



6 Congrès  
des **SAMU.URGENCES**  
**DES OUTRE-MER**

UFR SANTÉ // SAINT-PIERRE - LA RÉUNION  
**19-20-21 NOVEMBRE 2025**



ÉCOLE DE  
DE SANTÉ  
UNIVERSITÉ DE LA RÉUNION



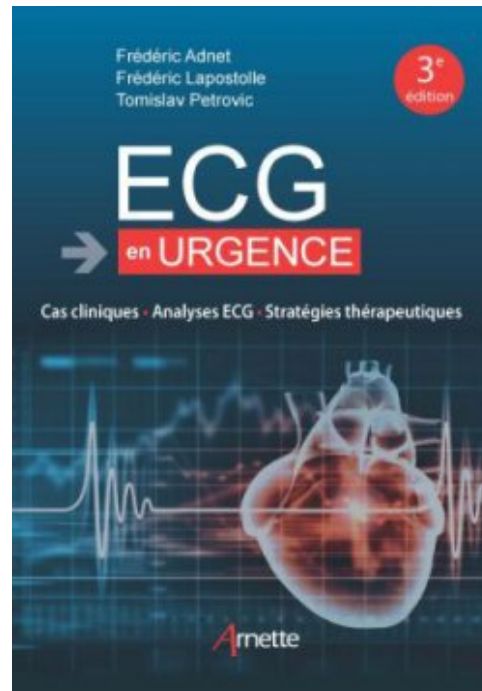
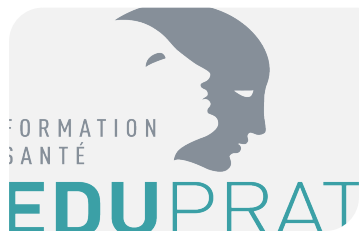


**6** Congrès  
des **SAMU.URGENCES**  
**DES OUTRE-MER**

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

# Disclosures

Partenariat recherche : Mundipharma, Serb, Teleflex



# URGENCES

PORTE COUPE-FEU  
SI INCENDIE NE PAS TOUCHER  
A LA SORTIE

URGENCES  
ENTREE  
ETROITEMENT RESERVEE  
POUR LES PATIENTS  
DES URGENCES

ACCUEIL

  
NE PAS  
TOUCHER



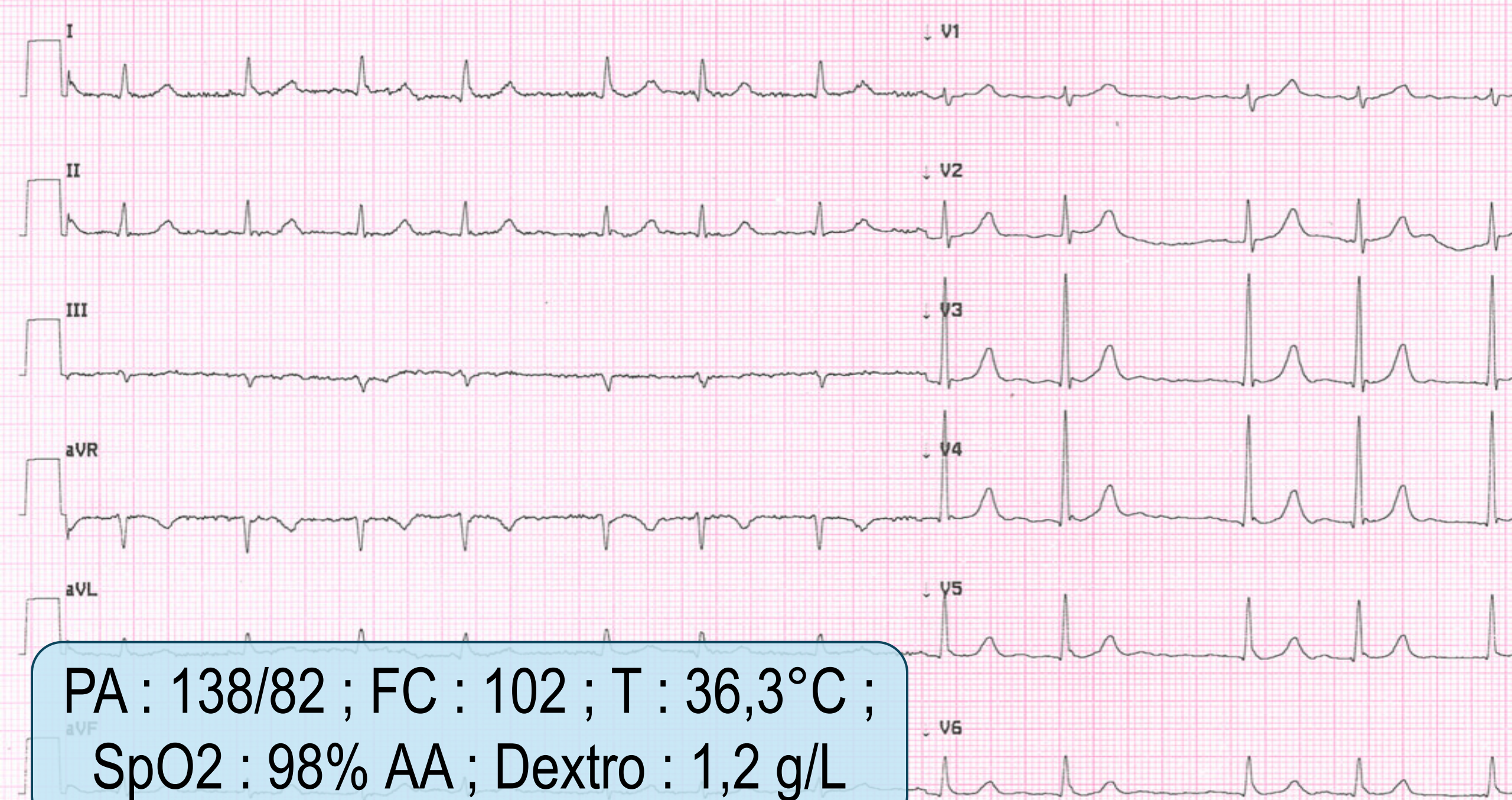


65 ans – HTA, UGD

Consultation samedi matin :  
palpitations, malaise, faiblesse générale

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





PA : 138/82 ; FC : 102 ; T : 36,3°C ;

SpO2 : 98% AA ; Dextro : 1,2 g/L

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

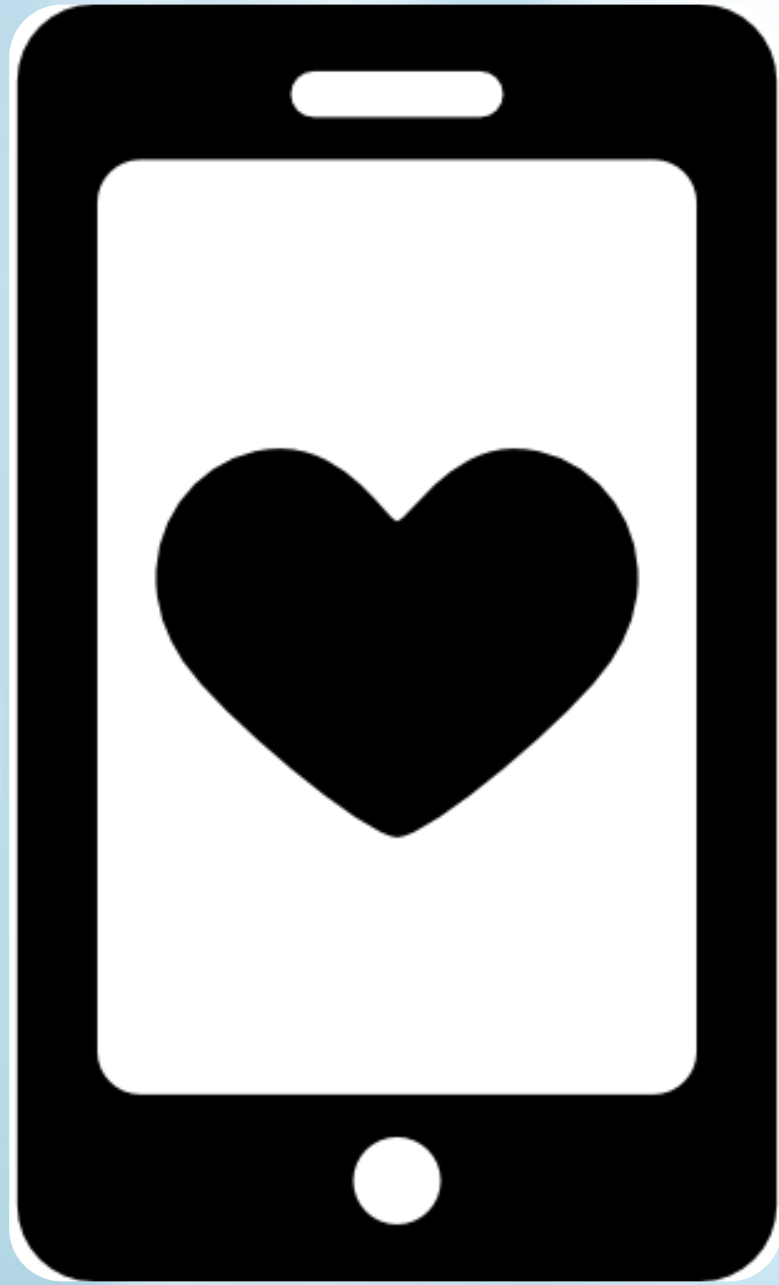


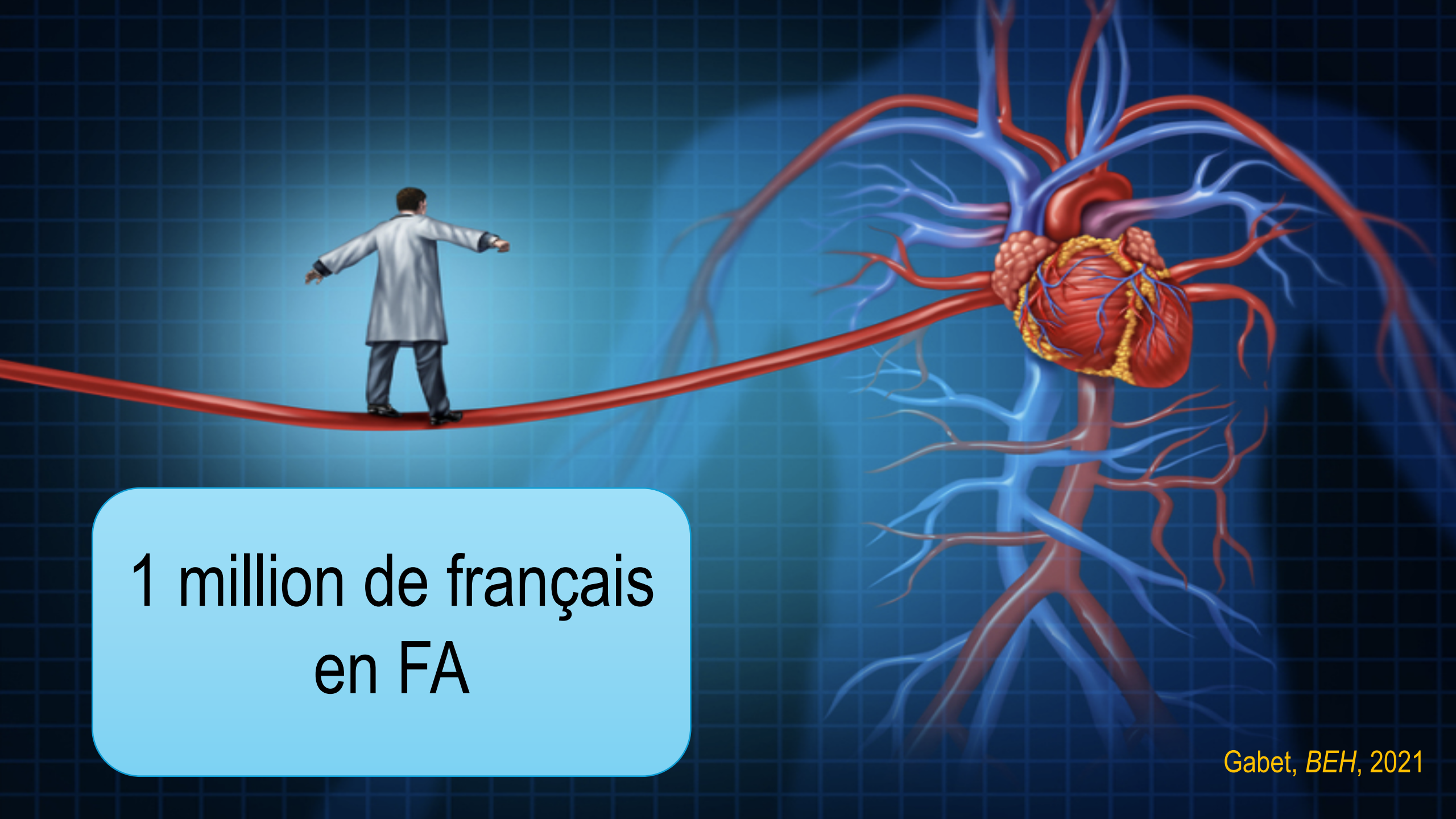
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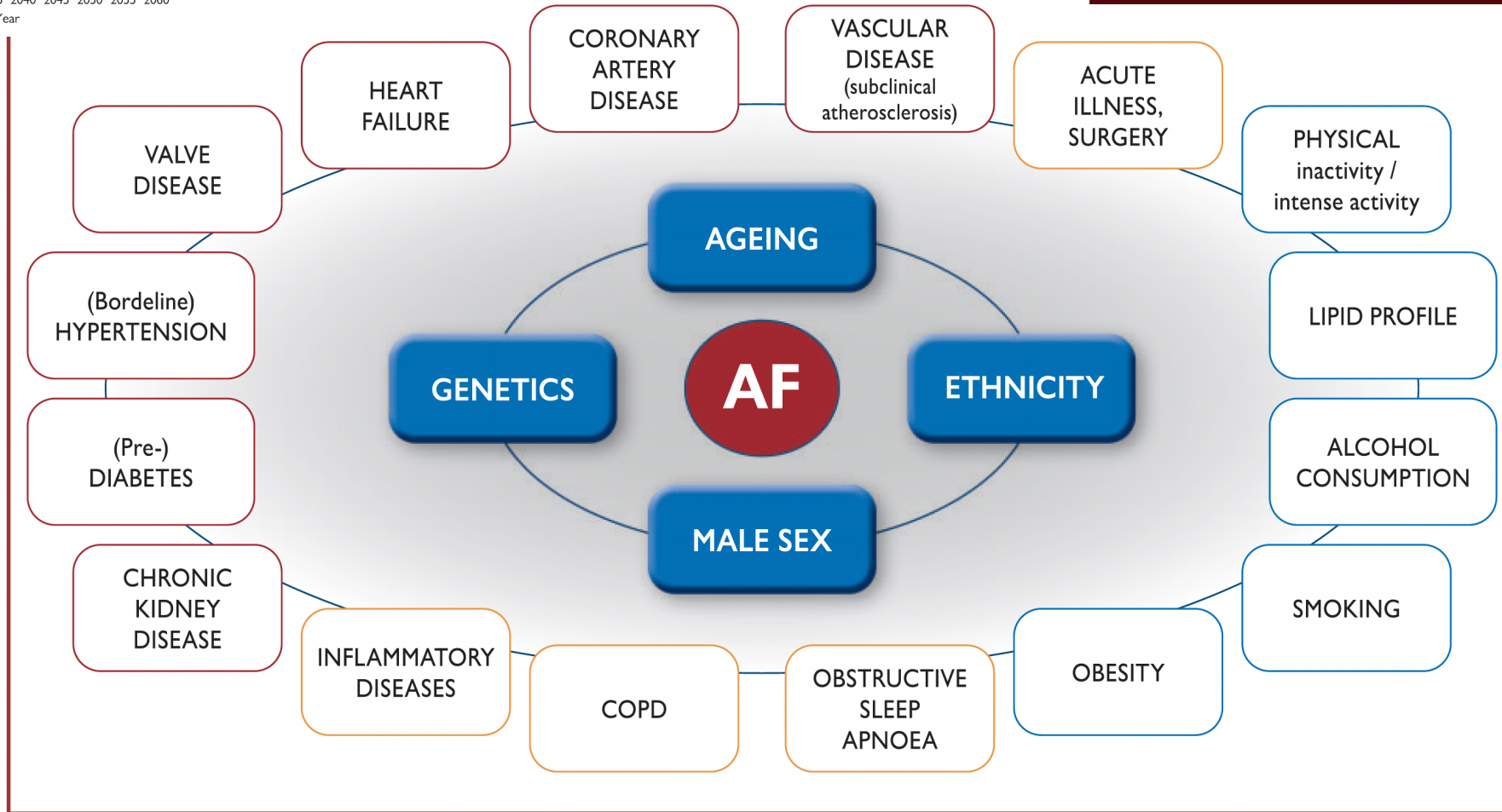
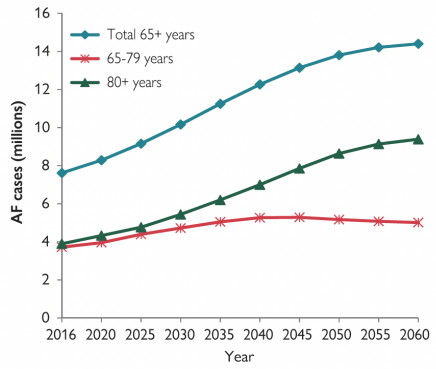






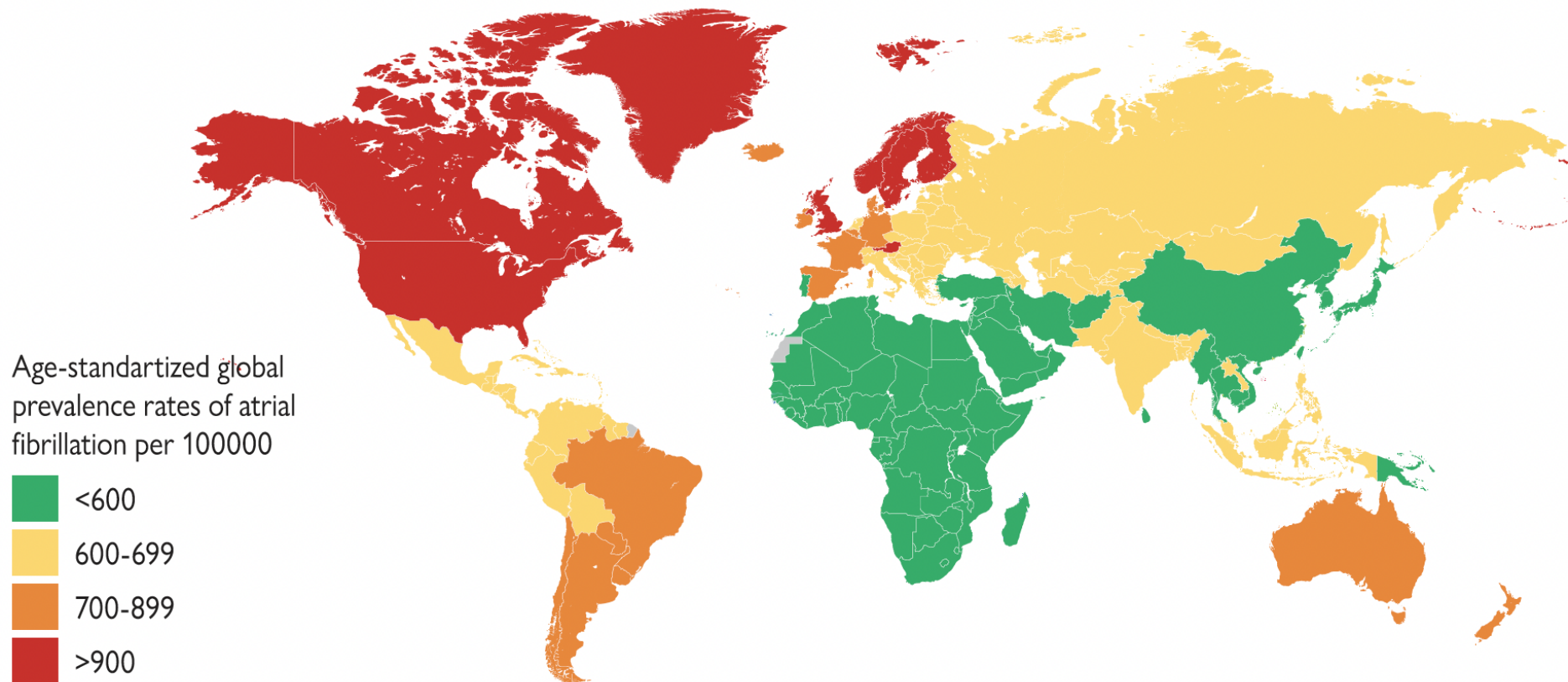
1 million de français  
en FA

**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)



**LIFETIME RISK for AF**  
**1 in 3 individuals**

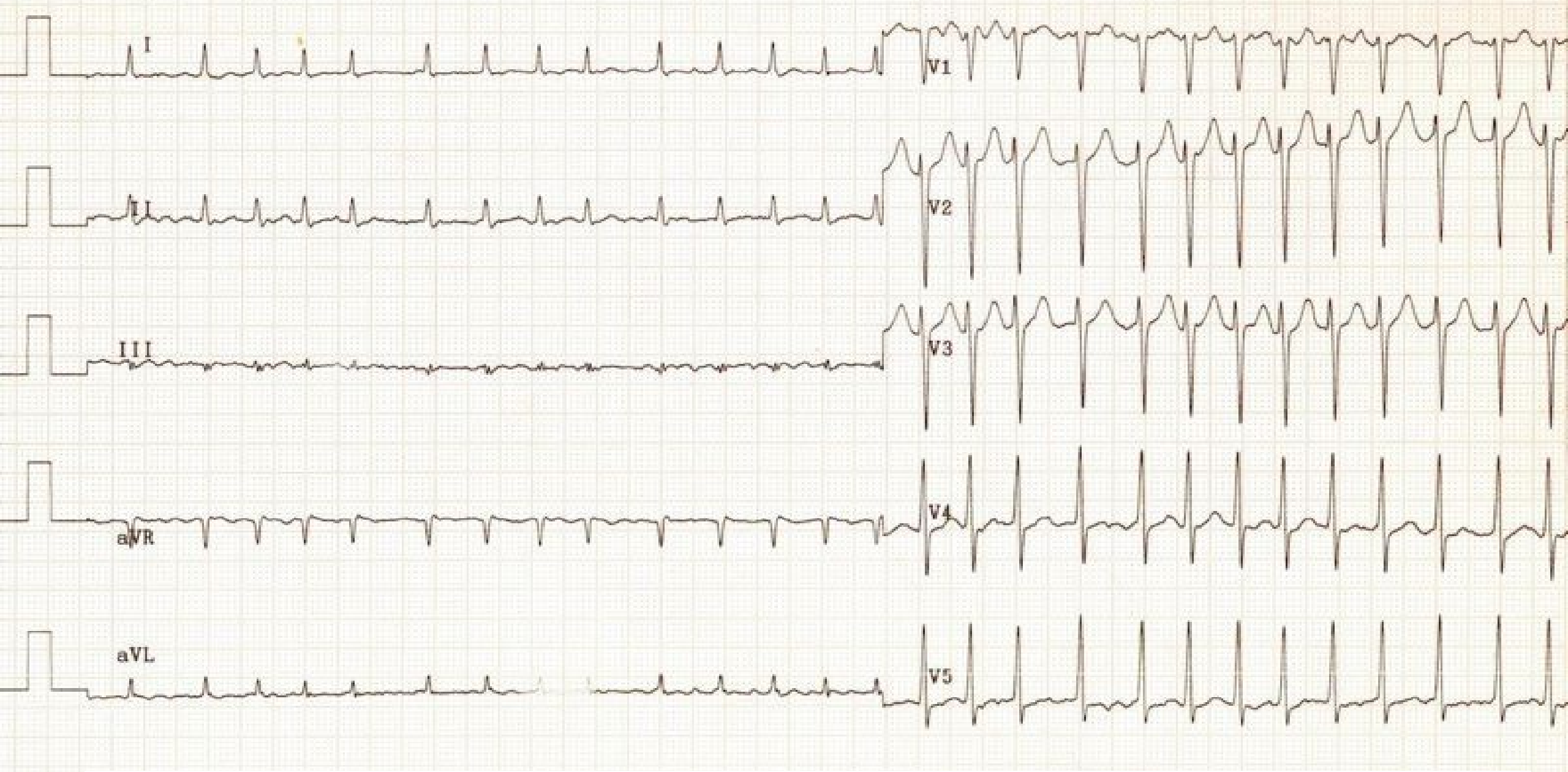


of European ancestry  
at index age of 55 years  
37.0% (34.3% to 39.6%)

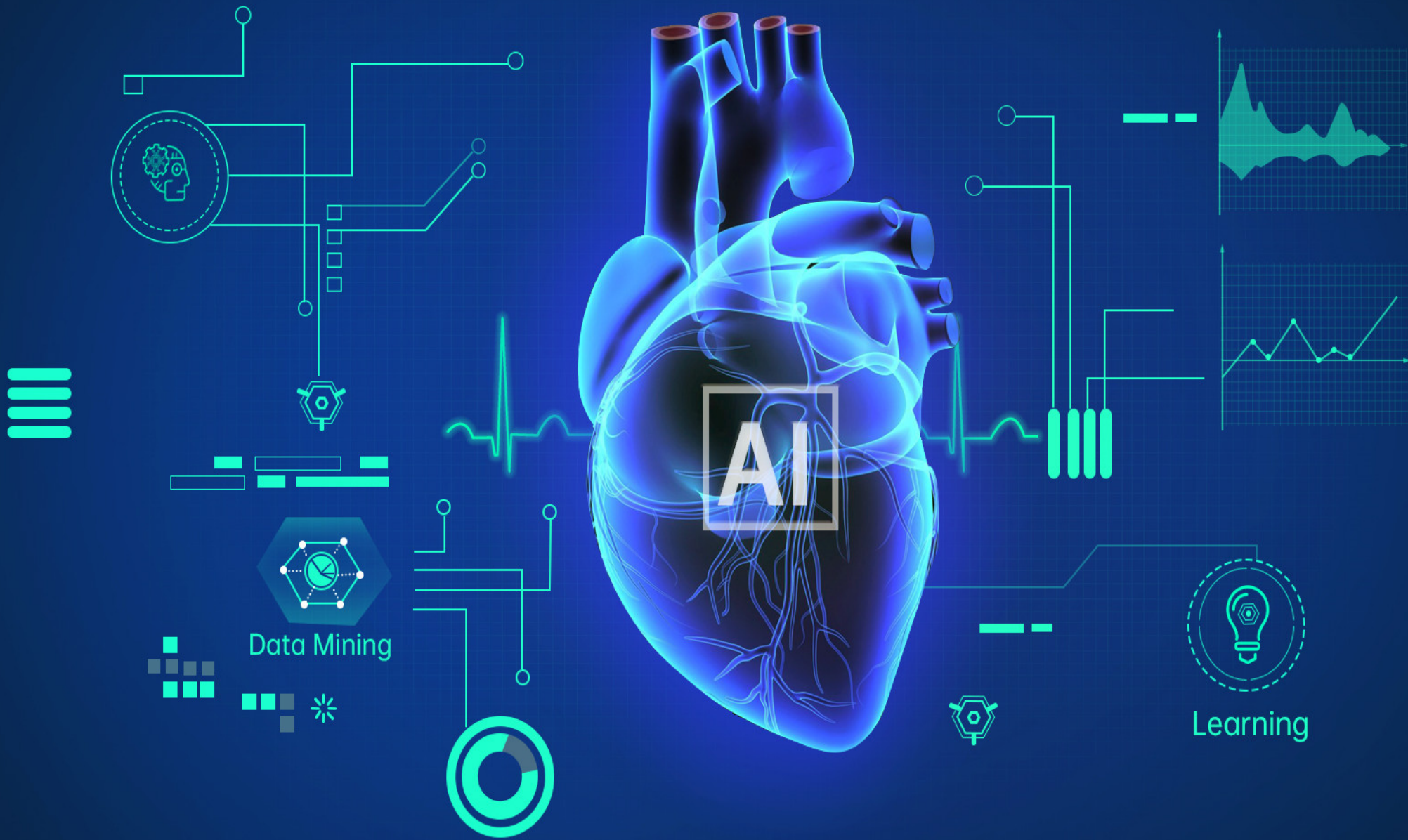


**Diagnostic**

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



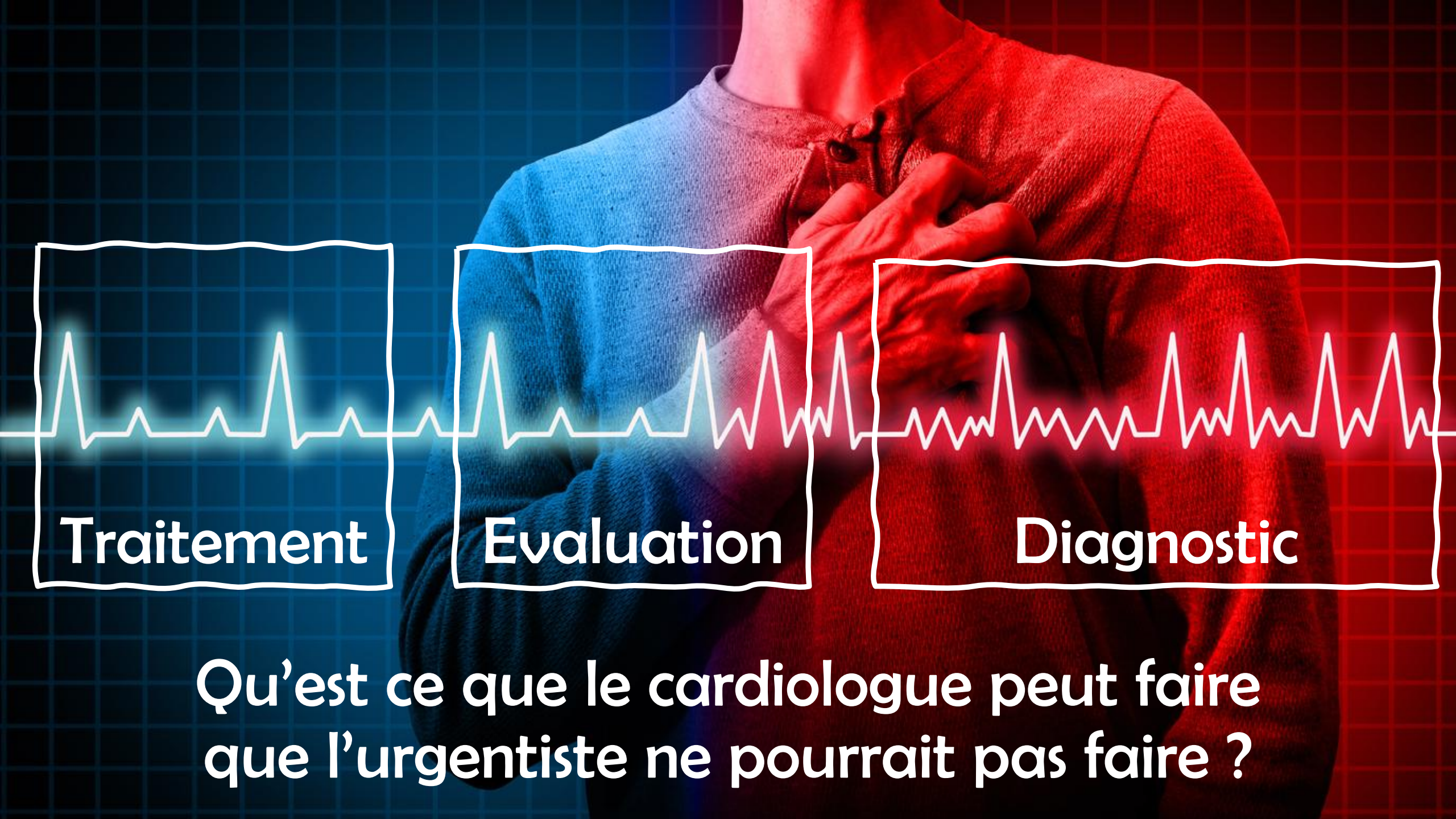
Tachycardie irrégulière à QRS (le plus souvent) fins



AI

Data Mining

Learning



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**

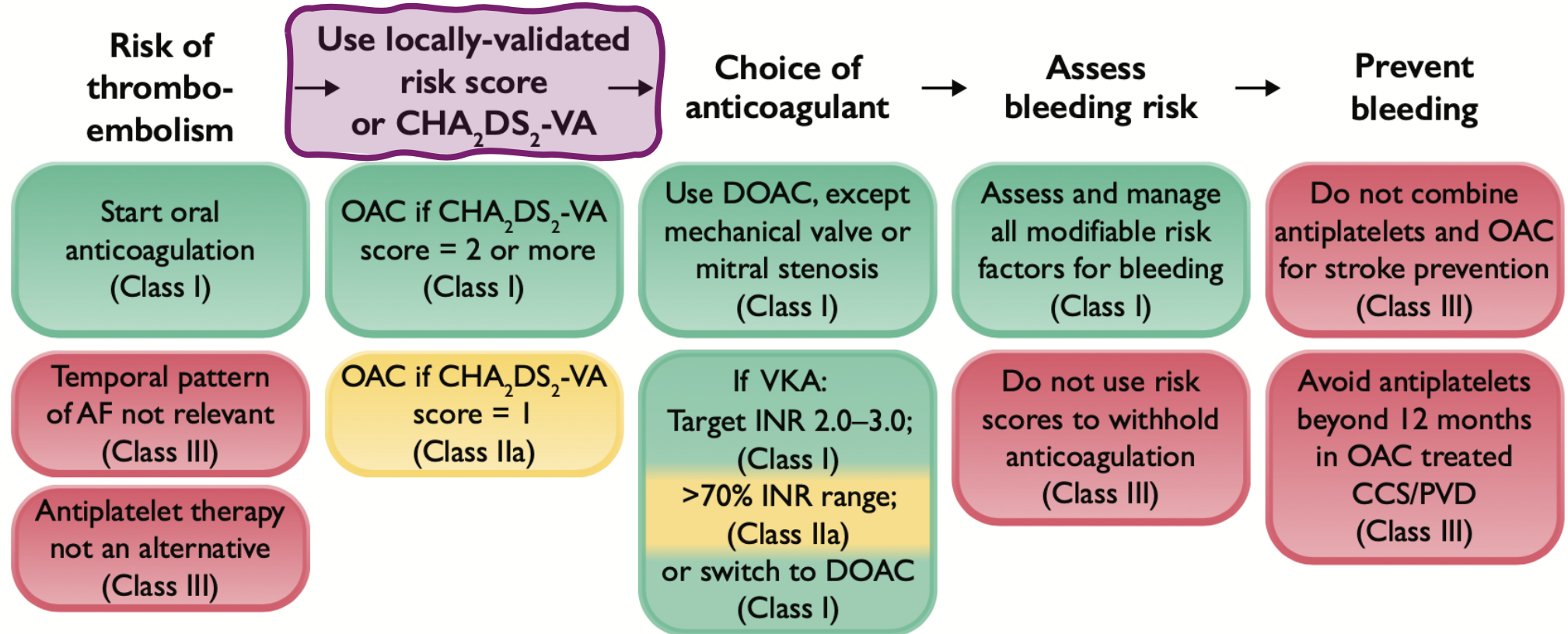
# **2024 ESC Guidelines for the management of atrial fibrillation developed in collaboration with the European Association for Cardio-Thoracic Surgery (EACTS)**

CHA<sub>2</sub>DS<sub>2</sub>-VASc

CHA<sub>2</sub>DS<sub>2</sub>-VA



### Avoid stroke and thromboembolism



Sc : sexe category

## Step 2

Consider stroke prevention (ie. OAC) in all AF patients with  $CHA_2DS_2-VASc \geq 1$  (male) or  $\geq 2$  (female)

**Address modifiable bleeding risk factors in all AF patients.**

**Calculate the HAS-BLED score.**

If HAS-BLED  $\geq 3$ , 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.

## CHA<sub>2</sub>DS<sub>2</sub>-VASc

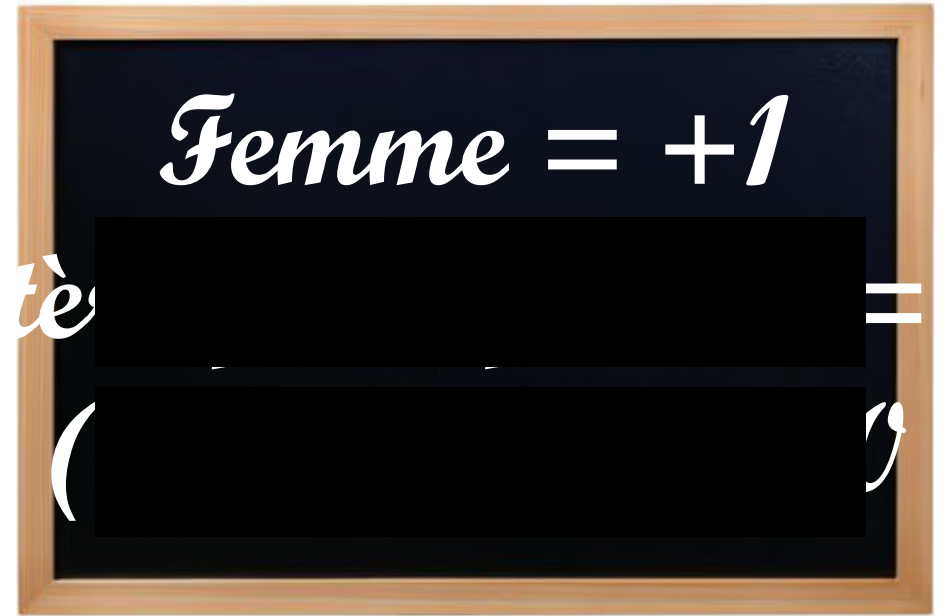
$\geq 1$  (male) or  $\geq 2$  (female)

OAC should be considered  
(Class IIa)

$\geq 2$  (male) or  $\geq 3$  (female)

OAC is recommended  
(Class IA)

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



## CHADS2 – VASc Score

<b>C</b>	Congestive Heart Failure	1
<b>H</b>	Hypertension (>140/90 mmHg)	1
<b>A</b>	Age $\geq 75$	2
<b>D</b>	Diabetes Mellitus	1
<b>S<sub>2</sub></b>	Prior TIA or stroke	2
<b>V</b>	Vascular disease (MI, aortic plaque etc)	1
<b>A</b>	Age 65-74	1
<b>Sc</b>	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 <sup>a</sup>	Level <sup>b</sup>	Recommendations in 2024 version	Class <sup>a</sup>	Level <sup>b</sup>
<b>Section 6.7—Bleeding risk</b>					
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 $\geq 3$ ) for early and more frequent clinical review and follow-up.	<b>IIa</b>	<b>B</b>	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.	<b>I</b>	<b>B</b>

↓  
**Step 2**

Consider stroke prevention (ie. OAC) in all AF patients with  
CHA<sub>2</sub>DS<sub>2</sub>-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.

↓  
CHA<sub>2</sub>DS<sub>2</sub>-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<sup>a</sup>)  
NOACs generally recommended  
as first line therapy for OAC





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palpitations, malaise, faiblesse générale

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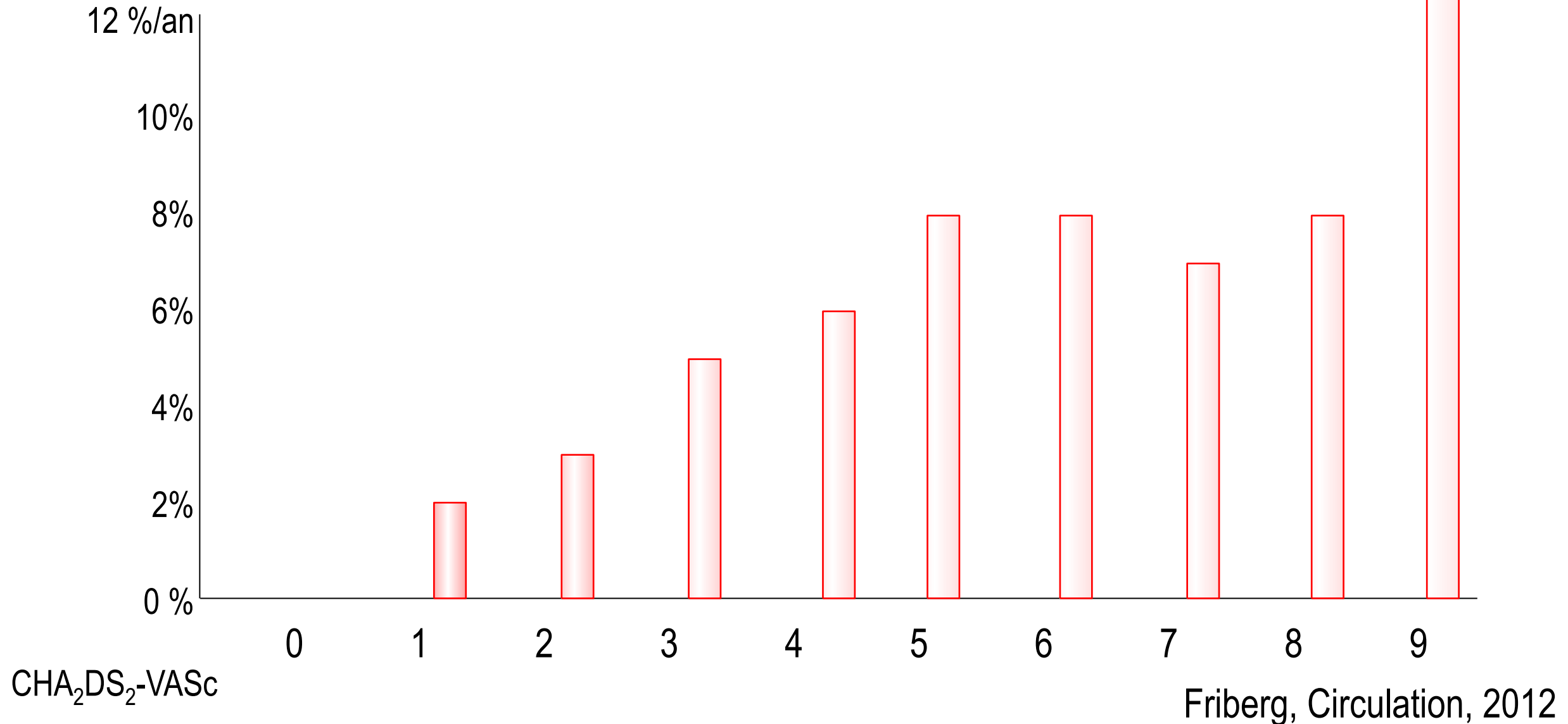
<b>CHA<sub>2</sub>DS<sub>2</sub>-VASc</b>	<b>Score</b>	<b>HAS-BLED</b>	<b>Score</b>
<u>C</u> ongestive heart failure/LV dysfunction	1	Hypertension i.e. uncontrolled BP	1
<u>H</u> ypertension	1	Abnormal renal/liver function	1 or 2
<u>A</u> ged ≥75 years	2	Stroke	1
<u>D</u> iabetes mellitus	1	<input type="checkbox"/> Bleeding tendency or predisposition	1
<u>S</u> troke/TIA/TE	2	<input type="checkbox"/> Labile INR	1
<u>V</u> ascular disease [prior MI, PAD, or aortic plaque]	1	Age (e.g. >65)	1
<u>A</u> ged 65-74 years	1	Drugs (e.g. concomitant aspirin or NSAIDs) or alcohol	1
<input type="checkbox"/> <u>S</u> ex category [i.e. female gender]	1		
<b>Maximum score</b>	<b>9</b>		<b>9</b>

2

3

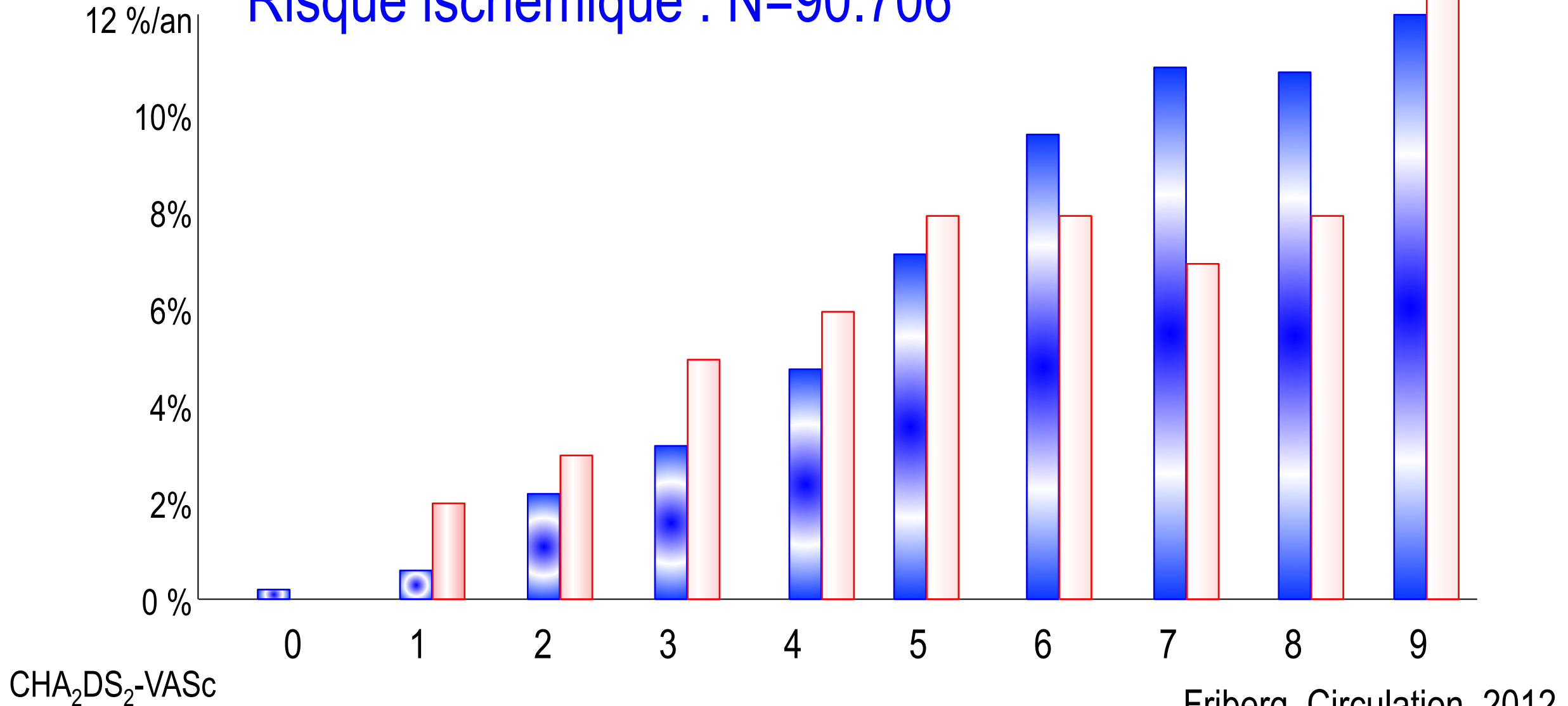


# Risque hémorragique : N=68.306



Risque hémorragique : N=68.306

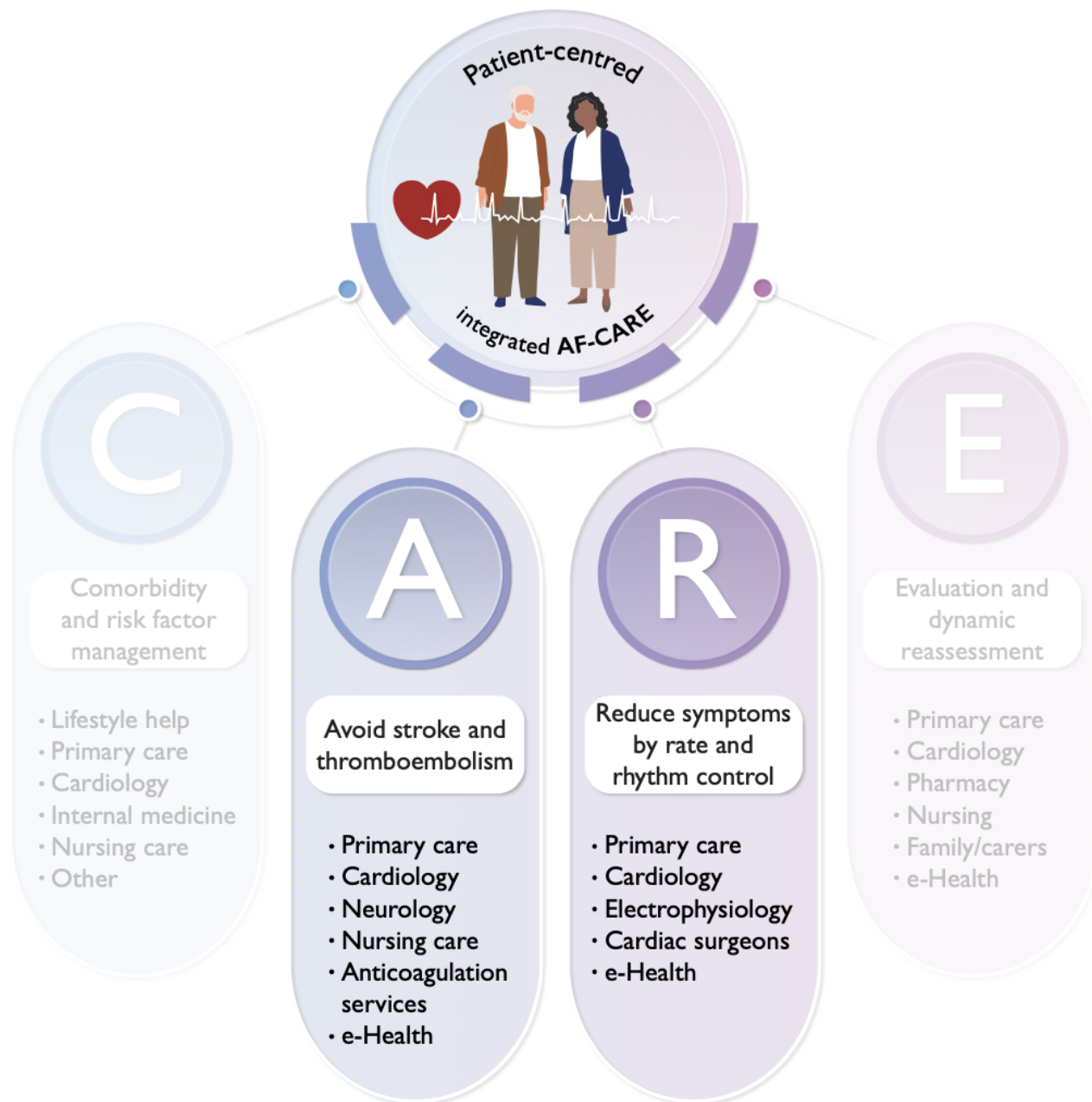
Risque ischémique : N=90.706



CHA<sub>2</sub>DS<sub>2</sub>-VASc

Friberg, Circulation, 2012

# Atrial fibrillation





**REGULATIONS**



**RULES**



**STANDARDS**



**COMPLIANCE**



**POLICIES**

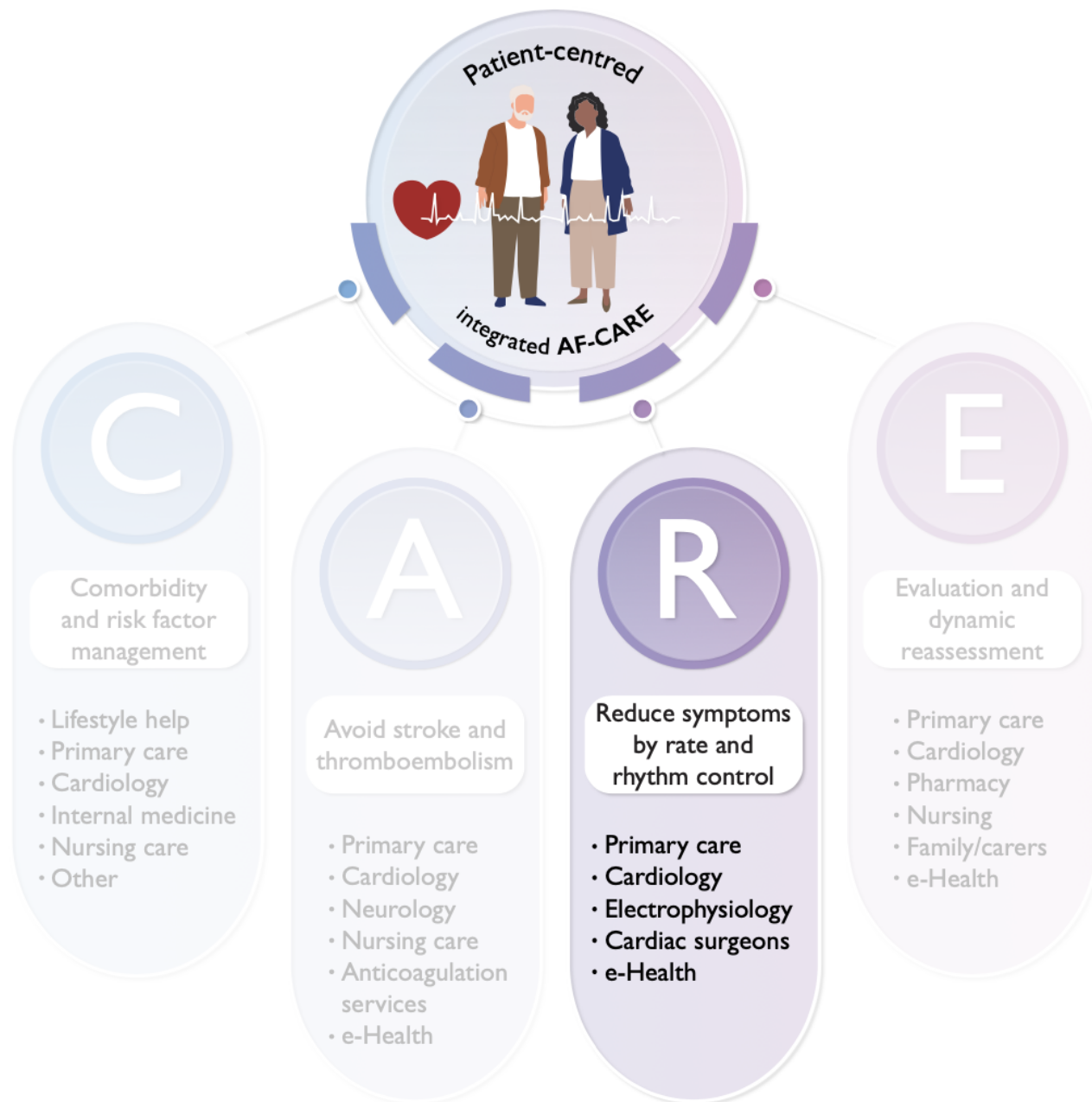


**LAW**

**REQUIREMENTS**



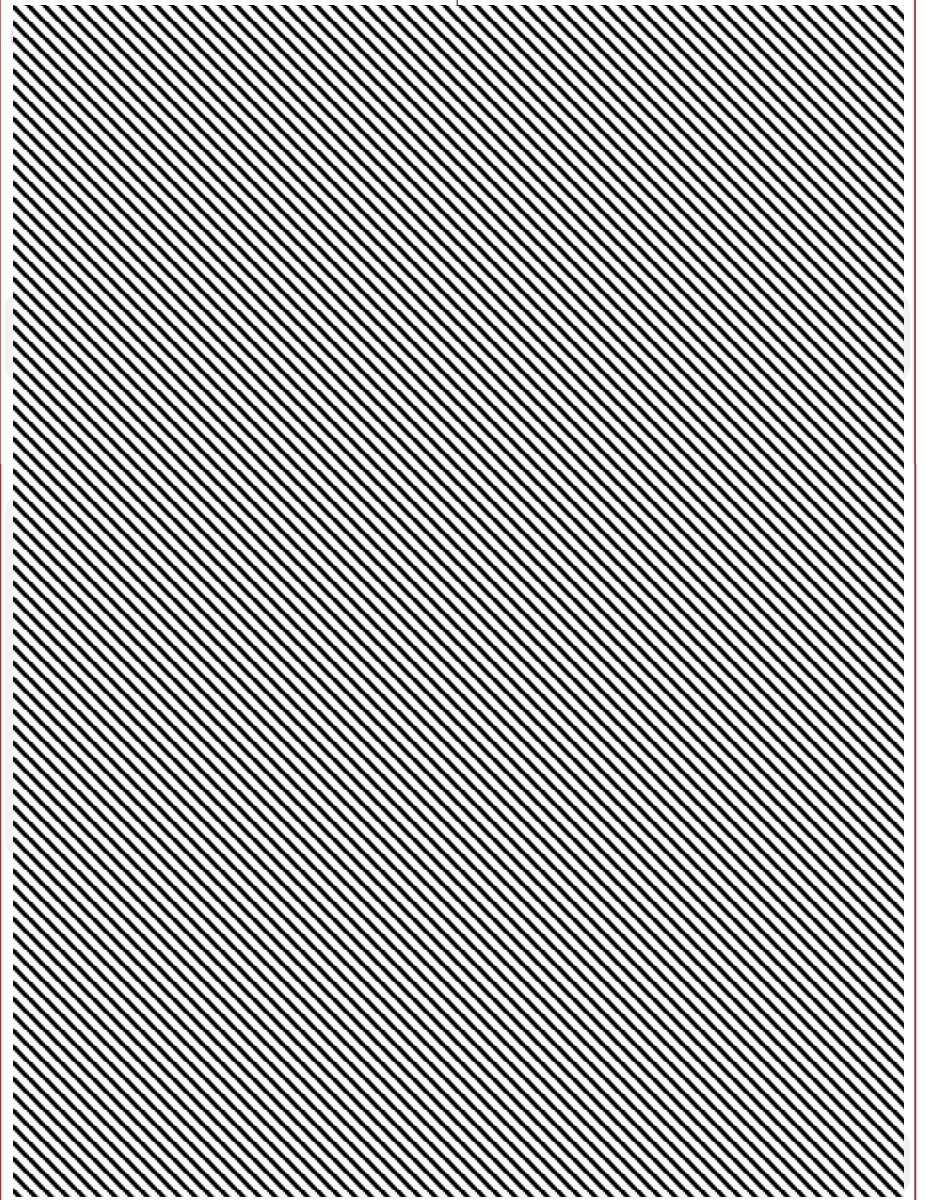
# Atrial fibrillation

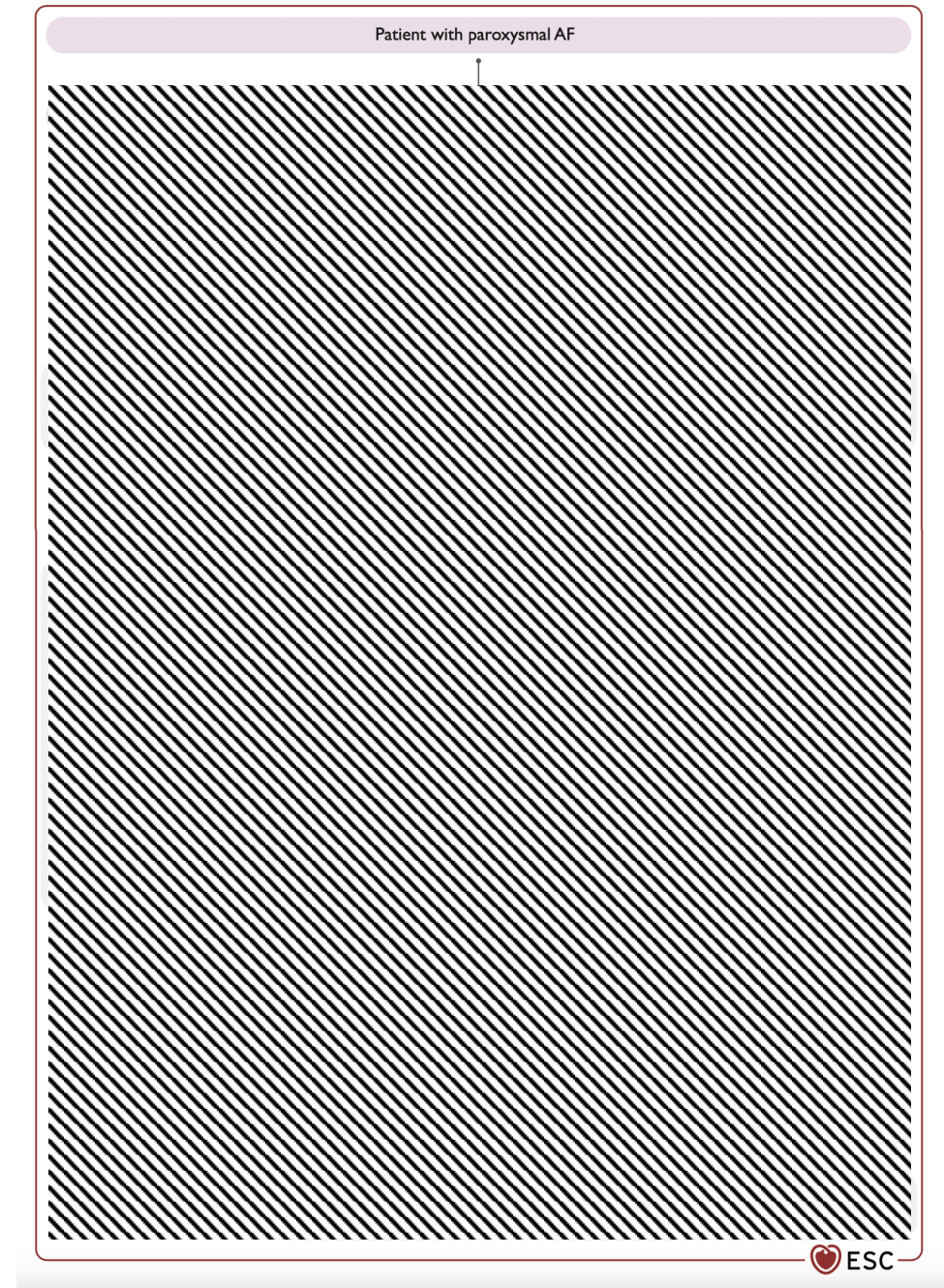
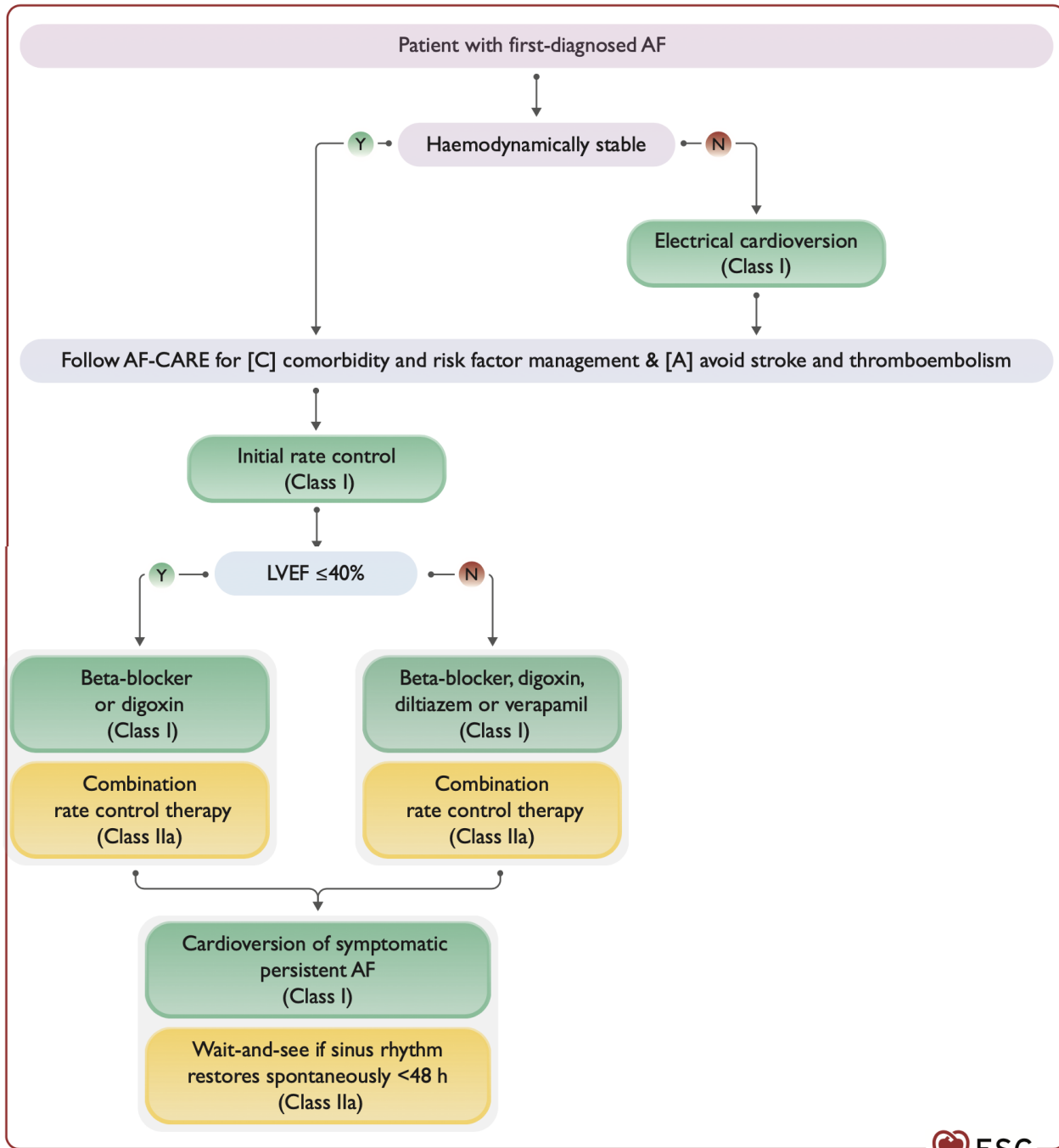


Patient with first-diagnosed AF



Patient with paroxysmal AF

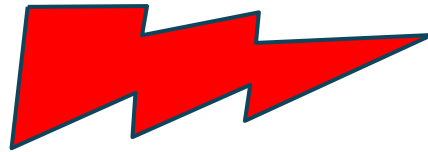




Patient with first-diagnosed AF



Haemodynamically stable



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

Initial rate control  
(Class I)

LVEF  $\leq$  40%

Y

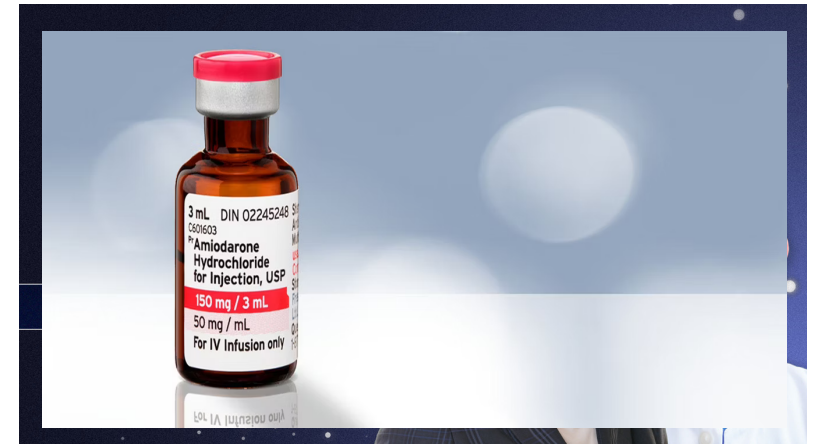
N

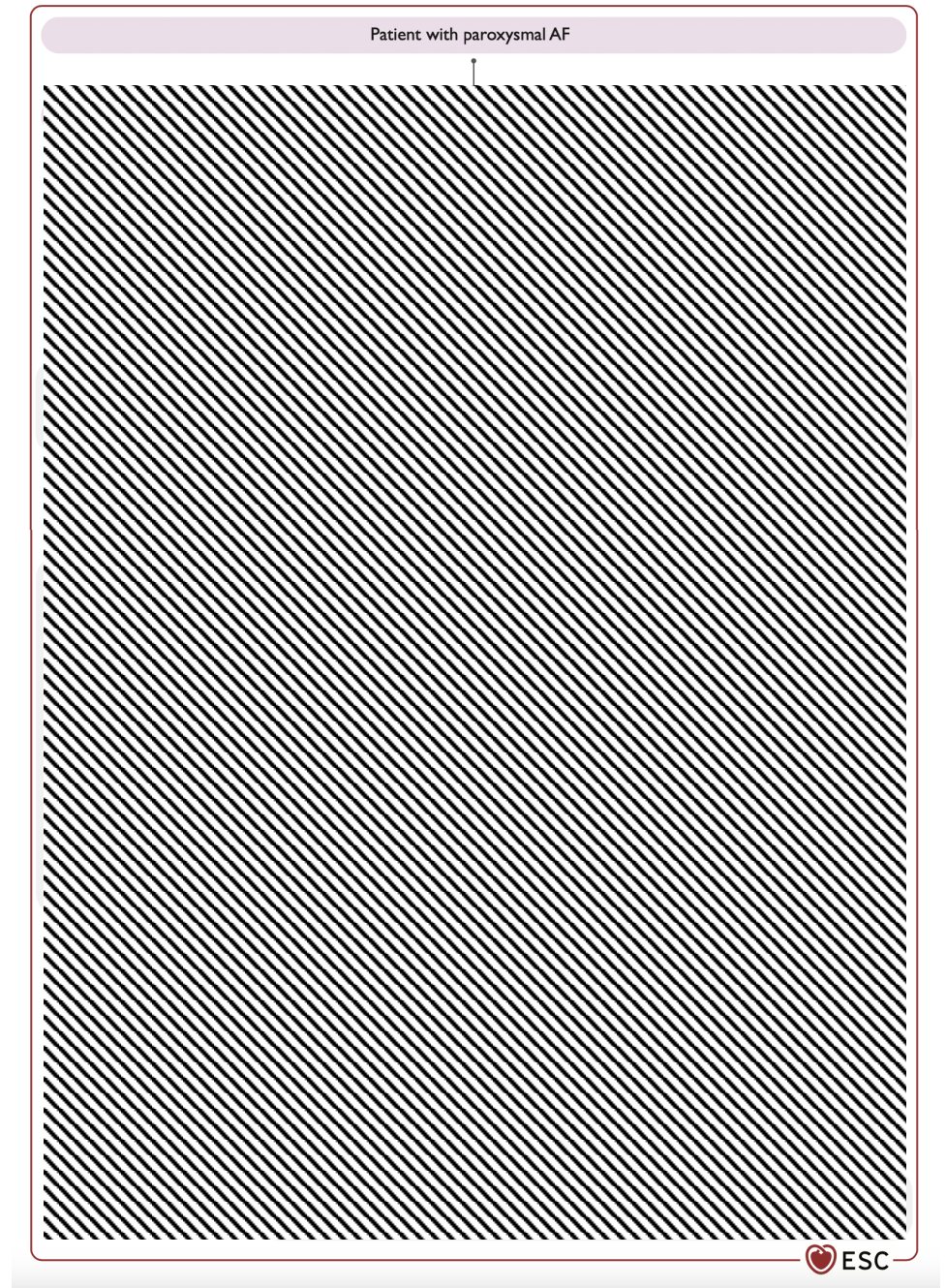
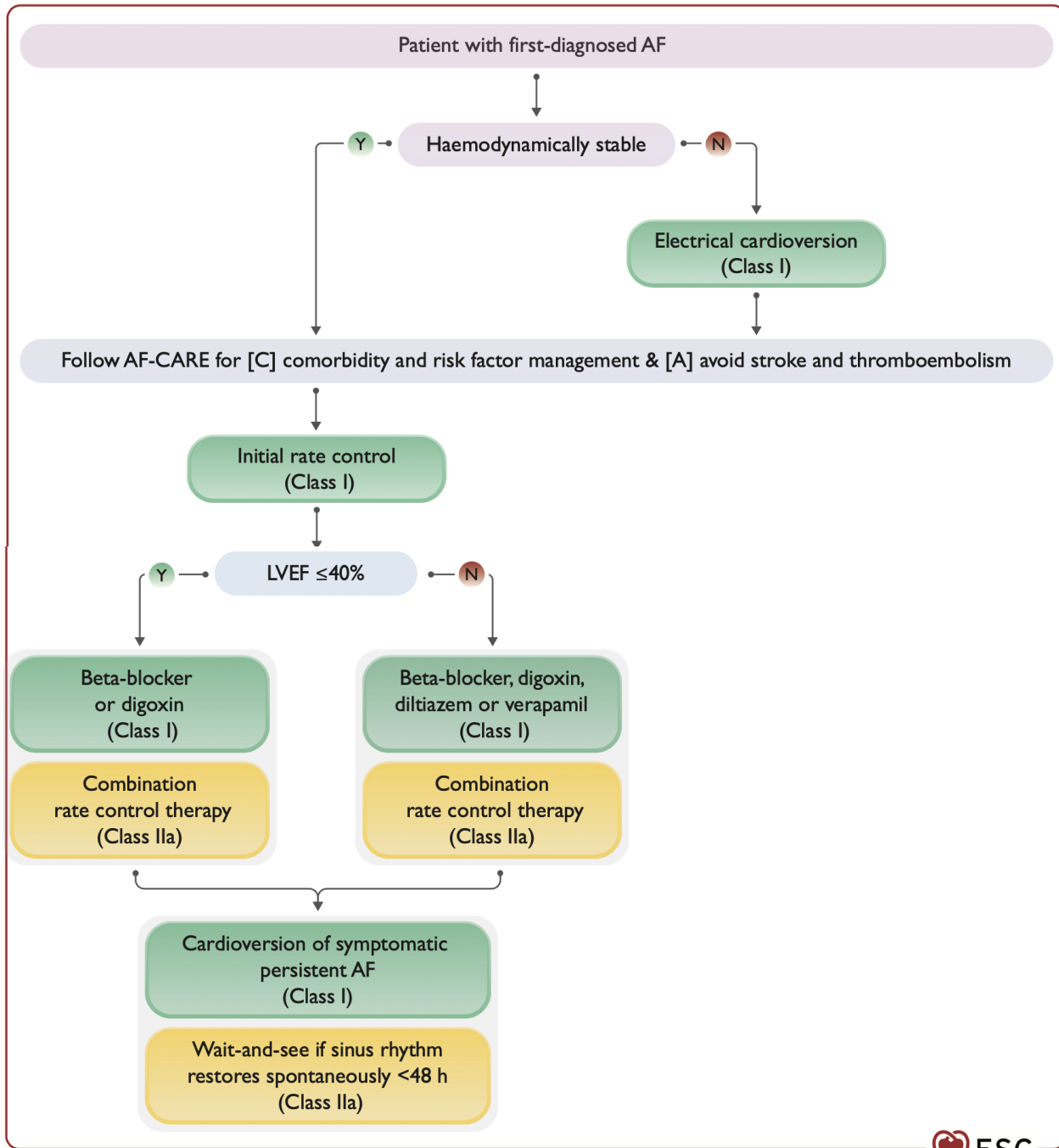
Beta-blocker  
or digoxin  
(Class I)

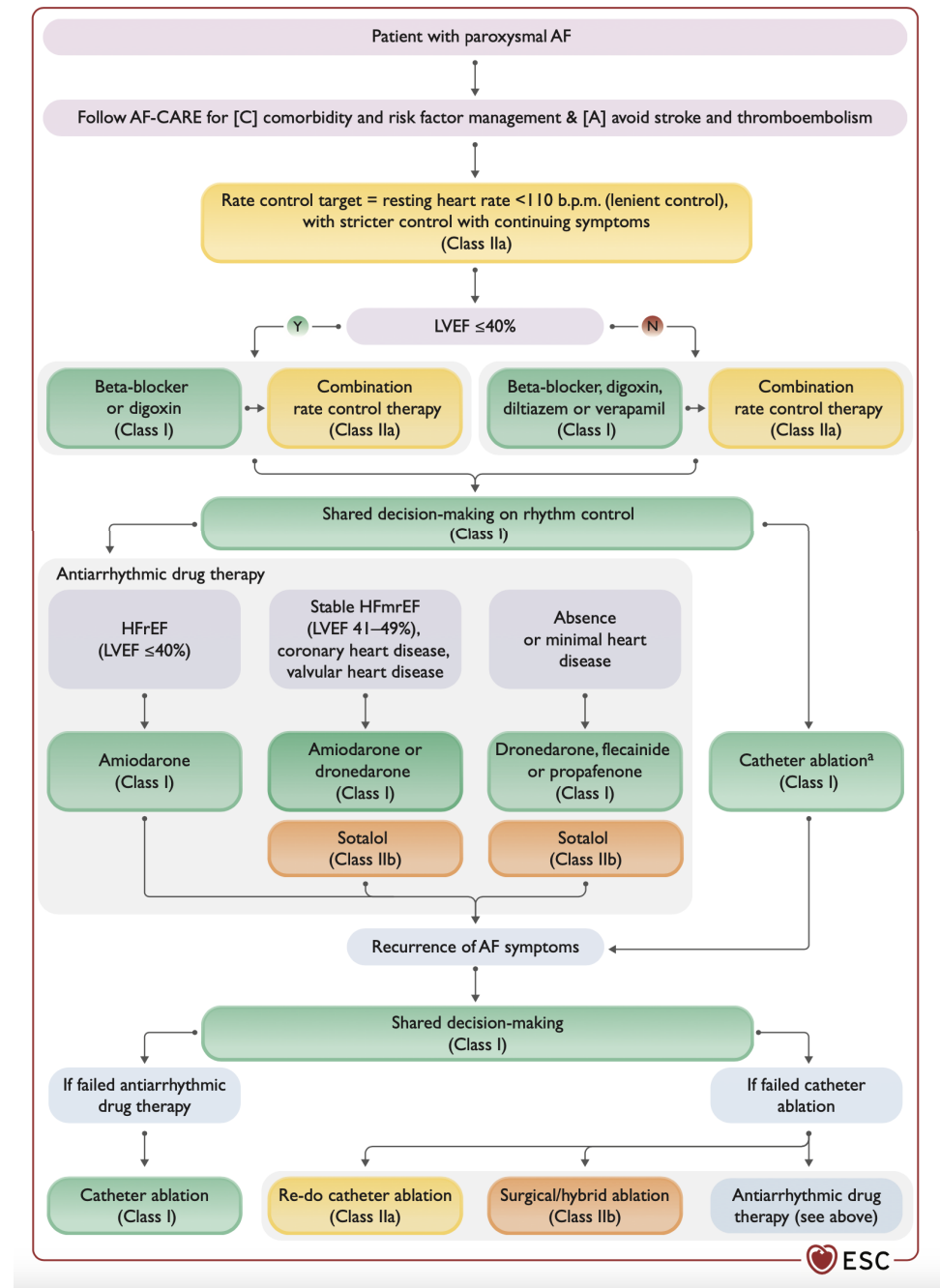
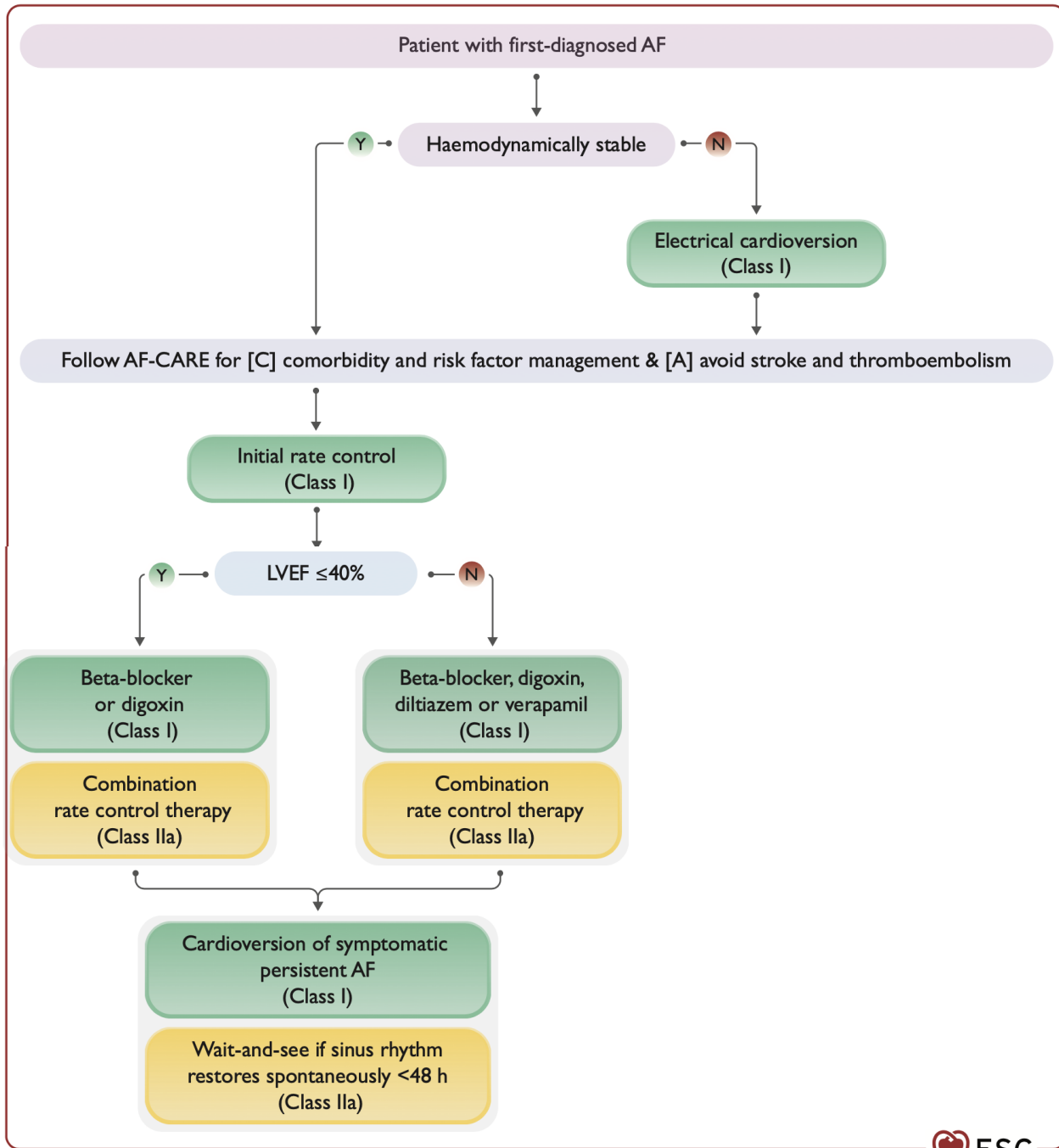
Combination  
rate control therapy  
(Class IIa)

Beta-blocker, digoxin,  
diltiazem or verapamil  
(Class I)

Combination  
rate control therapy  
(Class IIa)



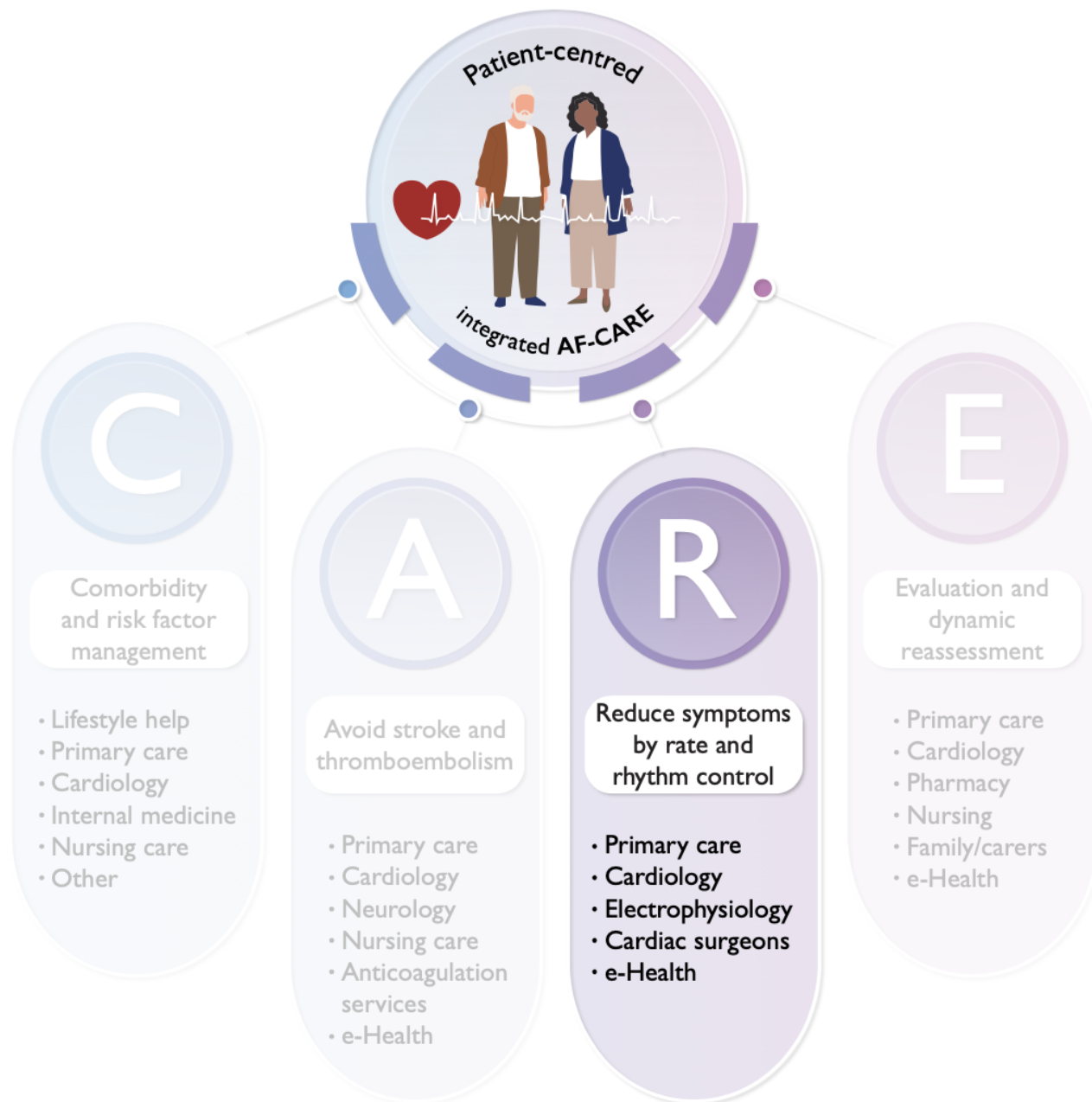




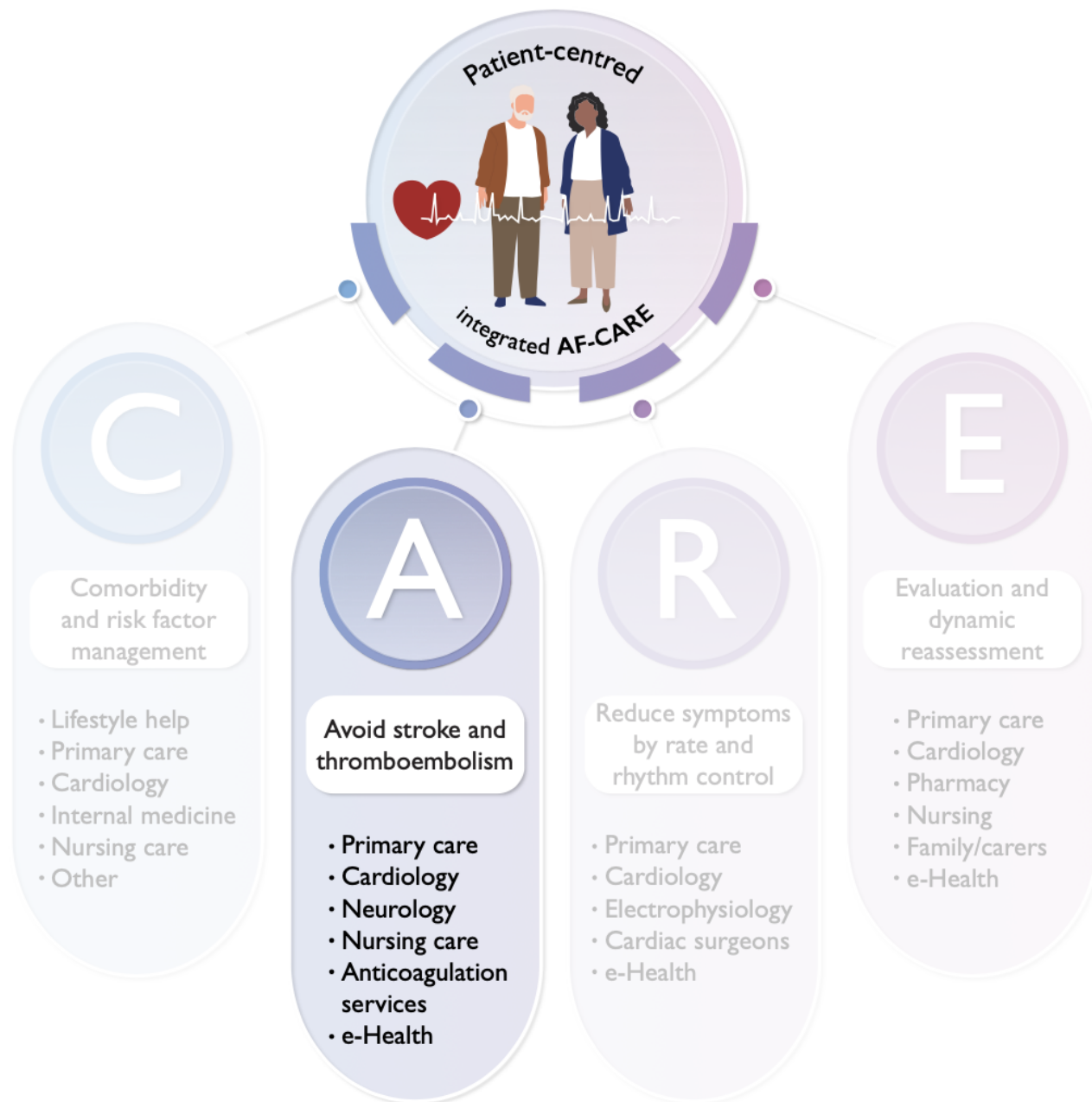
# Amiodarone



# Atrial fibrillation



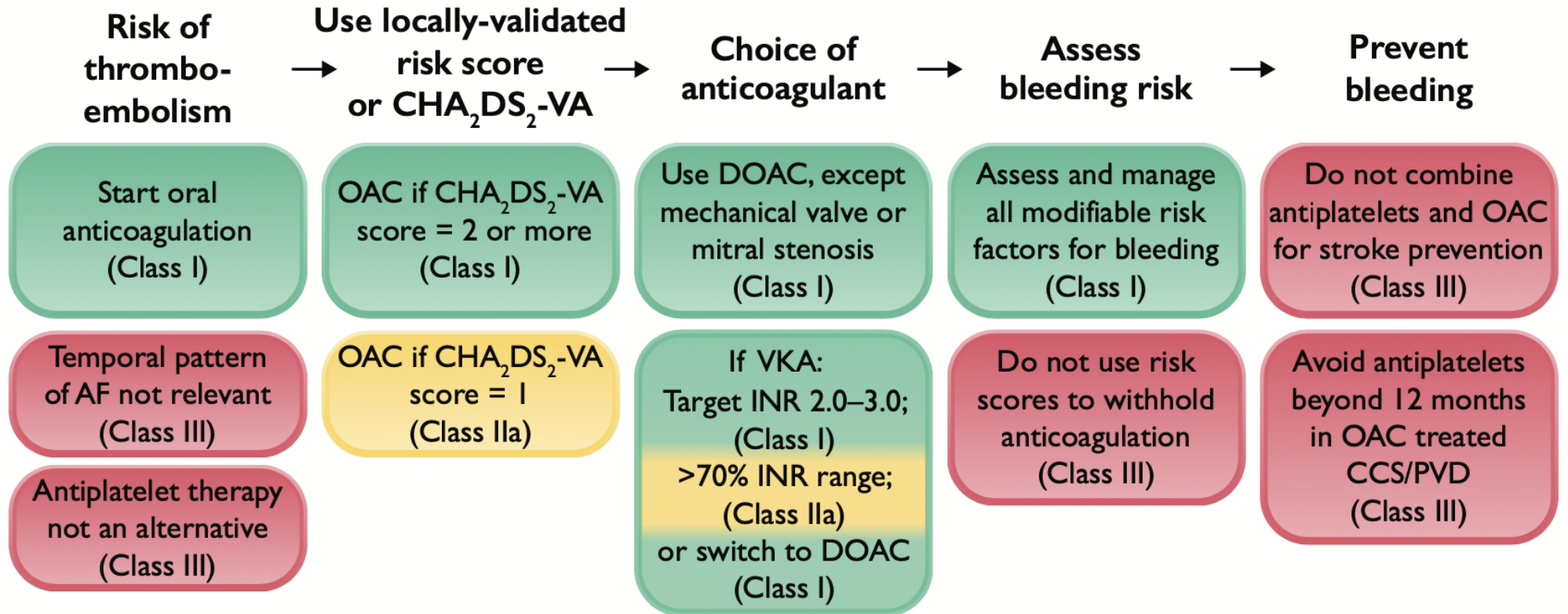
# Atrial fibrillation







## Avoid stroke and thromboembolism



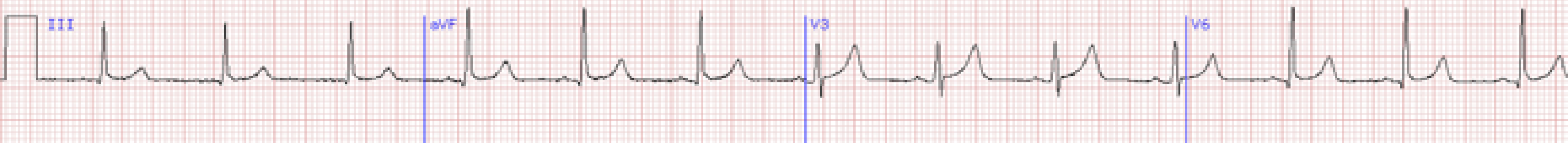
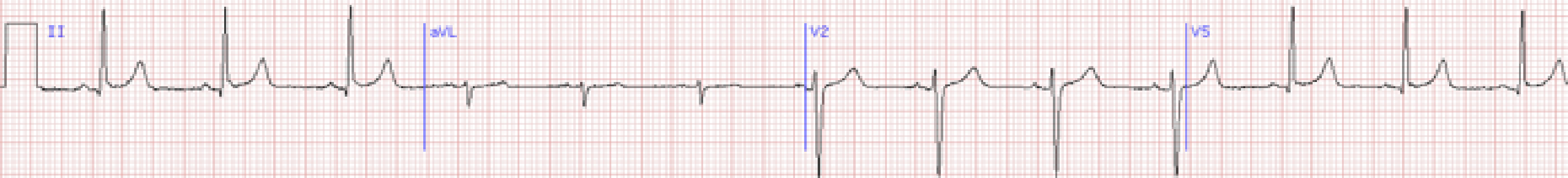
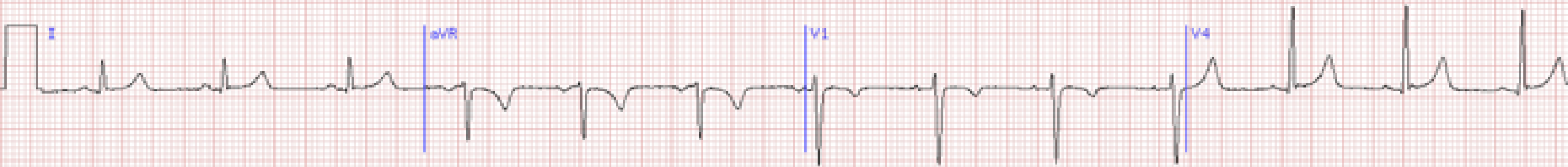


66 ans – HTA, UGD

Consultation samedi matin :  
palpitations, malaise, faiblesse générale

*« Il a pris une cuite hier,  
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30 minutes plus tard : se sent mieux...



Antiagrégant plaquettaire



Anticoagulant



Gestion risque hémorragique



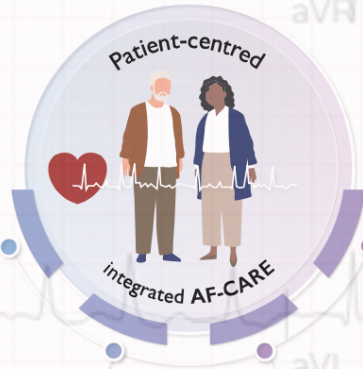
Anti-arythmique



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



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)



Setting individual targets for comorbidities and risk factors

Shared decision-making



Behavioural change

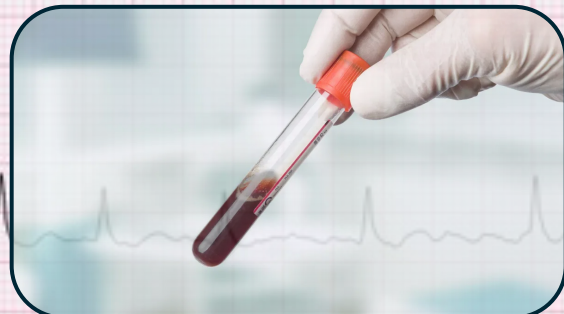
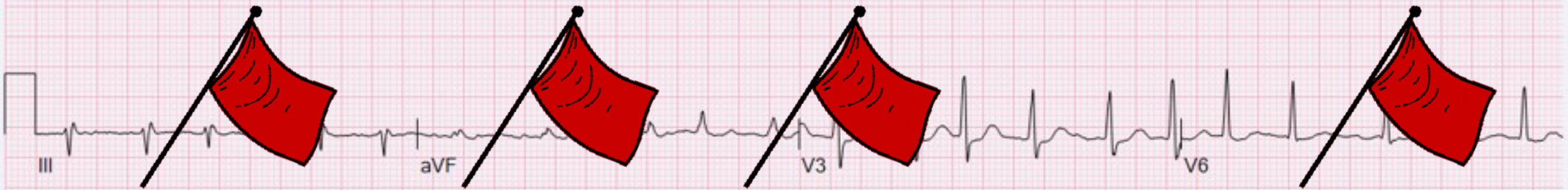
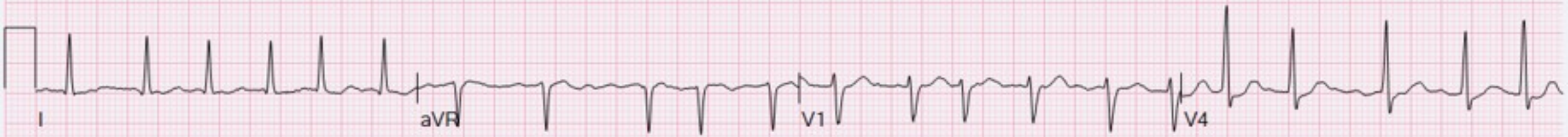


Focus on key risk factors

Achievable targets



Provide information without overloading



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

**Fibrillation atriale  
A-t-on toujours besoin  
d'un addictologue ?**





**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

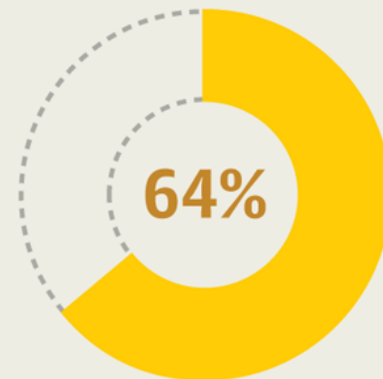
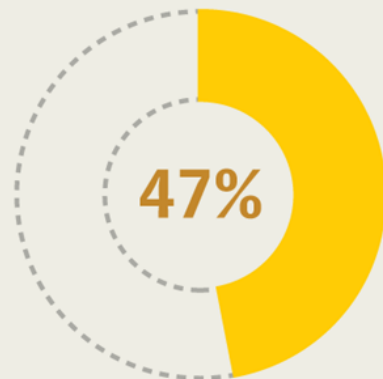


**Coffee  
consumption**  
100 Patients

**Coffee  
abstinence**  
100 Patients

Wong, JAMA Intern Med, Nov 2025

Rate of recurrence of AF or  
atrial flutter over 6 months

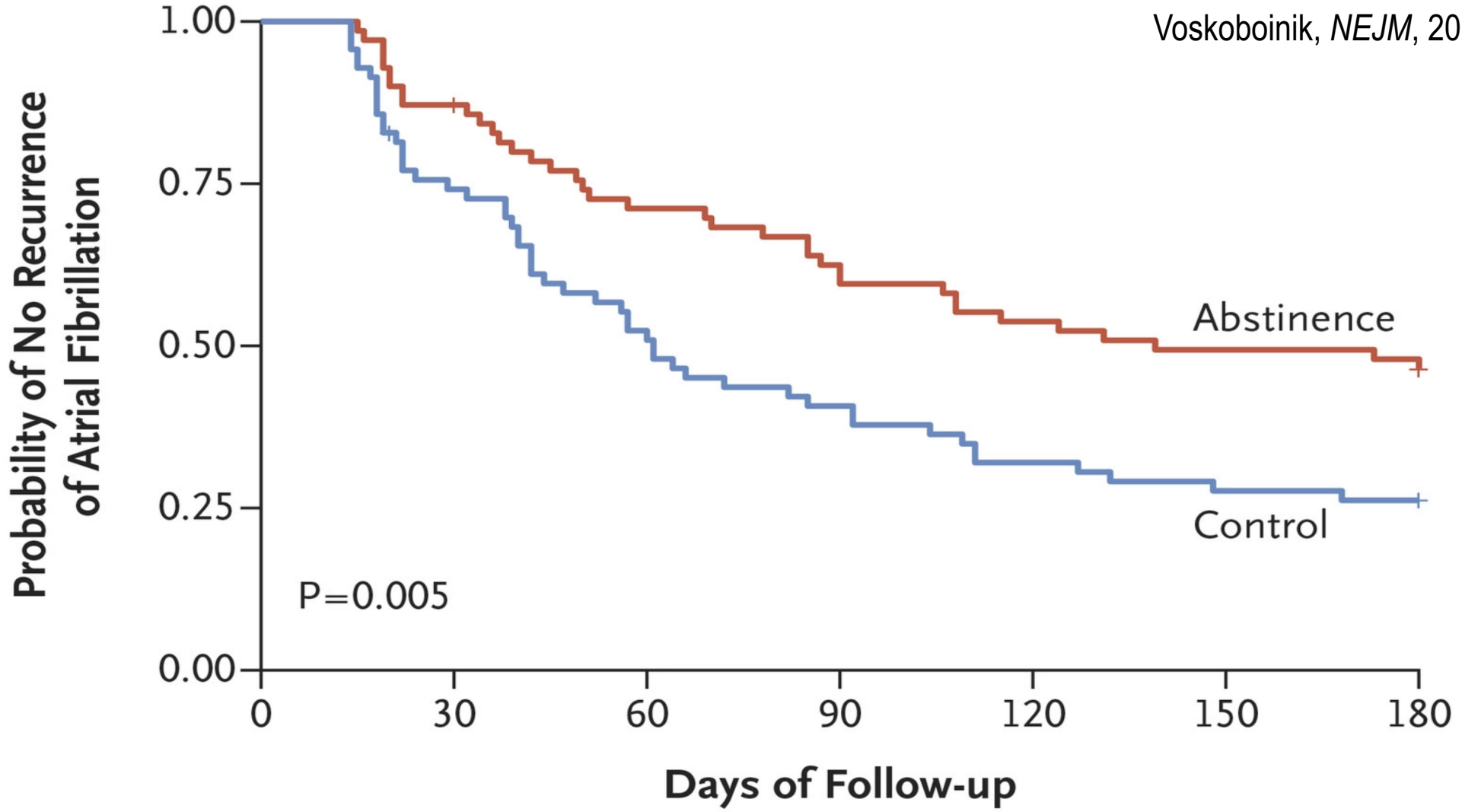




**7 (6-11)  
vs  
0 (0-2) tasses/jour**

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





**No. at Risk**

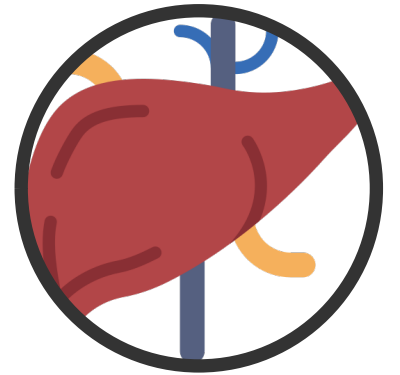
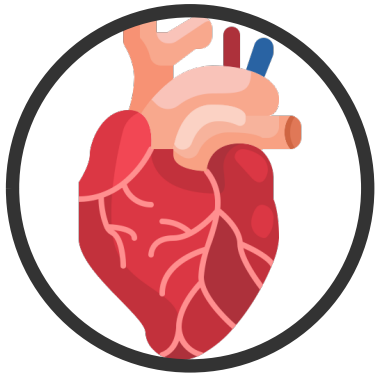
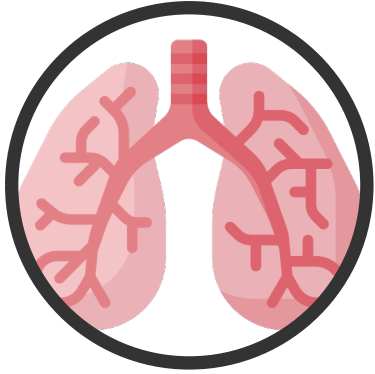
Abstinence	70	61	49	43	37	34	33
Control	70	51	36	28	22	19	18



sfmu  
Société Française de  
Médecine d'Urgence

Depuis  
1903  
ans

URGENTISTE





Congrès  
des **SAMU.URGENCES**  
DES OUTRE-MER

L'urgentiste doit gérer **toutes** les urgences !

Foto FLapo SAMU 93



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