Frequent atrial premature contractions as a surrogate marker for paroxysmal atrial fibrillation in patients with acute ischaemic stroke

D Wallmann, D Tüller, N Kucher, J Fuhrer, M Arnold, E Delacretaz

METHODS
Consecutive patients who suffered an acute ischaemic stroke and without known AF were identified. Patients with persistent severe cognitive disturbances and severe aphasia, as well as those with a life expectancy shorter than six months, were excluded. Furthermore, documented AF in the initial 24 hour ECG was an exclusion criteria. The patients underwent an echocardiography and a 24 hour ECG recording within 2–6 days after admission. Nine patients were excluded after initial enrolment because of death (n = 6), retrospectively known paroxysmal AF before ischaemic stroke (n = 1), or unconfirmed diagnosis of ischaemic stroke (n = 2). All 99 remaining patients were prospectively followed up by their primary care physicians. Ambulatory 24 hour and seven day ECG recordings were used at the discretion of the primary care physicians to document AF in patients who developed symptoms suggesting arrhythmias. Episodes of AF were correlated with the presence of frequent APCs in the initial ambulatory ECG. Patient allocation into two groups was based on frequency of APCs. High frequency (frequent APCs) was defined as the presence of frequent APCs in the initial ambulatory ECG. A subgroup of patients with frequent APCs was identified. Twenty four patients had frequent APCs (fourth quartile, 70 APCs or more in 24 hours) and 75 patients had infrequent APCs (quartiles 1–3, < 69 APCs in 24 hours). Table 1 lists the clinical characteristics of patients with and without frequent APCs. There was no significant difference between these two groups with respect to left ventricular mass index, left ventricular ejection fraction, and prevalence of cardiovascular risk factors and of coronary or valvar heart disease. Patients with frequent APCs were older and had larger left atria than did patients without frequent APCs. AF was documented in 12 of 99 patients during a mean follow up of 22.4 (17.8) months. AF occurred in eight patients with frequent APCs and in four patients without frequent APCs (33% vs 5%, respectively, p = 0.001). The increased incidence of AF among patients with frequent APCs was significant with an odds ratio of 9.3 (95% confidence interval 1.7 to 49.6, p = 0.01) after adjustments for age and left atrial diameter in a multiple logistic regression model.

RESULTS
A subgroup of patients with frequent APCs was identified. Twenty four patients had frequent APCs (fourth quartile, 70 APCs or more in 24 hours) and 75 patients had infrequent APCs (quartiles 1–3, < 69 APCs in 24 hours). Table 1 lists the clinical characteristics of patients with and without frequent APCs. There was no significant difference between these two groups with respect to left ventricular mass index, left ventricular ejection fraction, and prevalence of cardiovascular risk factors and of coronary or valvar heart disease. Patients with frequent APCs were older and had larger left atria than did patients without frequent APCs. AF was documented in 12 of 99 patients during a mean follow up of 22.4 (17.8) months. AF occurred in eight patients with frequent APCs and in four patients without frequent APCs (33% vs 5%, respectively, p = 0.001). The increased incidence of AF among patients with frequent APCs was significant with an odds ratio of 9.3 (95% confidence interval 1.7 to 49.6, p = 0.01) after adjustments for age and left atrial diameter in a multiple logistic regression model.

DISCUSSION
Increasing evidence suggests that AF episodes are often triggered by focal extrastolic activity.4 Conversely, ablation of the arrhythmogenic foci abolishes paroxysmal AF in selected patients, showing the pathophysiological importance of frequent APCs.4 These recent findings motivated the present attempt to correlate the presence of arrhythmogenic triggers with an increased incidence of AF.

Patients with ischaemic stroke were selected as a study group because improvement in detection of AF as a cause of stroke is desirable. Indeed, current diagnostic strategies often fail to detect AF as a potential cause of embolic events, and unrecognised intermittent AF is a major risk factor for recurrent stroke, which is potentially preventable.1

The present study showed, firstly, that frequent APCs can be recorded in a subgroup of patients with acute ischaemic stroke. Furthermore, frequent APCs are associated with a greatly increased incidence of AF. AF occurred in 33% of patients with frequent APCs, whereas only 5% of patients without frequent APCs developed AF. Thus, patients with frequent APCs constitute a subgroup at high risk of recurrent stroke. A search for paroxysmal AF in patients with frequent

Abbreviations: AF, atrial fibrillation, APC, atrial premature contraction

Heart 2003;89:1247–1248
APCs by repeated 24 hour ECGs or event recordings may allow the detection of paroxysmal AF earlier and may prevent complications.

APCs may be a marker of other risk factors for stroke—that is, they may be related to left atrial enlargement, which in turn may cause increased thrombus formation and stroke. Indeed, left atrial enlargement was associated with an increased incidence of AF in the present study, as in earlier reports. However, multivariate analysis showed that the presence of frequent APCs was an independent risk factor for the occurrence of AF.

Some patients may have developed episodes of asymptomatic AF that were not detected in the follow up. Furthermore, detection of paroxysmal AF does not establish AF as the cause of stroke.

This study showed an association between the presence of frequent APCs in 24 hour ECG recordings and a greatly increased incidence of AF in patients with ischaemic stroke. Further studies are needed to delineate the optimal management of patients with frequent APCs.

ACKNOWLEDGEMENTS
Etienne Delacretaz is supported by a grant from the Swiss National Foundation for Scientific Research.

Table 1  Clinical characteristics of 99 patients with ischaemic stroke in relation to frequency of atrial premature contractions

<table>
<thead>
<tr>
<th></th>
<th>Quartiles 1–3 (0–69 APCs) (n=75)</th>
<th>Quartile 4 (≥70 APCs) (n=24)</th>
<th>Odds ratio (95% CI)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>61 (14)</td>
<td>70 (12)</td>
<td>1.1 (1.01 to 1.09)</td>
<td>0.01</td>
</tr>
<tr>
<td>Male sex</td>
<td>42 (56%)</td>
<td>15 (63%)</td>
<td>1.3 (0.5 to 3.4)</td>
<td>0.58</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>12 (16%)</td>
<td>5 (21%)</td>
<td>1.9 (0.6 to 6.0)</td>
<td>0.25</td>
</tr>
<tr>
<td>Diabetes</td>
<td>15 (20%)</td>
<td>6 (25%)</td>
<td>1.3 (0.3 to 3.9)</td>
<td>0.6</td>
</tr>
<tr>
<td>Current or former cigarette smoker</td>
<td>25 (33%)</td>
<td>5 (21%)</td>
<td>0.5 (0.2 to 1.6)</td>
<td>0.25</td>
</tr>
<tr>
<td>Dyslipidaemia</td>
<td>31 (41%)</td>
<td>13 (54%)</td>
<td>1.7 (0.7 to 4.2)</td>
<td>0.27</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50 (67%)</td>
<td>13 (54%)</td>
<td>0.6 (0.2 to 1.5)</td>
<td>0.27</td>
</tr>
<tr>
<td>Two or more cardiovascular risk factors</td>
<td>35 (47%)</td>
<td>12 (50%)</td>
<td>1.1 (0.5 to 2.9)</td>
<td>0.78</td>
</tr>
<tr>
<td>Echocardiographic findings</td>
<td></td>
<td></td>
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<tr>
<td>Left atrial size (mm)</td>
<td>39 (7)</td>
<td>43 (9)</td>
<td>1.1 (1.0 to 1.1)</td>
<td>0.04</td>
</tr>
<tr>
<td>LV mass index (g/m²)</td>
<td>108 (36)</td>
<td>122 (40)</td>
<td>1.0 (0.996 to 1.0)</td>
<td>0.17</td>
</tr>
<tr>
<td>LV ejection fraction [%]</td>
<td>0.66 (0.07)</td>
<td>0.69 (0.08)</td>
<td>1.1 (0.995 to 1.2)</td>
<td>0.07</td>
</tr>
<tr>
<td>Mitral regurgitation</td>
<td>4 (5%)</td>
<td>1 (4%)</td>
<td>0.8 (0.1 to 7.2)</td>
<td>0.74</td>
</tr>
<tr>
<td>Paroxysmal AF</td>
<td>4 (5%)</td>
<td>8 (33%)</td>
<td>8.9 (2.4 to 33.1)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Values are mean (SD). APC, atrial premature contraction; AF, atrial fibrillation; LV, left ventricle.

REFERENCES


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Accepted 22 January 2003
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*Heart* 2003 89: 1247-1248
doi: 10.1136/heart.89.10.1247

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