Noninvasive Cardiac Monitoring for Detecting Paroxysmal Atrial Fibrillation or Flutter After Acute Ischemic Stroke
A Systematic Review

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Background and Purpose—Identifying paroxysmal atrial fibrillation/flutter is an essential part of the etiological workup of patients with ischemic stroke. However, there is controversy in the literature regarding the use of noninvasive cardiac rhythm monitoring with previous reviews reporting a low detection rate with routine monitoring. We performed a systematic review to determine the frequency of occult atrial fibrillation/flutter detected by noninvasive methods of continuous cardiac monitoring after acute ischemic stroke or transient ischemic attack.

Methods—Studies were identified from comprehensive searches of PubMed, EMBASE, Science Citation Index, and bibliographies of relevant articles. Only English language articles were included. Randomized controlled trials and prospective cohort studies of consecutive patients with acute ischemic stroke that fulfilled predefined criteria were eligible. Two authors conducted searches and abstracted data from eligible studies independently.

Results—Sixty studies were deemed potentially eligible. After application of eligibility criteria, 5 studies (736 participants) were included in the analysis. All studies evaluated Holter monitoring; 2 also evaluated event loop recording. In studies that evaluated Holter monitoring (588 participants), new atrial fibrillation/flutter was detected in 4.6% (95% CI: 0% to 12.7%) of consecutive patients with ischemic stroke. Duration of monitoring ranged from 24 to 72 hours. Two studies (140 participants) evaluated event loop recorders after Holter monitoring. New atrial fibrillation/flutter was detected in 5.7% and 7.7% of consecutive patients in these 2 studies.

Conclusions—Screening consecutive patients with ischemic stroke with routine Holter monitoring will identify new atrial fibrillation/flutter in approximately one in 20 patients. Although based on limited data, extended duration of monitoring may improve the detection rate. Further research is required before definitive recommendations can be made. (Stroke. 2007;38;2935-2940.)

Key Words: ambulatory electrocardiography ■ atrial fibrillation ■ ischemic stroke ■ systematic review ■ transient ischemic attack
Methods

Data Sources
Studies were identified from the PubMed and EMBASE databases between 1966 and May 2006 by crossreferencing the following MeSH terms: “monitoring, physiological” and “electrocardiography,” “atrial fibrillation,” “arrhythmia,” “brain ischemia,” “ischemic attack, transient” and “cerebrovascular attack”

Free Text Terms: “cardiac event recorder” and “telemetry”

Sorting Criteria
i) Studies looking at noninvasive cardiac monitoring, arrhythmias and cerebrovascular disease
ii) English language articles

Total Number of Studies = 60

Inclusion Criteria
1) Study Design: RCT or Prospective Cohort Study
2) Diagnosis of Ischemic Stroke or TIA
3) Non-Invasive Cardiac Rhythm Monitoring for >12hr
4) Presence of Previously Undiagnosed AF

Investigator #1 (JL) = 8 studies
Investigator #2 (ZK) = 11 studies

Final Review
with Investigator #3 (MOD)
a) Consecutive Stroke Patients
b) AF Detection Rate Reported in Ischemic Stroke Patients

Final Selection = 5 Studies

Data Abstraction
Data abstraction was conducted independently by two investigators (J.L., Z.K.) using standardized data abstraction forms developed before searches were conducted.

Statistical Analysis
The study-specific effect estimates were combined using a precision-weighted (ie, reciprocal of the variance), random-effects model and 95% CIs were calculated. Zelen’s exact test was used to determine whether there was statistical heterogeneity between individual studies. A 95% CI that did not include one was considered to be statistically significant. Minitab 14.3 statistical software was used for the analyses. The following factors were hypothesized, a priori, to influence the detection rate of AF: duration and timing of monitoring, stroke subtype and severity, and setting.

Results

Study Identification and Selection
The initial search identified 387 studies, reduced to 60 potentially eligible studies that fulfilled our sorting criteria.
After application of eligibility criteria, 5 prospective cohort studies (736 participants) were eligible (24,26–29) (Figure). No randomized, controlled studies were identified. Tables 1 and 2 describe the population, sample size and intervention in each of the individual studies.

**Frequency of Atrial Fibrillation and Atrial Flutter Detected by Routine Cardiac Monitoring**

Five studies (588 participants) evaluated Holter monitoring in the inpatient setting. (24,26–29) In these studies, rates of detection of new AF ranged from 3.8% to 6.1% (Table 3). When the results of these studies were combined in a random-effects model, new AF was detected in 4.6% (95% CI: 0% to 12.7%) of consecutive patients with ischemic stroke independent of baseline electrocardiogram and clinical examination (test for heterogeneity $P_{H0.05}$ 0.9). Two studies (140 participants) evaluated event loop recorders after Holter monitoring.26,28 New AF was detected in 5.7% and 7.7% of consecutive patients in these 2 studies. One study (159 participants) evaluated continuous cardiac monitoring using inpatient telemetry (48 hours) and detected new AF in 2.5% of participants (24) (Table 3).

**Stroke Subtype, Stroke Severity, and Setting**

Two studies reported the frequency of AF within ischemic stroke subtypes.26,28 In the largest of these studies ($n=149$), most cases of AF were detected in patients with total and partial anterior circulation ischemic strokes (68%), whereas no cases of AF were identified in patients with lacunar stroke.28 In the other study, no significant association between AF and stroke subtype was reported.26

Two studies reported stroke severity in participants with and without AF.27,28 Jabaudon et al28 reported more severe neurological deficit (National Institutes of Health Stroke Scale $\geq 10$) in patients with AF (22.7%) compared with patients without AF (31.1%). ($P=0.003$)27 Hornig et al26 did not report an association between stroke severity and AF.

<table>
<thead>
<tr>
<th>Study, Year</th>
<th>Inclusion and Exclusion Criteria</th>
<th>N</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barthelemy et al, 2003</td>
<td>Inclusion: ischemic stroke or TIA; exclusion: any other neurological pathology including metabolic, epilepsy, migraine</td>
<td>60</td>
<td>Cardiac event recorder</td>
<td>AF</td>
<td>None</td>
</tr>
<tr>
<td>Hornig et al, 1996</td>
<td>Inclusion: ischemic stroke or TIA</td>
<td>300</td>
<td>Holter monitor</td>
<td>AF</td>
<td>87% underwent Holter monitoring</td>
</tr>
<tr>
<td>Jabaudon et al, 2004</td>
<td>Inclusion: acute stroke or TIA; exclusion: previous AF, recent PAF, hemorrhagic stroke, acute large vessel dissection</td>
<td>149</td>
<td>Holter monitor, event loop recorder</td>
<td>AF and flutter</td>
<td>27% refused ELR</td>
</tr>
<tr>
<td>Rem et al, 1985</td>
<td>Inclusion: cerebral infarction, TIA; exclusion: ICH, tumor, SAH, syncope</td>
<td>184</td>
<td>Continuous cardiac monitoring, Holter monitor</td>
<td>AF, arrhythmia</td>
<td>30% underwent Holter monitoring; 2 participants without admission ECG</td>
</tr>
<tr>
<td>Schuchert et al, 1999</td>
<td>Inclusion: acute ischemic stroke likely embolic in origin, NSR; exclusion: history of AF or flutter, evidence of carotid lesions or intracardiac thrombus</td>
<td>82</td>
<td>Holter monitor</td>
<td>AF</td>
<td>Narrow inclusion criteria: only participants with likely cardioembolic stroke</td>
</tr>
</tbody>
</table>

PCS indicates prospective cohort study; TIA, transient ischemic attack; PAF, paroxysmal atrial fibrillation; ICH, intracerebral hemorrhage; SAH, subarachnoid hemorrhage; NSR, normal sinus rhythm; ELR, event loop recorder; ECG, electrocardiogram.

**Table 1. Study Characteristics**

<table>
<thead>
<tr>
<th>Study, Year</th>
<th>N</th>
<th>Mean Age</th>
<th>Female</th>
<th>History of Atrial Fibrillation/Flutter</th>
<th>History of Stroke or TIA</th>
<th>HTN</th>
<th>DM</th>
<th>Hyperlipidemia</th>
<th>Smoking</th>
<th>History of CAD or MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barthelemy et al, 2003</td>
<td>60</td>
<td>64</td>
<td>45%</td>
<td>ND</td>
<td>26.7%</td>
<td>50</td>
<td>6.7</td>
<td>50</td>
<td>36.7</td>
<td>ND</td>
</tr>
<tr>
<td>Hornig et al, 1996</td>
<td>300</td>
<td>59</td>
<td>38.7%</td>
<td>ND</td>
<td>45%</td>
<td>43.7</td>
<td>34</td>
<td>64.3</td>
<td>28.7</td>
<td>ND</td>
</tr>
<tr>
<td>Jabaudon et al, 2004</td>
<td>149</td>
<td>69</td>
<td>32.2%</td>
<td>4.7%</td>
<td>16.8%</td>
<td>58.4</td>
<td>16.8</td>
<td>55.7</td>
<td>34.9</td>
<td>16.8</td>
</tr>
<tr>
<td>Rem et al, 1985</td>
<td>184</td>
<td>63.5</td>
<td>33.7%</td>
<td>12.0%</td>
<td>31.5%</td>
<td>56.5</td>
<td>16.3</td>
<td>ND</td>
<td>39.1</td>
<td>31.5</td>
</tr>
<tr>
<td>Schuchert et al, 1999</td>
<td>82</td>
<td>*</td>
<td>42.7%</td>
<td>None</td>
<td>ND</td>
<td>36.6</td>
<td>ND</td>
<td>ND</td>
<td>16.9</td>
<td>ND</td>
</tr>
</tbody>
</table>

*AF group mean: 70; non-AF group: 59.

TIA indicates transient ischemic attack; HTN, hypertension; DM, diabetes mellitus; CAD, coronary artery disease; MI, myocardial infarction; ND, no data.

**Table 2. Patient Characteristics**
eligible studies included nonhospitalized patients with ischemic stroke only.24,26–29

**Duration and Timing of Monitoring**

All studies reported the duration of monitoring.24,26–28 Duration of monitoring ranged from 21 to 159 hours. Studies evaluating event loop recorder monitors reported a detection rate of 5.7% after 70 hours and 7.7% after 159 hours of monitoring.

Three studies reported on the timing of initiating of monitoring from the diagnosis of stroke.26,28,29 One study identified monitoring 55 days (median delay) postevent.28 Two studies reported that monitoring began on admission to the ward; however, the timing from onset of stroke was unclear.26,28 Two studies did not report the timing of initiating of monitoring.24,27

**Detection of Atrial Fibrillation Resulting in a Change in Management**

One study reported the proportion of patients in which the results of noninvasive monitoring resulted in a change in antithrombotic therapy.28 In that study, oral anticoagulation was started in 28.6% (2 of 7) of patients with new-onset AF detected by Holter monitoring and in all 5 patients with AF detected by event loop recorder.

**Discussion**

Our review suggests that routine Holter monitoring in consecutive hospitalized patients with ischemic stroke detects AF in approximately one in 20 patients, beyond that detected by physical examination and initial electrocardiogram. The range of detection rates (3.8% to 6.1%) is slightly more than that reported in an earlier review by Bell et al (1% to 5%).20 Our study differs from that review in a number of respects. First, we only included prospective studies. Second, most studies in the previous review were older and conducted (>20 years ago) when the clinical importance of paroxysmal AF was not appreciated, which may have influenced whether paroxysmal AF was reported.21–25 Third, 2 studies included in our analysis were published subsequent to the review by Bell et al.26,28

Very limited data suggest that confining Holter monitoring to patients with nonlacunar stroke may improve its diagnostic use. In the study by Jabaudon et al,28 no cases of AF were reported in patients with lacunar stroke. A potential limitation of the Jabaudon study28 is the unblinded evaluation of stroke subtype, which may have been biased by knowledge of the results of cardiac monitoring. One retrospective study, not included in this review, reported that Holter monitoring identified the greatest yield of AF in patients with unexplained embolic stroke.30 This is further supported by the results by Schuchert et al,29 which found a relatively higher detection rate of 6.1% in patients with suspected cardioembolic ischemic stroke. Furthermore, there are 2 observational studies that suggest that oral anticoagulation may not be associated with the same benefit for prevention of recurrent stroke in patients with AF presenting with lacunar stroke compared with those presenting with other ischemic stroke subtypes.11,31 Although based on very limited data, these observations suggest that limiting Holter monitoring to patients with nonlacunar ischemic stroke might be reasonable, but further research is required before definitive recommendations can be made.

Increased duration of monitoring appears to be associated with increased rates of detection of AF (Table 3). In the 2 studies that evaluated event loop recorders (140 participants), new AF was detected in 5.7% and 7.7% of consecutive patients in these 2 studies.26,29 Our review is unable to determine the optimal duration of monitoring. Similarly, the best time to initiate cardiac monitoring after a stroke is uncertain. No study explicitly evaluated and reported on early monitoring (within 48 hours) from onset of stroke symptoms.

<table>
<thead>
<tr>
<th>Study, Year</th>
<th>N</th>
<th>Intervention</th>
<th>Duration of Monitoring</th>
<th>Definition of Atrial Fibrillation</th>
<th>New Atrial Fibrillation/Flutter</th>
<th>Initiation of Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barthelemy et al, 2003</td>
<td>60</td>
<td>Cardiac event recorder (n=52)</td>
<td>4 days (70.1 hours)</td>
<td>≥30 seconds</td>
<td>7.7%</td>
<td>10 days from stroke event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holter monitor (n=55)</td>
<td>24 hours</td>
<td></td>
<td>5.5%</td>
<td>Admission to neurology ward</td>
</tr>
<tr>
<td>Jabaudon et al, 2004</td>
<td>149</td>
<td>Holter monitor (n=139)</td>
<td>21 hours</td>
<td>Not stated</td>
<td>5.0%</td>
<td>8 days after admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Event loop recorder (n=88)</td>
<td>159 hours</td>
<td>AF detected by manual review</td>
<td>5.7%</td>
<td>55 days after admission</td>
</tr>
<tr>
<td>Hornig et al, 1996</td>
<td>261</td>
<td>Holter monitor (n=261)</td>
<td>24 hours</td>
<td>Not stated; evaluated by cardiologist</td>
<td>3.8%</td>
<td>ND</td>
</tr>
<tr>
<td>Rem et al, 1985</td>
<td>184</td>
<td>Continuous cardiac monitoring (n=159)</td>
<td>48 hours</td>
<td>Not stated; evaluated by neurology resident</td>
<td>2.5%</td>
<td>ND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holter monitor (n=51)</td>
<td>24–48 hours</td>
<td></td>
<td>3.9%</td>
<td>ND</td>
</tr>
<tr>
<td>Schuchert et al, 1999</td>
<td>82</td>
<td>Holter monitor (n=82)</td>
<td>72 hours</td>
<td>At least 1 minute</td>
<td>6.1%</td>
<td>2–3 weeks after acute stroke</td>
</tr>
</tbody>
</table>

*<sup>n</sup> values indicate subjects without atrial fibrillation/flutter on history or previously. ND indicates no data.
Table 4. General Principles of Good Screening

<table>
<thead>
<tr>
<th>Atrial fibrillation in acute ischemic stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The condition should be an important problem               ✓</td>
</tr>
<tr>
<td>2. The condition should be common                              +/−</td>
</tr>
<tr>
<td>3. The condition should have a readily available and acceptable treatment.                                  ✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Holter monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. The screening test should be accurate                      ✓</td>
</tr>
<tr>
<td>5. The screening procedure should have a reasonable cost       ✓</td>
</tr>
<tr>
<td>6. The screening procedure should be acceptable to the patient and society.                                 ✓</td>
</tr>
</tbody>
</table>

Our review has several limitations. Eligible articles were restricted to published studies in English language journals, and conference abstracts were not accessed. Thus, unpublished studies may have been overlooked. Furthermore, because only hospitalized patients were included in eligible studies, we are unable to comment on the use of Holter monitoring in the outpatient stroke population. Our strict inclusion criteria resulted in fewer numbers of eligible articles compared with a previous review. Furthermore, sample sizes of studies included were relatively small. As a result, the confidence interval about the summary estimate is wide (95% CI: 0% to 12.7%), a clear limitation of this review. However, we believe that restricting eligibility to prospective studies is an overall strength of our review.

Do the results of this review have implications for clinical practice? Should all patients with ischemic stroke be screened with Holter monitoring? If we apply the general Principles of Good Screening, we observe that Holter monitoring fulfills most criteria (Table 4).32–36 However, in unselected patients, it remains open to argument whether AF is insufficiently prevalent to justify routine screening.

In conclusion, screening consecutive patients with ischemic stroke with routine Holter monitoring will identify new AF in approximately one in 20 patients. Extended duration of monitoring and confining its use to patients with nonlacunar stroke may improve detection rates. However, further research is needed to evaluate extended monitoring, using newer techniques, in patients with ischemic stroke.

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Disclosures

None.

References

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