

Letter by Diomedi et al Regarding Article "Continuous Stroke Unit Electrocardiographic Monitoring Versus 24-Hour Holter Electrocardiography for Detection of Paroxysmal Atrial Fibrillation After Stroke"

Marina Diomedi, Silvia Di Legge and Fabrizio Sallustio

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Letter to the Editor

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Letter by Diomedì et al Regarding Article “Continuous Stroke Unit Electrocardiographic Monitoring Versus 24-Hour Holter Electrocardiography for Detection of Paroxysmal Atrial Fibrillation After Stroke”

To the Editor:

We read with interest the article by Rizos et al.¹ The authors reported on the efficacy of continuous stroke unit ECG monitoring (CEM) in the detection of paroxysmal atrial fibrillation (AF) compared with 24-hour Holter ECG. With a median recording time of 64 hours, CEM proved to be superior with a significant higher percentage of paroxysmal AF diagnosis. We totally agree with the authors on the unnecessary use of 24-hour Holter ECG in addition to CEM in the in-hospital setting because the latter allows longer-recording time and an automated processing of data.

Nevertheless, as observed by Flint et al² in their loop-recorder study, paroxysmal AF was detected in >50% of patients between 10 and 30 days after stroke onset. Thus, in our opinion, the risk to underestimate a cardiogenic embolism could be too high. Therefore, identification of risk markers for atrial fibrillation³ during hospitalization could enhance the selection of a subgroup of patients who may benefit from a prolonged CEM.

In our experience, among >1000 transient ischemic attack and stroke patients admitted in stroke unit in the acute setting without any history of AF, 8.1% had a new-onset AF detected with a continuous monitoring during hospitalization with a mean recording time of 5.6 days. Echocardiographic examination showed an enlarged left atrium in 62% of patients with new-onset AF and in only 25% of those without (unpublished data).

In accordance with previous studies,^{3,4} reporting left atrium enlargement and P-wave dispersion as a risk factor for cardiovascular events and AF, our data suggest a possible role of

morphological echocardiographic characteristics in stratifying the risk of a new-onset AF, to justify the need for a prolonged CEM. A better patient selection could be cost-effective in terms of human resources and diagnostic procedures.

In light of these considerations, we hypothesize that in clinical practice echocardiographic variables could add critical informations, although the association between dilated left atrium and new-onset AF in acute stroke patient should be evaluated in a large population study.

Disclosures

None.

Marina Diomedì, MD
Silvia Di Legge, MD
Fabrizio Sallustio, MD

*Stroke Unit, Dipartimento di Medicina dei Sistemi
University of Rome Tor Vergata
Rome, Italy*

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