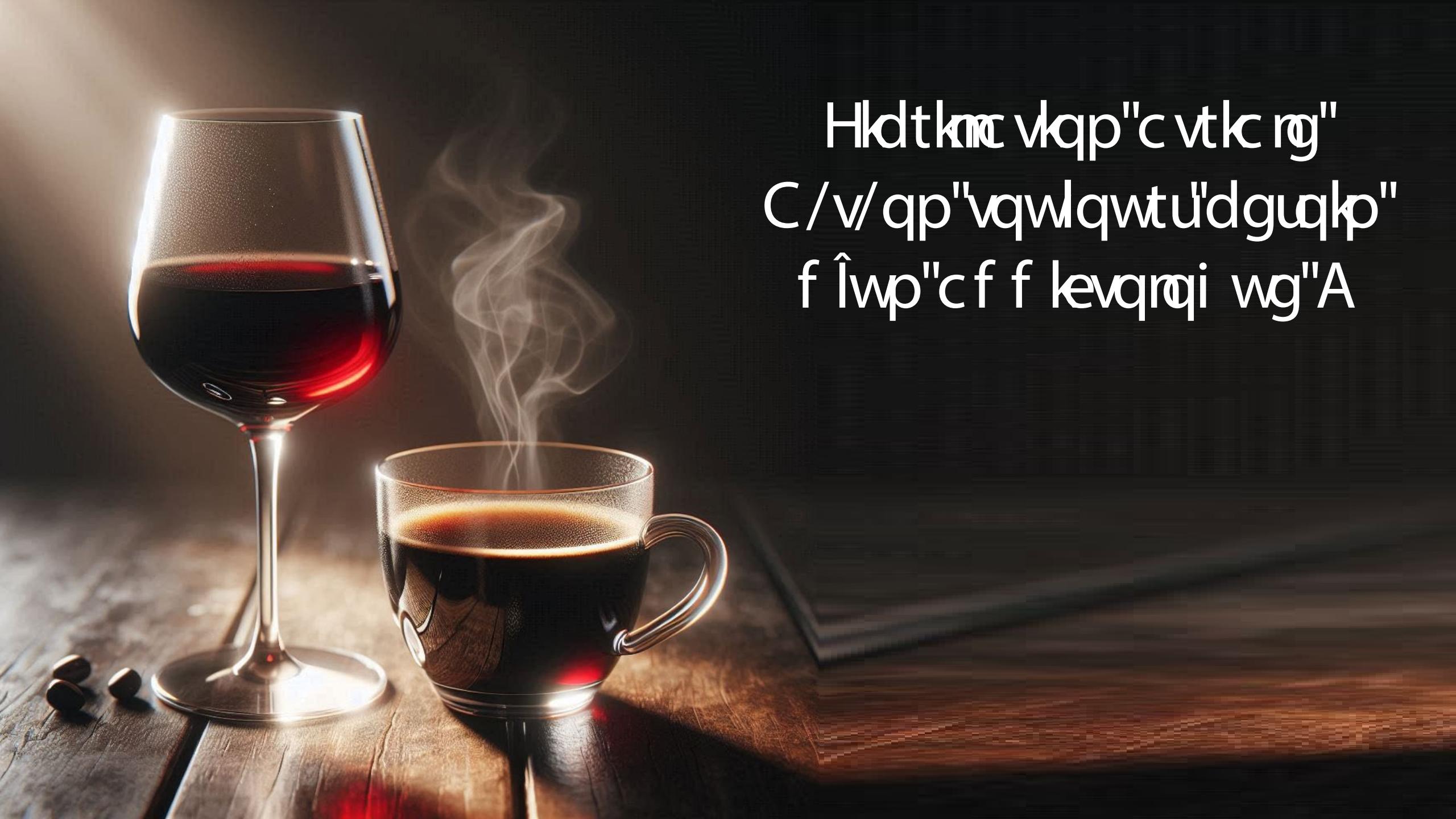
Provide information
without overloading

Focus on key
risk factors



PA : 138/82 ; FC : 125 ; T : 36,3° ;
SpO₂ : 98% AA ; Dextro : 1,2 g/L

Hkdtkm̄ v̄qp"c vt̄k n̄g"
C/v̄qp"v̄qlqwtu'dguqkp"
f̄ lwp"cf f̄ kevqrqi wg"A





7 (6-11)
vs
0 (0-2) tasses/jour

Caffeinated Coffee Consumption or Abstinence to Reduce Atrial Fibrillation

The DECAF Randomized Clinical Trial

Wong, JAMA Intern Med, Nov 2025

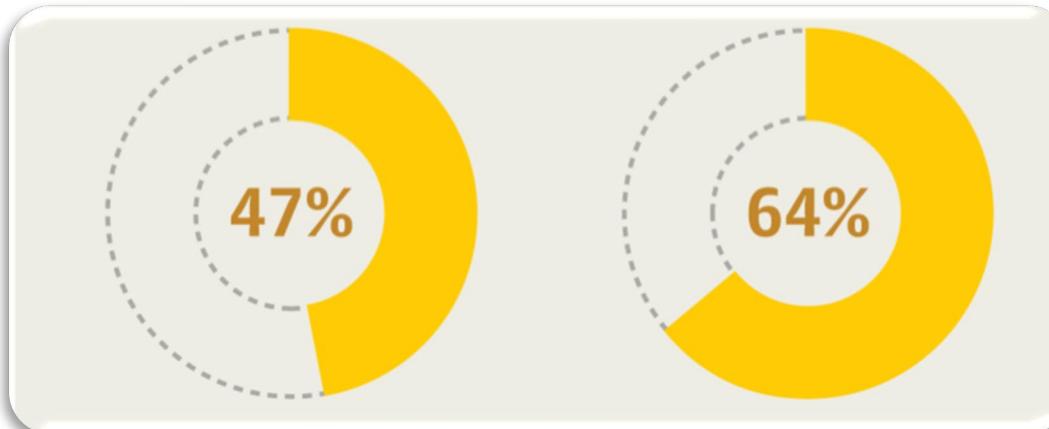


Coffee consumption
100 Patients

Coffee abstinence
100 Patients

Wong, JAMA Intern Med, Nov 2025

Rate of recurrence of AF or atrial flutter over 6 months

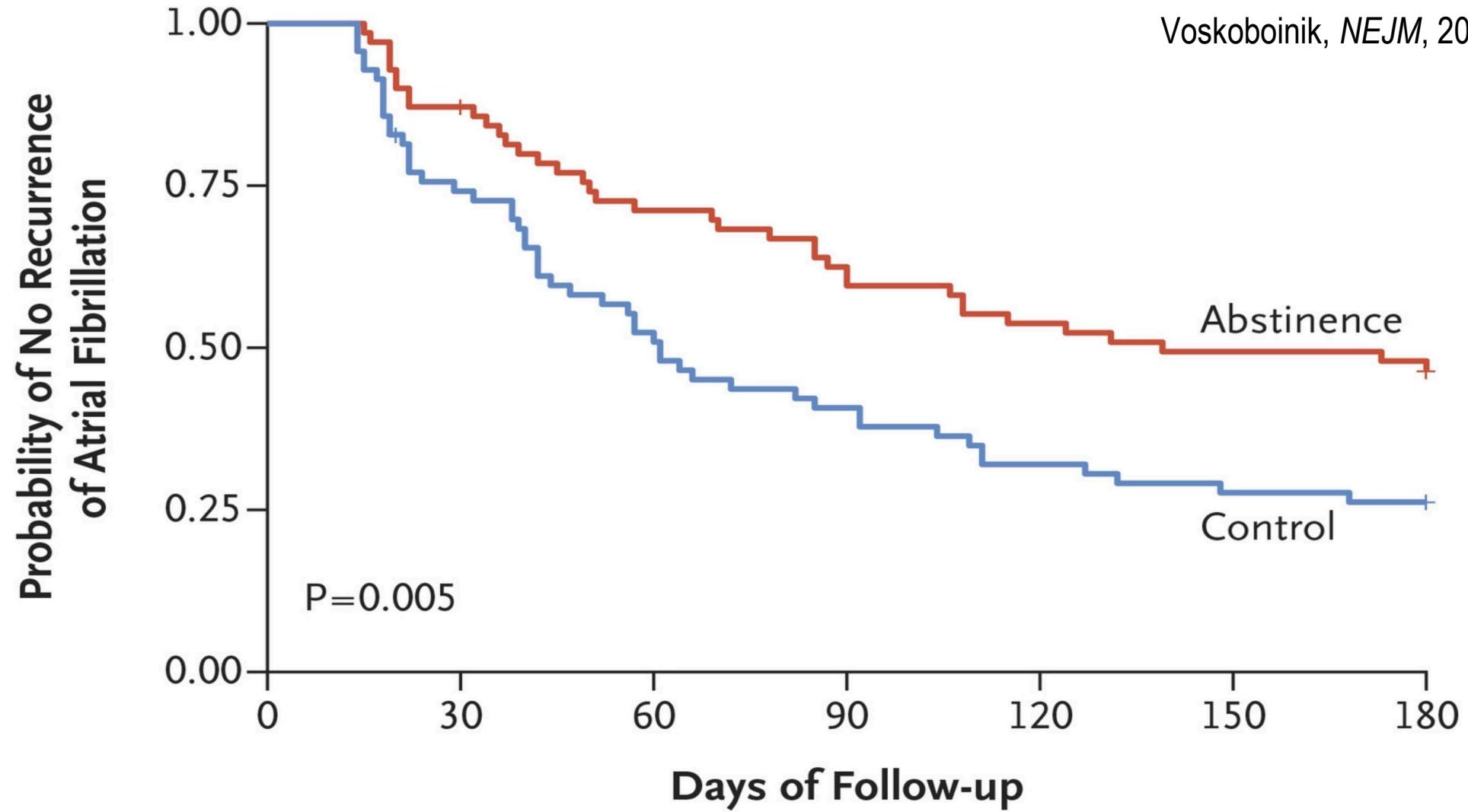




16 vs 13 verres/semaine
vs
17 vs 2 verres/semaine

7 (6-11)
vs
0 (0-2) tasses/jour

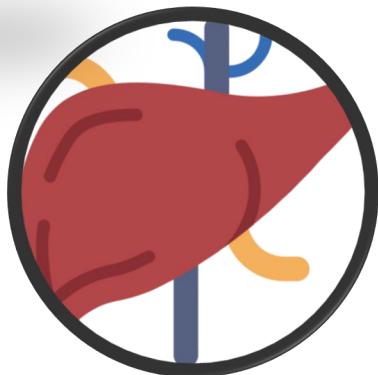
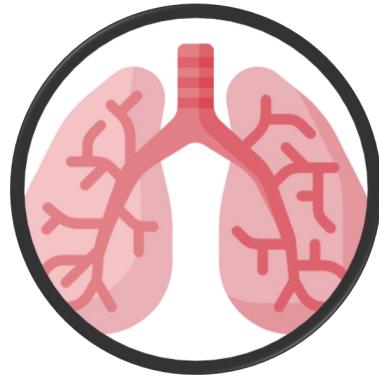
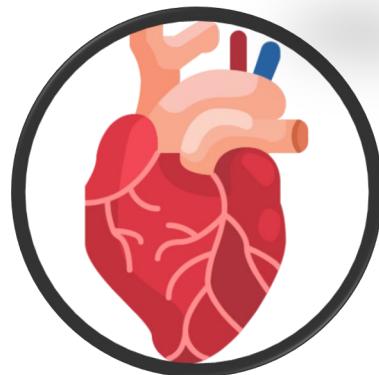




No. at Risk

Abstinence	70	61	49	43	37	34	33
Control	70	51	36	28	22	19	18







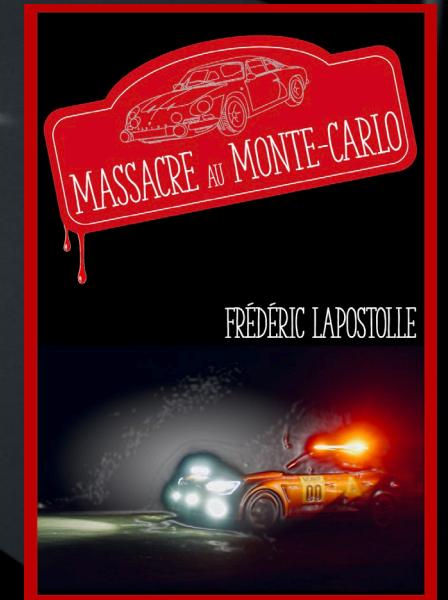
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Nîwti gpvkg'f qkv'i †tgt"vqwgu"ngu'wti gpegu"

Foto FLapo SAMU 93



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