

SOUTHLAKE EP + PACE CARDIOLOGY

Atrial Fibrillation in 2026:

What family physicians **need to know**

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Orillia Family Medicine Update | June 3, 2026

What We'll Cover Tonight

1

AF basics for primary care

CHADS-65, the three pillars, what to start tonight.

2

Who benefits most (and least) from ablation

And what's different about Pulsed Field Ablation (PFA).

3

What to do while patients await procedure

Rate control, rhythm choices, and the amiodarone trap before ablation.

4

When and how to refer

Heart Rhythm Triage Office, PACE Cardiology pathways, urgent vs. routine.

AF in Primary Care: What You Already Know

~700K

Canadians with AF today

1 in 4

Lifetime risk after 40

5x

Stroke risk increase

~40%

Discontinue OAC within 2 years

It's common

You already see this in your panel every week.

It's risky if missed

Stroke, HF, hospitalisation, cognitive decline.

It's increasingly treatable

Ablation, LAAO, and combined procedures are evolving fast.

CHADS-65: The Canadian Algorithm

Used at every routine AF visit in primary care. Three branches, one decision.

Age \geq 65?

YES

DOAC

Any patient 65+ with AF gets oral anticoagulation.

Stroke risk factor?

YES

DOAC

CHF, HTN, diabetes, prior stroke / TIA - any one of these triggers OAC even if <65.

CAD or PAD?

YES

ASA 81 mg

No AF stroke risk + age < 65, but vascular disease. Antiplatelet only.

If all three answers are NO -> no antithrombotic. CCS 2020 / 2023 update.

The Three Pillars of AF Care

Rate Control

Keep heart rate manageable

Beta-blocker or non-DHP CCB.

Target < 100 bpm resting heart rate

Rhythm Control

Restore sinus rhythm if symptomatic

Cardioversion +/- antiarrhythmic OR ablation.

Generally a specialist conversation.

Stroke Prevention

Anticoagulate by CHADS-65

DOAC for almost everyone who needs it.

LAAO if OAC is truly not tolerable.

Rate Control: Your Toolkit

Agent	When to use	Watch out for
Beta-blocker (metoprolol, bisoprolol)	First-line for most. Especially good with CAD, post-MI, HFrEF.	Bradycardia, fatigue, bronchospasm.
Non-DHP CCB (diltiazem, verapamil)	BB intolerant or contraindicated. Good with COPD.	Avoid in HFrEF / LVEF < 40%. Constipation.
Digoxin	Add-on if BB or CCB insufficient. Useful in sedentary/elderly.	Narrow therapeutic window. Renal dosing. Not for active patients.
Amiodarone	Rarely just for rate control. Mostly rhythm.	See next slide - has real implications before ablation.

Targets: Resting HR < 100 bpm is fine for asymptomatic patients (RACE II). Aim < 80 if still symptomatic, of ↓EF presumed due to rate.

Rhythm Control: The Menu

Agent	Good fit for	Avoid in
Flecainide / propafenone	Structurally normal heart, no CAD. PAF. 'Pill in pocket' option (with BB or CCB).	CAD, prior MI, HFrEF, LVH.
Sotalol	AF + LVH or CAD. Combines rate + rhythm.	QT prolongation, renal dysfunction, HFrEF.
Dronedaron	Paroxysmal AF in patients with normal LV function.	Permanent AF, advanced HF, liver disease.
Amiodarone	Last resort. HFrEF if needed. Refractory cases.	Pre-ablation - see next slide.

For most family-medicine starts: flecainide or sotalol cover 80% of cases. Anything more complex - send to us early.

The Amiodarone Trap Before Ablation

STOP AMIODARONE 6-12 WEEKS BEFORE ABLATION

Long half-life

~60 days. Even off the drug, tissue levels stay therapeutic for weeks - distorting our mapping signals.

Masks substrate

Amiodarone suppresses the very triggers and arrhythmias we need to provoke and map during ablation.

Worse outcomes

Recurrence rates are higher when ablation is performed on a patient still loaded - especially for redo procedures.

What to do: if a patient is on the wait list - or even being considered - call us before adding amiodarone. Almost always a better choice.

Who Benefits MOST from AF Ablation

BEST CANDIDATES

- + Symptomatic paroxysmal AF**
Highest success rate. >85% freedom from AF at 1 year with PFA.
- + Younger patients (< 65)**
Better outcomes, longer benefit, often fewer comorbidities.
- + Normal or near-normal LA size**
LA < 4.5 cm typically does well. Substrate hasn't remodelled.
- + AF + HFrEF**
CASTLE-AF showed mortality and HF hospitalisation benefit - even more than rhythm benefit.
- + Early in disease**
EAST-AFNET-4: early rhythm control improves outcomes vs. rate-only.
- + Failed antiarrhythmic drugs**
Drug-refractory AF is the classic indication. Don't keep cycling drugs.

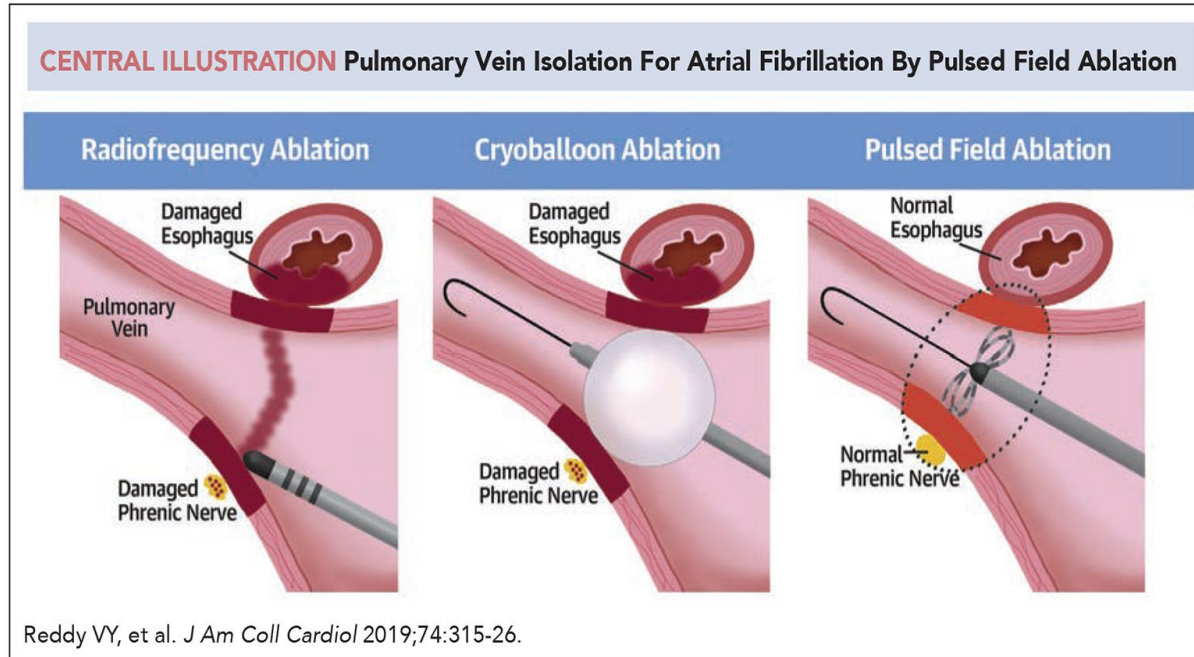
Who Benefits LEAST from AF Ablation

DON'T PROMISE TOO MUCH

- Long-standing persistent AF (>1 yr)**
Atrial substrate is severely remodelled. Multi-procedure success ~50-60%.
- Severely dilated LA (> 5.5 cm)**
Predicts recurrence regardless of energy or strategy.
- Frail / elderly with multiple comorbidities**
Procedural risk rises, symptom benefit may not justify it.
- Asymptomatic AF (Normal LV)**
Hard to demonstrate quality-of-life benefit. Treat rate + stroke risk only.
- Severe sleep apnea, untreated**
AF will recur. Address OSA first. Same for obesity, alcohol.
- Significant valvular disease awaiting surgery**
Surgical Maze at time of valve procedure is usually better.

Pulsed Field Ablation in One Slide

Figure 2 Safety Concerns With RF Ablation vs. Cryoballoon Ablation vs. PFA



Old approach: heat (RF) or cold (cryo) to make scar.

PFA: high-voltage electrical pulses kill heart cells without burning. Esophagus and phrenic nerve are largely spared.



Faster

~45 min instead of 2-3 hours.



Safer for neighbours

No atrio-esophageal fistulas in 17,000+ cases.



Same-day discharge

Most patients home in 4 hours.



Equal (or greater) effectiveness

~85% freedom from AF at 1 year (PAF).

What Your Patients Can Expect at Southlake

Our first 233 Farapulse cases - paroxysmal and persistent AF combined.

~47 min

Average procedure time

100%

Acute pulmonary-vein isolation

0

FARAWAVE injuries

Same day

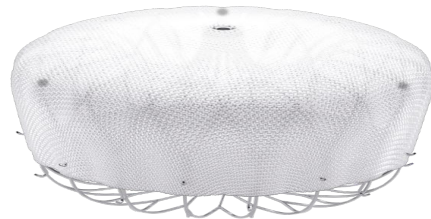
Discharge for most patients

LAAO: When OAC Just Isn't Working

For patients who: have bled on DOAC, can't tolerate OAC, prior ICH, or simply prefer not to take lifelong anticoagulation.

Watchman FLX Pro

Boston Scientific | Single 'plug'



Post-op: 1/2-dose DOAC x 45 days, then ASA.

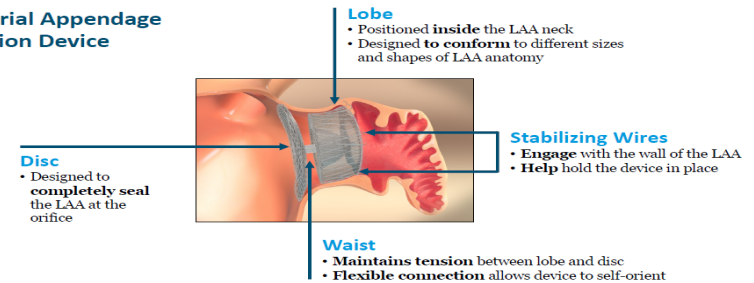
Most common choice at Southlake.

Amulet (Amplatzer)

Abbott | Lobe + disc

DESIGN
Amplatzer™ Amulet™

Left Atrial Appendage Occlusion Device



Post-op: single antiplatelet from day 1 in most cases.

Useful when DOAC truly not an option even short-term.

OCEAN: Do We Still Need OAC After a Successful Ablation?

Canadian-led RCT | Andrew Verma et al. | NEJM 2026

The question: after a successful AF ablation in a low-risk patient, is rivaroxaban better than ASA at preventing stroke?

1,284

Patients randomised

3 yrs

Median follow-up

Futility

Trial stopped early - rivaroxaban not superior to ASA

More bleeding On rivaroxaban (CRNM 5.5% vs 1.6%)

For you: don't reflexively restart OAC for life in a low-CHADS post-ablation patient. Discuss with cardiology.

'Farawatch': Ablation + LAAO in One Sitting

For carefully selected patients with paroxysmal AF AND an elevated bleeding risk - we can do both procedures in a single anaesthetic.

One anaesthetic

Same GA, same transseptal puncture, same recovery room.

~70 min total

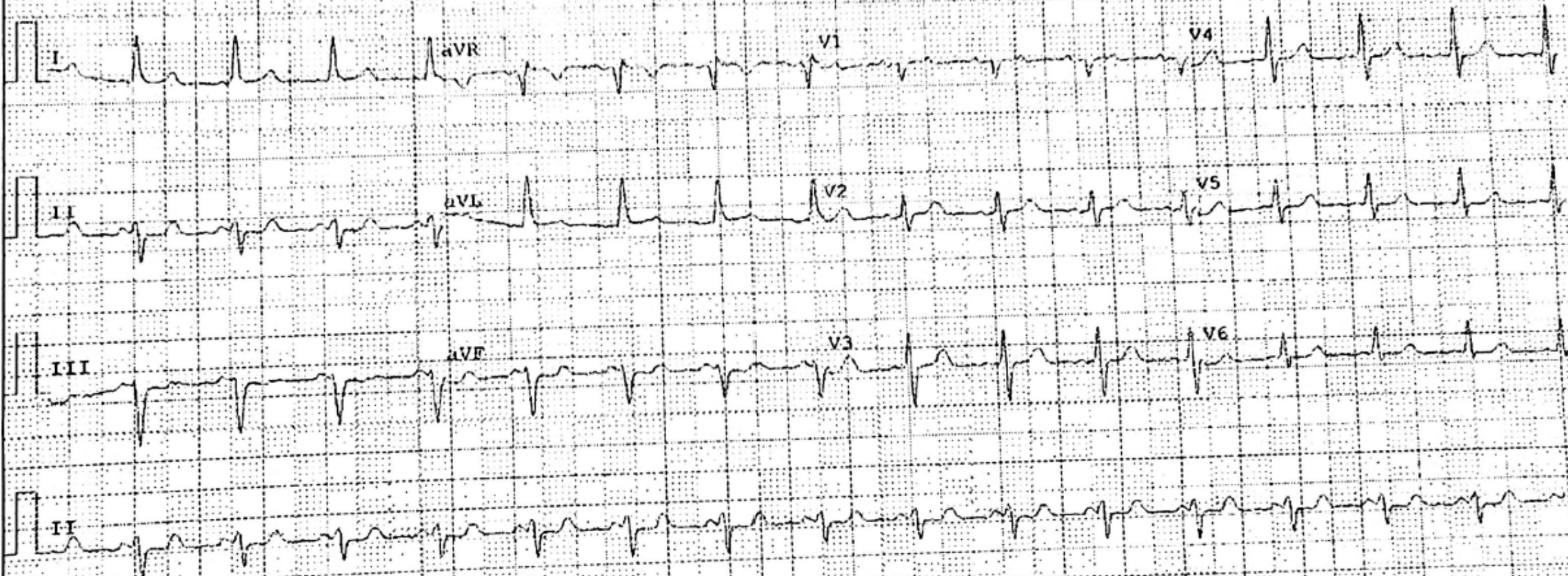
Roughly 45 min PFA + 25 min Watchman.

Two problems solved

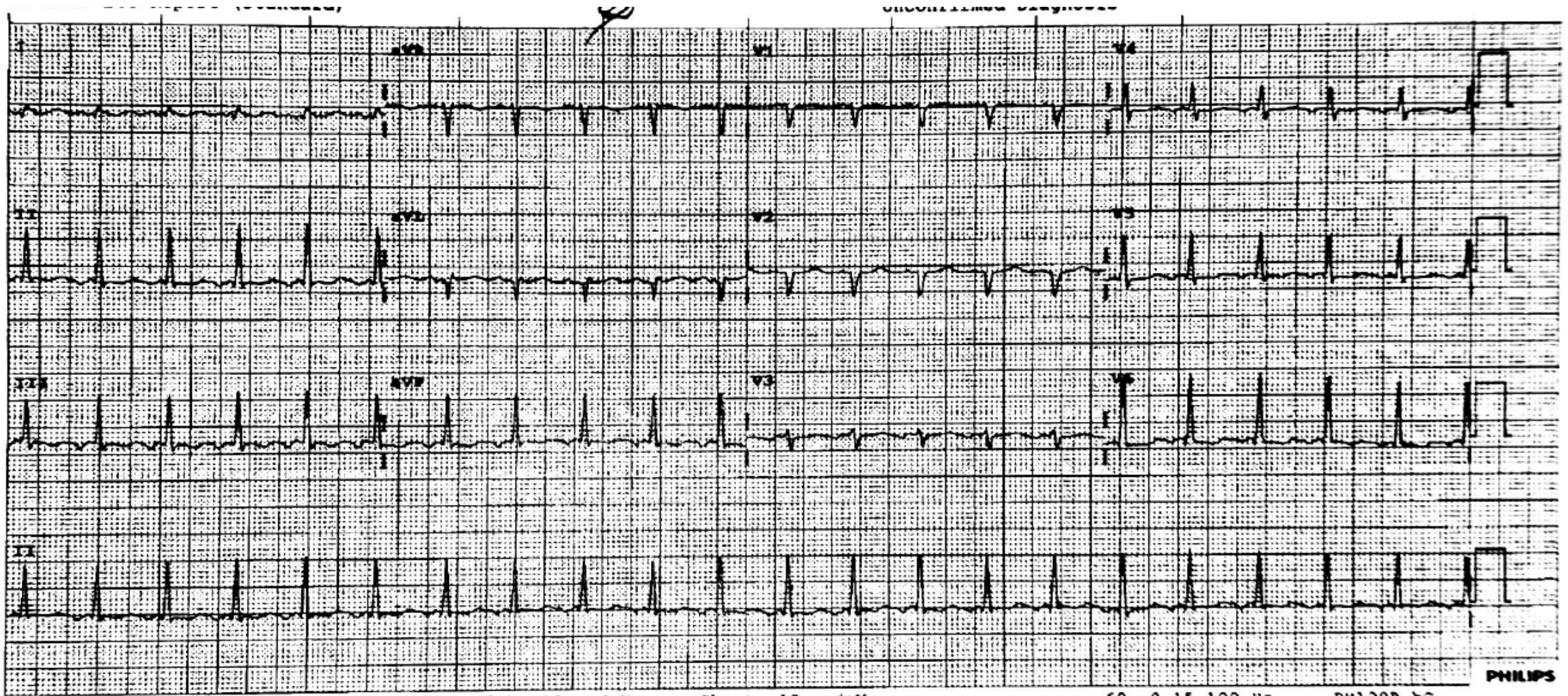
Rhythm + stroke prevention - and patient off OAC long-term.

Right patient: symptomatic paroxysmal AF + high bleed risk (prior major bleed, ICH, HAS-BLED ≥ 3 , polypharmacy). Send these patients to us.

Simultaneous



25 mm/sec 10 mm/mV [0.5-35] Hz -60Hz



Device: Y201

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10 mm/mV

60- 0.15-100 Hz

PH100B SC

PHILIPS

HR 134 [ST] . SINUS TACHYCARDIA
RR 448 [LVHPR] . PROBABLE LVH WITH SECONDARY REPOL ABNRM
PR 140 [IMI3] . BORDERLINE INFERIOR Q WAVES
QRSD 108
QT 272
QTc 406

F Code:H

-- AXIS --

P 81
QRS 61
T 252

- ABNORMAL ECG -

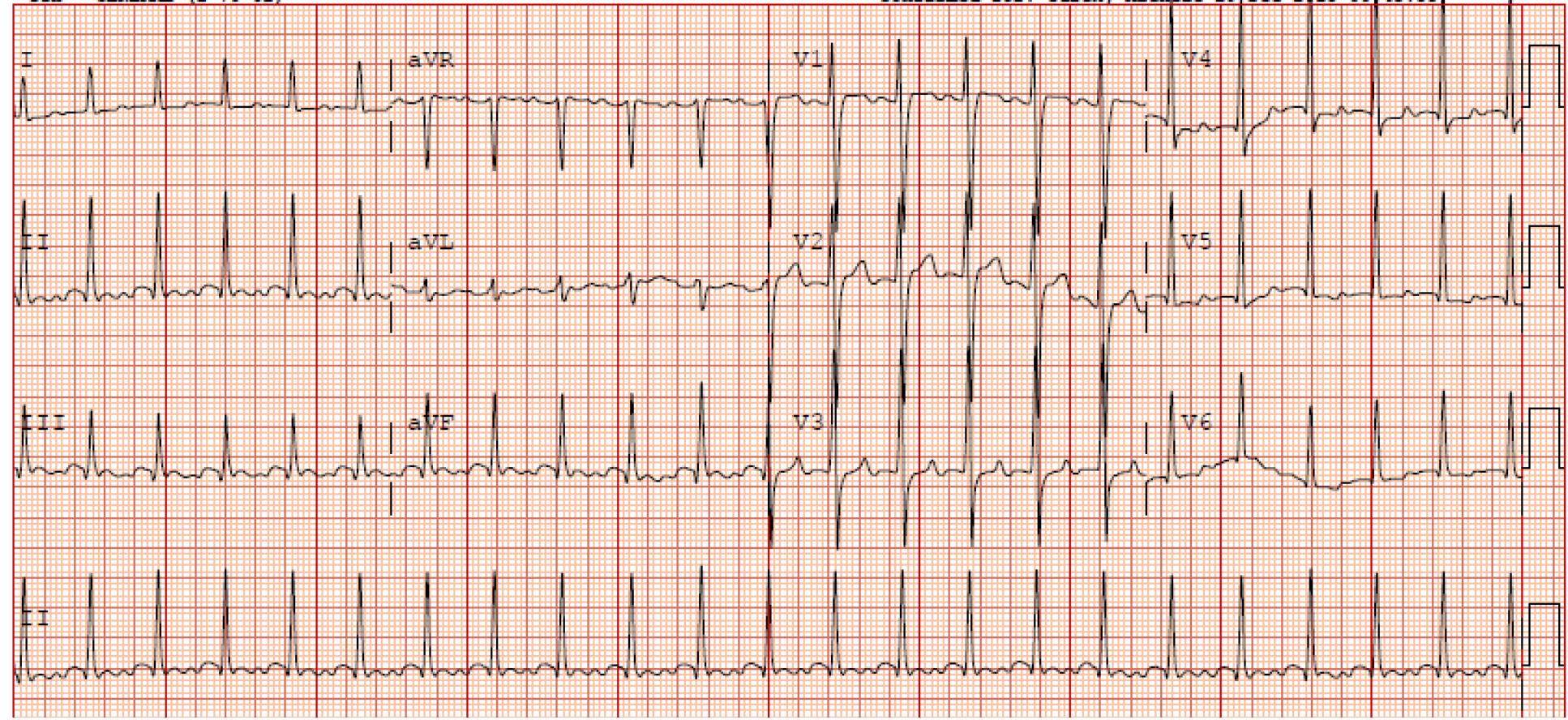
PREVIOUS ECG:24-Dec-2015 09:29:40 - Abnormal Unconfirmed

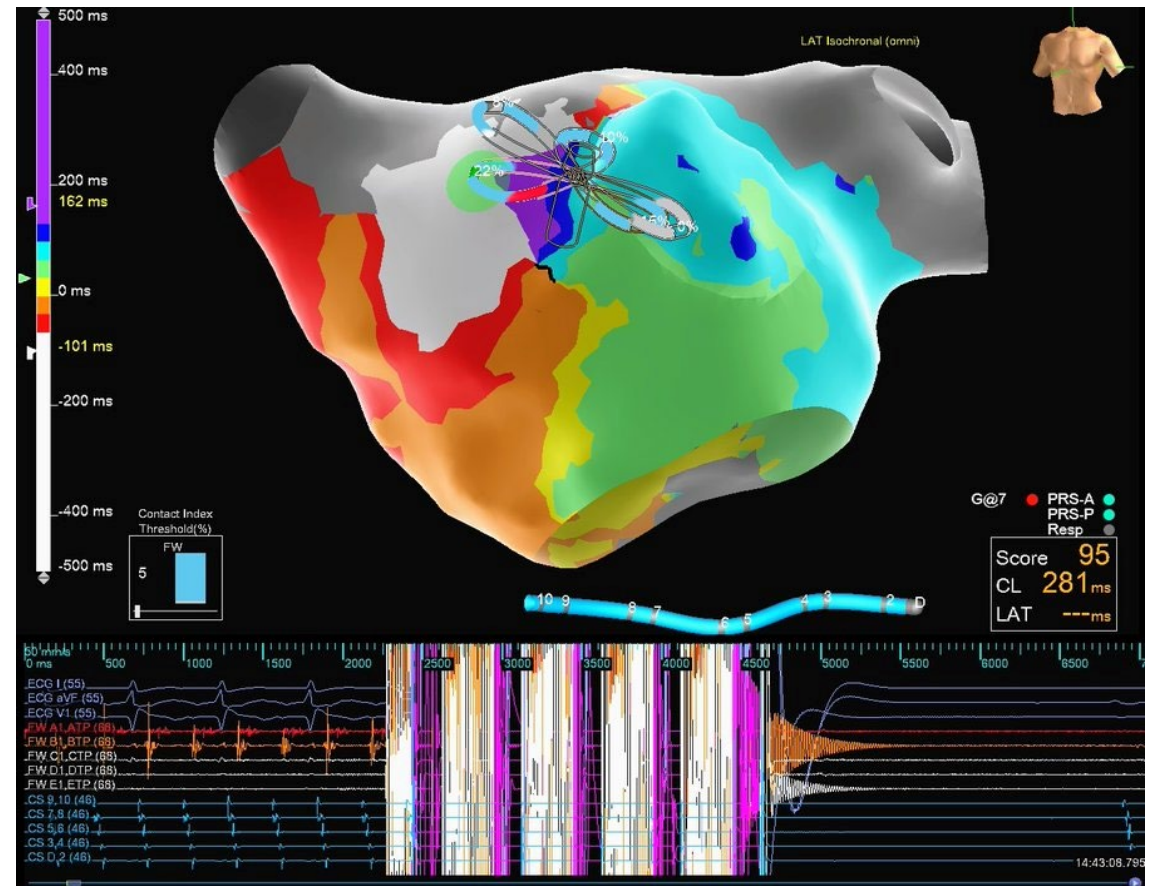
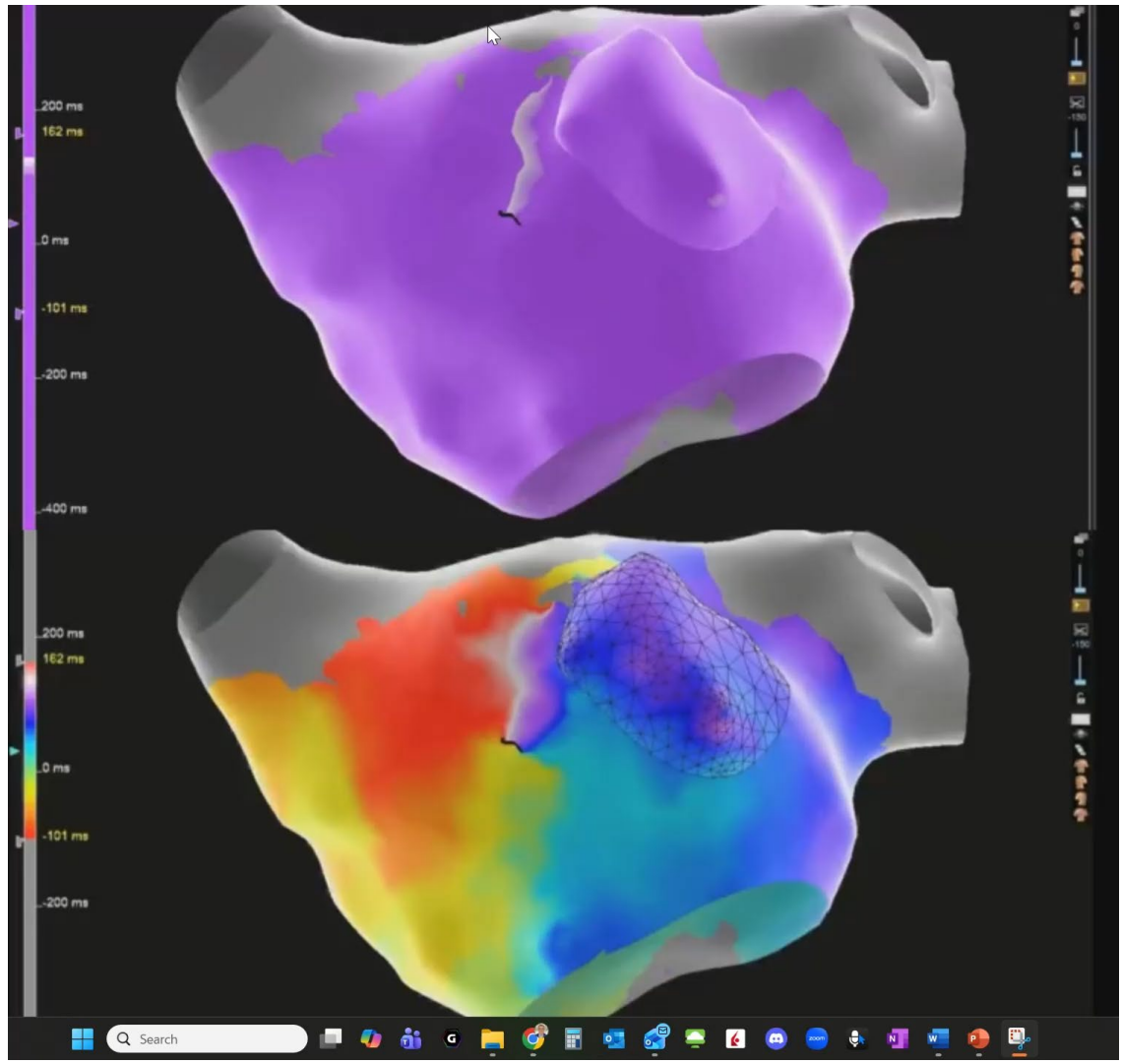
Standard 12

Requested By: MICROYS

TOH - GENERAL (1-78-02)

Confirmed for: Turek, Michele 29+Dec-2015 08:43:55





After Ablation: Atypical Flutters

Up to 5-10% of post-ablation patients develop **atypical (non-CTI) atrial flutter** in the months following PVI - especially after persistent-AF or extensive ablation.

Perimitral

Around the mitral annulus. P-waves usually positive in V1 and lead I. Cycle length 200-300 ms.

Roof-dependent

Around the LA roof. Variable P-wave morphology. Often short cycle length.

Anterior LA flutter

Around scar on the anterior LA wall. Often after extensive substrate ablation - distinct from typical flutter.

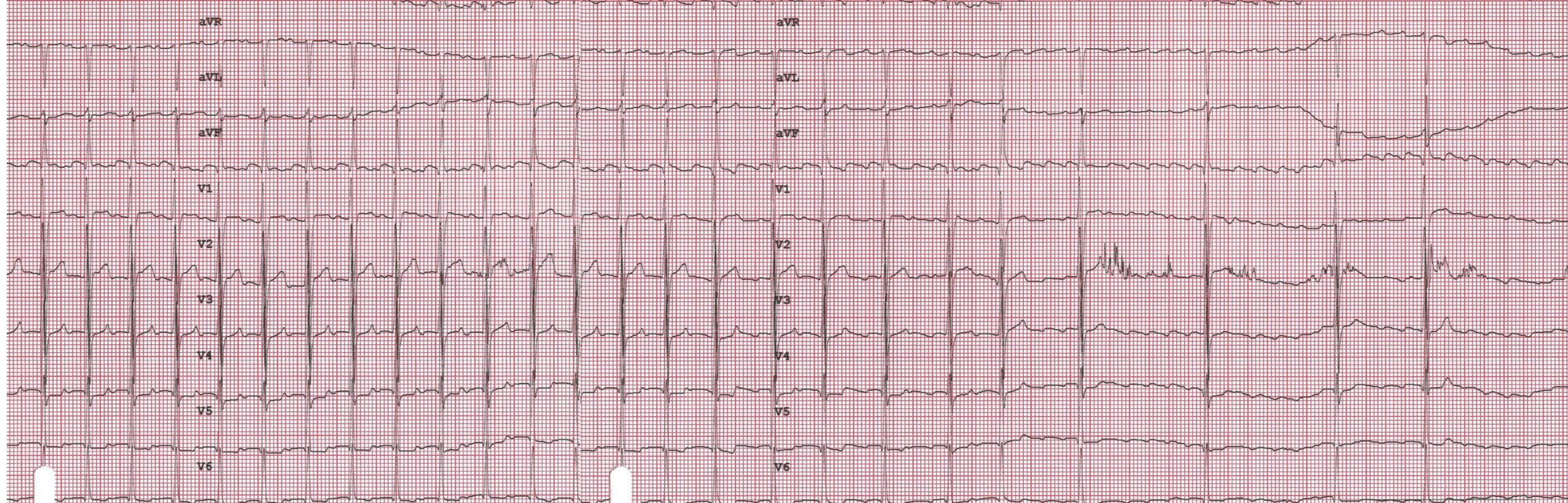
What to do as the family doctor:

1. Recognise it - new 'flutter' months after ablation is rarely the same typical flutter.
2. Don't load amiodarone - it will only delay redo ablation (recall slide on amio).
3. Refer back to the Heart Rhythm Triage Office - these are very ablatable but need mapping.

ECG Recognition: Sinus or Flutter?

Sinus Rhythm vs Atrial Tachycardia / Flutter:

- HR: variable (60–90) vs fixed (~100)
- Rate variability: normal vs minimal
- P-wave morphology: consistent vs subtle change, particularly positive in V1
- PR interval: stable vs variable
- Onset/Offset: gradual vs abrupt



Device: ICU Speed: 25 mm/sec Limb: 10 mm/mV

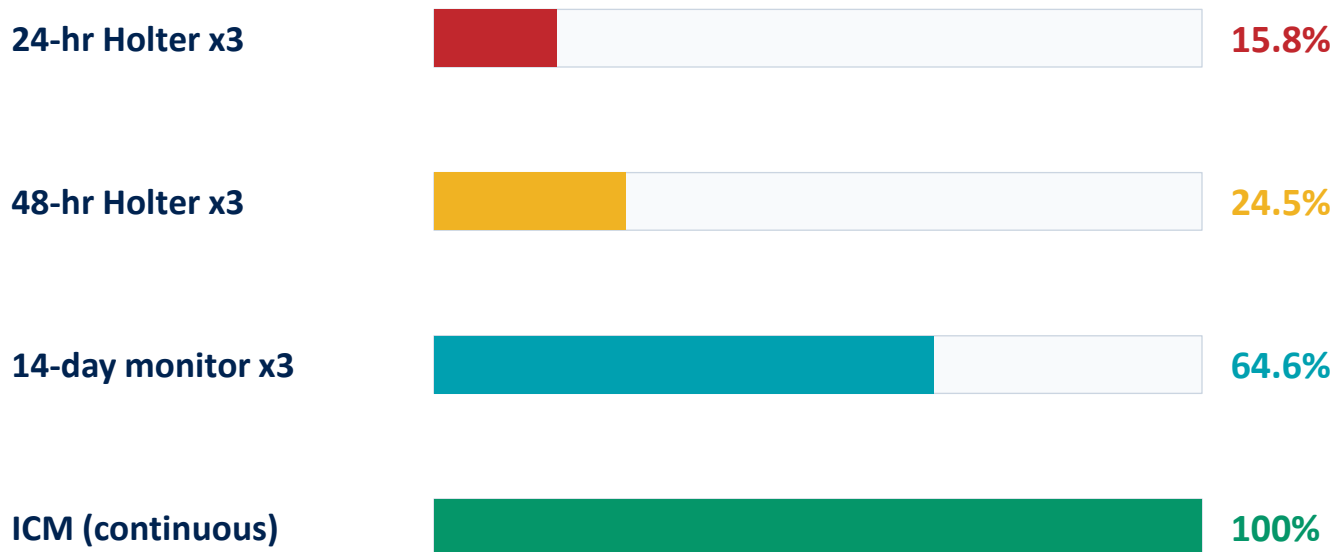
Device: ICU Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

Monitoring Matters: How Hard Are We Looking?

Most 'successful' ablations are judged by a 24- or 48-hour Holter. **That's not nearly enough.**

Sensitivity for detecting arrhythmia recurrence vs. implantable loop recorder



Aguilar M et al. Circulation 2021;143:2503-2515 (CIRCA-DOSE substudy; N=346; 126,290 monitoring days).

Practical: don't 'clear' a post-ablation patient on a single 24-hr Holter.

What this means

Short Holters miss 75-85% of recurrences.

OAC decisions, repeat-ablation decisions, and post-procedure reassurance are all only as good as the rhythm record they're based on.

Where the field is going

Continuous wearable ECG

Myant Skiin: smart-textile multi-lead ECG worn under clothes. Days to weeks of continuous rhythm data, patient-friendly, no skin breakdown.

Disclosure: speaker serves as Chief Medical Officer, Myant Inc.

While They Wait for Procedure: GP Checklist

1

Anticoagulate (CHADS-65)

DOAC if indicated. Don't stop during pre-procedure period - we'll instruct on dose hold.

2

Rate control

Beta-blocker or non-DHP CCB. Target < 100 unless symptomatic.

3

AVOID starting amiodarone

Especially for redo procedures. Call us first - usually a better option.

4

Lifestyle 'big four'

Weight (LEGACY: 10% weight loss = 6x freedom from AF). Alcohol. OSA screening. Hypertension control.

5

Treat the comorbidities

OSA / CPAP, BP < 130, glycemic control, address thyroid. These shape ablation outcome.

6

Symptom diary

Helps us decide rhythm vs. rate strategy at the consult.

Red Flags - When to Escalate Sooner

ED OR URGENT REFERRAL

Hemodynamic instability

BP drop, syncope, chest pain or new HF with AF -> ED for cardioversion.

Rapid ventricular response > 150 with symptoms

Not responding to rate-control dose adjustment - bring in.

Bleeding on DOAC

Hold drug, assess severity, contact us about resuming or LAAO conversation.

Acute neurologic deficit

Stroke workup. Don't delay - tPA window is short.

New decompensated HF on top of AF

AF may be the trigger. Treat both - and call us.

Wide-complex tachycardia on the strip

Could be VT or AF with aberrancy. Treat as VT until proven otherwise. ED.

How to Refer

FOR ABLATION / LAAO

Heart Rhythm Triage Office

Include

Recent ECG, Holter / monitor, TTE, eGFR, OAC history, symptom burden.

Specify

Routine, semi-urgent, or urgent. Mark redo if applicable.

Avoid

Adding amiodarone in the 3 months before referral if at all possible.

Turnaround

Routine within 6-9 months; urgent within 3 months.

FOR LONGITUDINAL CARE

PACE Cardiology

Use for

Ongoing rhythm management, anticoagulation review, lifestyle counselling, post-ablation follow-up.

Locations

Newmarket, Barrie, and virtual

Online

pace-cardiology.com, afibclinic.ca

Best when

Patient needs more than the family practice can absorb - dedicated EP clinic.

Take-Homes for Tonight

1**Start with CHADS-65 every time.**

It's the Canadian decision tree. Age 65+ or any major risk factor: DOAC.

2**Rate, rhythm, stroke.**

Beta-blocker/CCB. Symptomatic rhythm control or refer to us. CHADS-65 for stroke.

3**Don't start amiodarone right before a procedure.**

It has a 60-day half-life and will distort the map. Call us first - especially for redo cases.

4**Refer ablation candidates early.**

Best results in symptomatic paroxysmal AF, normal LA, younger, AF + HFrEF. Less benefit in long-standing persistent, big LA, frail, asymptomatic.

5**PFA + Watchman in one sitting is a real option.**

For paroxysmal AF + bleeding risk. Send these patients to the Heart Rhythm Triage Office.

Thank you.

Questions - and your referrals - are very welcome.

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