Hybrid AF™ Therapy: Pre– and Post–Op Quick Reference

Hybrid AF Therapy includes subxiphoid access using a catheter, cannula, endoscope and radiofrequency (RF) generator to ablate the epicardial surface of cardiac tissue.

Contraindications to Hybrid AF Therapy

- Patients with current thrombus of left atrial appendage
- Patients with a history of Barrett's Esophagitis
- Patients with an active infection or sepsis

Procedure Day

Nurses Should Verify the Following

- Patient is NPO
- Updated bloodwork and diagnostics are on file
- Day and time patient stopped taking their anticoagulation therapy along with all other medications, vitamins and supplements
- Patient has signed all pertinent consents (Epicardial, Endocardial, TEE, etc.)

Patient Prep

- General anesthesia
- Central line usually placed after TEE (if needed)
- Arterial line
- Foley catheter

Post–Op Orders

Typical patient flow within the hospital length of stay (LOS) is an overnight stay in a critical–care unit; stepdown or telemetry the second day, and discharge home on the third day.

Respiratory Concerns

- Should start receiving instruction on Incentive Spirometry pre–operatively (and should begin immediately upon arrival to post–op unit)

Wound Care

- Subxiphoid incision will have dressing — keep dry — follow nursing standard of care
- Groin care: Bruising is common and can sometimes be extensive. Monitor closely.

DVT Prophylaxis

- No contraindication to using mechanical DVT prevention, unless the EP objects (venous sticks in the groins)

Pain

- Typically, is greatest in the first 24 hours, then quickly abates
- PCA (Morphine or Dilaudid) may be used but is not routinely necessary
- Chest pain is typically a result of surgery (pericarditis) and most likely not a result of any type of ischemia

Steroids

- Thought to help reduce pericarditis, post–op pain & pericardial effusion

NSAIDs

- Toradol is most commonly used in the immediate post–op period contingent on patient status to contraindications of renal function, age and allergy
- Indocin is also very effective when patient is taking PO meds without dyspepsia or ileus
- Should be very careful to account for any history of GI bleed
- Ibuprofen can also be used especially in outpatient setting

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GI Prophylaxis

- Most institutions use PPI or H2 Blocker for prevention of stress gastritis

Fluid Balance

- Monitor patient's fluid balance during the procedural time
- Patient may need diuretics due to fluid load during the procedure

Ambulation

- Goal: patient out of bed night of surgery and mobilized by post–op day one

Pericardial Drain Management

- Drain output is typically serosanguineous (pinkish in tint or dark pink). The surgical team should be called when output is bright, frank blood.
- Follow existing standard–of–care protocol for removal of drain

Antiarrhythmic and Anticoagulation Management

- It is not uncommon for patients to experience intermittent recurrence of arrhythmia(s) during the blanking period. This expectation should be communicated with the patient prior to procedure.
- Pre-operative antiarrhythmic drugs should be resumed post-procedure (during the blanking period as determined by the physician)
- Bridging with heparin is suggested if the patient will be maintained on coumadin
- Restarting of DOACs should be coordinated by HCPs: typically, 6 hours post–procedure
- Anticoagulation should be initiated regardless of patient's CHA2DS2–VASc Score

Discharge Instructions

- Post–op restrictions as per standard nursing protocol
- Driving need not be restricted (except when prescribed narcotics)
- Patient should immediately contact their HCP in the event of any fevers, nausea, diarrhea, abdominal or chest fullness, difficulty swallowing and/or increase in pain
- As mentioned above, after an ablation many patients experience heart rate and rhythm changes which are not atypical and can occur for several months

This resource aims to be a detailed and comprehensive guide for initiating a Hybrid AF Therapy Convergent program. Included are clinical insight and best practice across the perioperative spectrum compiled from sites with extensive experience in Hybrid AF Therapy Convergent. This guide should not be construed as medical advice or medical opinion related to any specific facts or circumstances. There are potential risks including (but not limited to) infection, cardiac tamponade, pulmonary vein stenosis, pericardial effusion, esophageal fistula, myocardial infarction, new arrhythmias, thromboembolic complication. It is the responsibility of the individual clinician — and facility — to select the protocols, procedures, equipment and medications most appropriate for their patients' specific considerations.

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