Left atrial appendage obliteration: Quo vadis?

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Received for publication Oct 14, 2018; accepted for publication Oct 15, 2018; available ahead of print Dec 6, 2018.

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J Thorac Cardiovasc Surg 2019;157:999

0022-5223/\$36.00

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<https://doi.org/10.1016/j.jtcvs.2018.10.074>

The left atrial appendage (LAA) has been associated with stroke risk in patients with atrial fibrillation (AF). The safety, efficacy, and longitudinal impact of obliterating the LAA in patients with AF have long been topics of investigation and innovation.

For patients with nonvalvular AF, transcatheter closure was found to be noninferior to warfarin,¹ stimulating its widespread use² despite residual questions on prothrombotic complications³ and a protracted time to reach cost-effectiveness.⁴ Surgical LAA obliteration as a concomitant component of a Cox maze operation may be less controversial because of both its negative electrophysiologic impact and the potential ability to manage patients in sinus rhythm without anticoagulation.^{5,6} For patients with AF not undergoing surgical ablation, the indications and efficacy of surgical LAA obliteration are less clear. Although signals of potential benefit are present from clinical registries,⁷ randomized investigation has proved difficult.⁸

So, where do we go from here?

As we interpret the growing body of evidence to determine the best therapy for our patients, we must distinguish between patients undergoing surgical ablation and those who are not. In this issue of the *Journal*, Drs Dawn Hui and Richard Lee⁹ and Dr Craig Smith¹⁰ attempt to provide insight into the questions surrounding LAA obliteration by delivering erudite arguments on both ends of the ideologic spectrum.

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Central Message

The left atrial appendage has long been implicated in the stroke risk of atrial fibrillation. Does the evidence provide a clear path forward to answer the question to obliterate or not to obliterate?

See Commentaries on pages 1000 and 1004.

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