

Management of patient with atrial fibrillation with rapid ventricular response seen in the emergency room

DOI: <https://doi.org/10.36104/amc.2025.4772>

Dear Editor:

We carefully read the article by Oliveros-Muñoz et al. published in your recent issue (1). We especially appreciate the initiative of describing this condition in a regional context which is usually under-represented in the national scientific literature.

This study represents progress in the local characterization of a growing and clinically challenging problem. As emergency medicine physicians interested in public health and continuous patient care improvement, we would like to offer some observations that, far from discrediting this effort, seek to enrich the discussion.

First, while there was partial adherence to international clinical guidelines, it is interesting to note the significant use of amiodarone in stable scenarios, as well as the preference for digoxin as the first strategy for rate control. This contrasts with the current recommendations in the 2024 ESC guidelines that suggest prioritizing beta blockers or non-dihydropyridine calcium channel blockers and limiting the use of amiodarone to specific contexts (2).

Likewise, the low proportion of anticoagulated patients even among those on rate control medications evidences a concerning gap in stroke prevention. This phenomenon has also been reported in other Colombian institutions (3). We believe that risk stratification protocols (CHA₂DS₂-VA, HAS-BLED) must be implemented in the emergency room to help make anticoagulation decisions beginning at the first care contact (4, 5).

The study does not address subsequent clinical outcomes (repeat consultations, hospitalization, adverse events), which limits its operational applicability. Furthermore, its single-center nature restricts generalization of the findings; therefore, we recommend the design of multicenter studies with prospective analysis.

Finally, we highlight the need to incorporate comprehensive care models in the emergency room that include extended observation, patient education, and effective connection with ambulatory cardiology, key components of today's approaches to atrial fibrillation.

Dr. Felipe Salas. Residente de tercer año en Medicina de Urgencias, Pontificia Universidad Javeriana. Cali
E-Mail: fesaled90@javerianacali.edu.co,

Dra. Estefanía Cristancho. MD Esp. Médica Emergencióloga, Clínica Farallones. Cali (Colombia)
estefaniacristanchog@javerianacali.edu.co

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ANSWER

Dear Editor:

We are deeply grateful to our colleagues who devoted time and attention to reading our paper critically (1) and drafting their letter. Their observations are valuable, and we are honored by their recognition of the pertinence of a regional exploration of a highly clinically relevant condition like atrial fibrillation with rapid ventricular response in the emergency room.

We completely agree with the importance of adjusting treatment strategies to the international guidelines' most recent recommendations. As you have pointed out, the widespread use of amiodarone and inclusion of digoxin as the first choice for rate control in some cases are practices largely explained by the limited availability of drugs at our institution. However, we recognize that this situation should not be considered the optimal pathway, but rather a reflection of the actual care context in institutions with limited resources. Your comments reinforce the need to update local protocols to coincide with the 2024 ESC guidelines and, at the same time, recognize the different treatment options available in different parts of the country.

As far as the low proportion of anticoagulated patients, we fully concur with your concern. Our analysis confirmed this gap in stroke prevention and, while our article highlighted the relevance of implementing timely anticoagulation, we accept that it should have addressed this point in greater detail. Your suggestions regarding the systematic use of risk scales like CHA₂DS₂-VA and HAS-BLED, starting at the first care contact in the emergency room, are a valuable contribution for future interventions, and we are convinced that their incorporation could contribute to a significant change in daily clinical practice.

We also agree that the lack of subsequent clinical outcomes limits our study's operational applicability. The retrospective and single-center nature of the design was recognized as a limitation from the outset, but your comments highlight the urgency of encouraging multi-center, prospective, longitudinal projects. These initiatives will not only strengthen the external validity of the findings but will also help improve understanding of the impact of initial emergency room decisions on the long-term clinical course.

Finally, we value your proposal to advance toward comprehensive care models in the emergency room. We concur that atrial fibrillation demands not only immediate pharmacological intervention, but also educational components, adequate clinical observation, and seamless articulation with ambulatory cardiology. These elements are key for improving adherence to treatment and reducing recurrent events.

In summary, we are deeply grateful for your contributions that enrich scientific discussion and encourage us to continue perfecting our work. We are convinced that collective construction, fed by respectful and well-founded criticism, is the path to achieving better practices for our patients' benefit.

Cordially,

Dra. Jhoana Carolina Oliveros-Muñoz. *En nombre de los autores del artículo*

Correspondencia: Dra. Jhoana Carolina Oliveros-Muñoz. Armenia (Colombia)

E-Mail: jhois1626@gmail.com

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