心房細動に対しては大まかな心拍コントロールで十分なようである

RACE II：心房細動患者は厳密な心拍コントロールをしなくても健康を維持できるようである

RACE II: Patients with atrial fibrillation stay healthy even without strict control of heart rate

最新のガイドラインに反して、心房細動（AF）患者の心拍コントロールは大まかであっても厳密にコントロールするのと同等のようである、と第59回American College of Cardiology学会で発表され同時にNew England Journal of Medicineに掲載された。慢性心房細動の心拍コントロールの有効性（Rate Control Efficacy in Permanent Atrial Fibrillation：RACE II）スタディではAF患者614人を大まかな心拍コントロール（安静時心拍数<110bpm）または厳密なコントロール（安静時<80bpmおよび中等度の労作時<110bpm）を行う群に無作為に割り付けた。目標心拍数に達するためにβ遮断薬、カルシウム拮抗薬、および/またはジゴキシンが用いられた。追跡観察中に大まかな心拍コントロール群患者のうち38人および厳密な心拍コントロール群患者のうち43人が心血管死または心不全による入院をしたかあるいは脳卒中、血栓、重篤な出血または生命にかかわる不整脈を発現した。これらのイベントの3年間の累積発現率は大まかなコントロール群で12.9%、厳密コントロール群で14.9%であり、大まかなコントロールの「非劣性」が示された。標的心拍数の達成度は厳密コントロール群よりも大まかなコントロール群の方が優れており（98%対67%）診察を必要とする回数も少なかった。

Full Text

Contrary to current guidelines, taking a lenient approach to controlling heart rate in patients with atrial fibrillation appears to be just as good as taking a strict approach and poses no greater risk of death or other serious complications, according to research presented at the American College of Cardiology's 59th annual scientific session.

The Rate Control Efficacy in Permanent Atrial Fibrillation (RACE II) study evaluated whether therapy aimed at achieving a resting heart rate of less than 110 beats per minute in patients with atrial fibrillation was "noninferior" to therapy targeted at a resting heart rate of less than 80 beats per minute. RACE II, the first randomized trial to investigate the best level of heart rate control in patients with atrial fibrillation, found that clinical outcomes were similar with the two approaches, but lenient control was easier and less time-consuming to achieve.

"Guidelines, though not evidence-based, recommend strict rate control in patients with atrial fibrillation to reduce symptoms and the risk of heart failure, bleeding and stroke, and to improve quality of life, exercise tolerance and survival," said Isabelle C. Van Gelder, M.D., a cardiology professor at the University Medical Center Groningen, University of Groningen, Groningen, The Netherlands, and the Interuniversity Cardiology Institute Netherlands, Utrecht, The Netherlands. "Our study suggests that lenient rate control is the first-choice strategy in patients with permanent atrial fibrillation."

Previous studies have shown that patients fare just as well when medications are used to control the heart rate, rather than trying to force the heart back into a normal rhythm. But whether maintaining a near normal heart rate (strict rate control) is necessary to keep patients healthy over the long run has been unknown.

The researchers recruited 614 patients with atrial fibrillation, randomly assigning them to lenient rate control, defined as a heart rate of less than 110 bpm at rest, or to strict rate control, defined as a heart rate of less than 80 bpm at rest and less than 110 bpm during moderate exercise. To achieve the target heart rate, patients were treated with beta-blockers, calcium-channel blockers, and/or digoxin. During a follow up that ranged from two to three years, 38 patients in the lenient-control group and 43 patients in the strict-control group either died of cardiovascular causes, were hospitalized for heart failure, or experienced a stroke, a blood clot, serious bleeding or a life-threatening arrhythmia. The estimated cumulative incidence of these events at 3 years was 12.9 percent in the lenient-control group and 14.9 "noninferiority" of the lenient-control strategy.

Efforts to achieve the target heart rate were more successful with lenient control than with strict control (98 percent vs. 67 percent) and required fewer visits to the doctor (75 vs. 684, with a median of 0 and 2 visits, respectively). Symptoms were comparable in the two groups.

"For both patients and health care providers, lenient rate control is more convenient," Van Gelder said.

The RACE II study was funded by a major grant from the Netherlands Heart Foundation, additional grants from the Interuniversity Cardiology Institute Netherlands and the Working group Cardiology The Netherlands, and by unrestricted educational grants from AstraZeneca, Biotronik, Boehringer Ingelheim, Boston Scientific, Medtronic, Roche and Sanofi Aventis France, which were paid to the Interuniversity Cardiology Institute Netherlands. Dr. Van Gelder has received consulting fees from Sanofi-Aventis, Boehringer Ingelheim and Cardiome, grant support from Medtronic, Biotronik and St. Jude Medical, and lecture fees from Sanofi-Aventis, Boehringer Ingelheim and Medtronic.

This RACE II study will be simultaneously published in the New England Journal of Medicine and was released online at the time of presentation.

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