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## Preface

Atrial fibrillation (AF) is nowadays an “epidemic disease” and is associated to an increased risk of ischemic stroke. Because of that, oral anticoagulation with non-vitamin K-antagonist oral anticoagulants (NOACs, including dabigatran, rivaroxaban, apixaban and edoxaban), or vitamin K antagonists (e.g. warfarin) is warranted in the majority of cases. The recognition that AF is often associated to coronary artery disease, for which percutaneous coronary intervention with stent implantation (PCI) has become the standard of care, makes the issue of antithrombotic treatment complex as well as of great epidemiological relevance. While oral anticoagulation is the optimal therapy for stroke prevention in AF, dual antiplatelet therapy with aspirin and a P2Y<sub>12</sub>-receptor inhibitor, including clopidogrel, prasugrel, or ticagrelor, is the most effective treatment for the prevention of stent thrombosis and/or recurrent cardiac events after PCI. No randomized, double-blind, prospective studies comparing different antithrombotic strategies in these patients are available, and current management is addressed by documents essentially based on consensus of experts.

At variance from most of the available documents, in this handbook we aim at guiding the management of AF patients who are submitted to PCI starting from individual clinical scenarios, including the stable setting and both ST-elevation and non-ST-elevation acute coronary syndromes, rather than giving an overview of the current recommendations. By doing so, we aim at more closely reproducing the clinical reasoning which is generally developed in everyday clinical practice when dealing with these patients. Also, we discuss the management of patients with AF and coronary stent implantation both when the arrhythmia is preexistent and when it develops early after PCI. Specific situations which may be commonly encountered when managing these patients, such as the need for nondeferrable surgery and the occurrence of a major bleeding event, are also discussed. Finally, the different clinical scenarios are presented for AF patients who are on oral anticoagulation both with a NOAC and warfarin.

While acknowledging that most of the recommendations given in this handbook are based on suboptimal evidence, as are those provided in the various consensus documents issued by study groups and scientific societies, we nonetheless hope to have provided a tool which can be found useful to those clinicians, including clinical and interventional cardiologists, internists, specialists in thrombosis and hemostasis, and also surgeons, who may be involved in the management of this complex

and increasing population. In hope to be successful in this task, we need to acknowledge the invaluable effort and expertise of our eminent colleagues who authored the various chapters and without whom this result could not be accomplished. Also to be acknowledged is the expert, timely, and precise assistance of the personnel at the editorial office of Springer which definitely made our endeavor less strenuous.

Bologna, Italy  
Birmingham, UK

Andrea Rubboli, MD, FESC  
Gregory Y.H. Lip, MD, FRCP, FESC, FACC

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Rubboli, A.; Lip, G.Y. (Eds.)

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