Commentary: Treating Atrial Fibrillation in Women: Guidelines versus Reality

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Disclosures: Ibrahim Sultan receives institutional research support from Abbott, Atricure, Artivion, Gore, Edwards, Medtronic, Terumo Aortic

Word count: 486
Central Message

Gender disparities are evident in non-mitraI cardiac surgery, with women less likely to receive treatment for concomitant atrial fibrillation despite guideline recommendations.

Central Picture Legend

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Journal Pre-proof
The Society of Thoracic Surgery (STS) has consistently recommended treating concomitant atrial fibrillation (AF) as a Class 1 indication in patients undergoing non-mitral surgery in both the 2017 and 2023 guidelines. This recommendation is driven by patient-level data demonstrating improvement in survival and stroke outcomes associated with the concomitant AF treatment during cardiac surgery. With this context in mind, it is reassuring that Wagner and colleagues have reported a clear upward trend in the adoption of guideline-directed AF therapy since 2017 in the State of Michigan. However, it was disappointing to discover the significant gender disparity in the treatment of concomitant AF. Specifically, women in the state of Michigan are 26% less likely to undergo surgical ablation for AF despite risk adjustment for baseline characteristics. The authors diligently investigate why this gender disparity exists; revealing that women had a higher preoperative risk profile that could have contributed to an elevated perceived risk of concomitant AF treatment. Their data advocates that this gender disparity persists after controlling for factors such as demographics and comorbidities. A key takeaway in this study is that once a surgeon decides to treat AF, the type of surgical strategy did not vary between men and women. This implies that undertaking an additional procedure in a patient with an already elevated STS risk score varies with surgeon and institutional experience. An limitation of the study is the lack of consideration of intraoperative anatomic variables. Cardiovascular disease in women is different than in men, more often complicated by coronary microvascular dysfunction, small vessels, and aortic annulus diameter. It would be relevant to consider if the decision to proceed with concomitant AF treatment changed based on the perceived or actual difficulty of the operation. Health care disparities reflected in data are often rooted in subtle variations in practice. While these may depend on a surgeon's experience and comfort level with the surgical ablation of AF, there are also unaccounted biases that influence decision-making. For instance, consider the gender of the operating surgeon treating these patients. A woman cardiac surgeon might be more aware of the potential for higher stroke rates in women with AF and the fore might adopt a more aggressive approach to...
This approach could be further supported by the recent 2023 STS guideline change, which elevated left atrial appendage ligation to a class I indication. Moreover, the advent of the all-encompassing left atrial posterior wall radio frequency clamp which provides an ablation technique without the cost of increased ischemic times.

AF is one of the most common comorbidities among patients undergoing cardiac surgery. Surgeons and surgical societies are motivated to improve long-term outcomes with coronary or valvular surgery as catheter-based therapies become more prominent. An effective strategy would be to treat concomitant AF, which can lead to improved survival, fewer hospital readmissions, and a reduced risk of stroke. This approach should be equally prioritized for women as it is for men.
REFERENCES


