



LETTER TO THE EDITOR

The Once-Conventional 48-h Elective Cardioversion Threshold for “Recent-Onset” Atrial Fibrillation Is No Longer Recommended

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We appreciate the article by Rotella et al. [1] and applaud the authors for underscoring the need for a uniform definition of recent-onset paroxysmal atrial fibrillation (AF) in patients presenting to the emergency department (ED). We agree that the current inconsistency in nomenclature “has critical implications for clinicians’ decisions and patient safety,” especially for frontline emergency physicians whose time-sensitive decision-making would benefit from clearly defined terminology.

The authors correctly point out that the 48-h threshold for safe elective cardioversion is “by no means [a] universal threshold” [1]. Recent guidelines suggest the safe cardioversion window is even shorter than the 48-h window the authors champion. This narrower timeframe is a response to evidence suggesting increased risk of embolic complications in the latter part of the 48-h window [2].

The latest 2024 version of the European Society of Cardiology (ESC) AF guidelines, referenced by the authors, no longer endorses the 48-h threshold the ESC had previously supported. In 2020, the ESC had made this assertion: “Early cardioversion can be performed without [transoesophageal echocardiography] (TOE) in patients with an AF duration of < 48 h” [3]. Note ESC’s revision in 2024: “Cardioversion is not recommended if AF duration exceeds 24 h, unless the patient has already received

at least 3 weeks of therapeutic anticoagulation or a TOE is performed to exclude intracardiac thrombus” (Figure 1) [4]. The change was made because “safety should come first” [4]. The 48-h symptom threshold is not completely absent from the 2024 ESC guidelines, though it does have a greatly diminished role. It now serves only to estimate the probability of spontaneous cardioversion in a ‘wait-and-see approach,’ as approximately two-thirds of those with clear AF onset will cardiovert on their own within 48 h [4].

The ESC is not the only society to have shortened their elective cardioversion window for the unanticoagulated. The American College of Cardiology (ACC) and the American Heart Association (AHA) explain in their 2023 AF guidelines that “Time to cardioversion > 12 h has been reported as an independent predictor for thromboembolic complications” [2]. For patients with AF duration < 48 h who have high thromboembolic risks but have not taken weeks of preceding anticoagulation, they advise consideration of “imaging evaluation to exclude intracardiac thrombus.” On the other hand, for patients without high thromboembolic risks and AF duration < 12 h, they state that “the role of pericardioversion thromboembolic evaluation or prophylaxis is uncertain.” Though the recent ESC and AHA/ACC guidelines recommend slightly different eligibility criteria for safe elective cardioversion, they both agree that elective

2020 ESC AF Guidelines	AF onset <12h*	AF onset 12-48h*	AF onset >48h		
	Only if no previous TE	Only if CHA ₂ DS ₂ -VASc score ≤1 _m or ≤2 _f	• Only if already received therapeutic anticoagulation for a minimum of 3w • Or if a TOE has excluded intracardiac thrombus		
AF duration, h	0	12	24	48†	etc.
2024 ESC AF Guidelines	AF onset <24h*		AF onset >24h		
	Only if cardioversion cannot wait		• Only if already received therapeutic anticoagulation for a minimum of 3w • Or if a TOE has excluded intracardiac thrombus		

FIGURE 1 | Effect of definite AF onset on evolving ESC indications for immediate unscheduled cardioversion of haemodynamically stable patients in the emergency department. AF, atrial fibrillation; ESC, European Society of Cardiology; f, female; m, male; TE, thromboembolism; TOE, transoesophageal echocardiography. *3 w of prior therapeutic anticoagulation is not required before immediate cardioversion; however, anticoagulation should be initiated as soon as possible if not already underway for all patients undergoing immediate cardioversion and continued for at least 4 w. † The 2024 ESC AF guidelines suggest “a wait-and-see approach for spontaneous conversion to sinus rhythm within 48h of AF onset should be considered in patients without haemodynamic compromise as an alternative to immediate cardioversion.” Approximately two-thirds of these patients will spontaneously cardiovert within 48h of AF onset.

cardioversion of stable patients with recent-onset AF beyond 24 h is unsafe without adequate pre-procedural anticoagulation or negative TOE. Canadian and Spanish guidelines have also abandoned the 48-h threshold in favour of a shorter timeline with a more nuanced approach incorporating stroke risk (see Table A1) [5].

We agree that adopting precise terminology is important for accurate knowledge translation, particularly in this area where guidelines are frequently being updated. It is similarly important to ensure that cardioversion is used in the safest way possible. The simple 48-h cardioversion window once recommended for all comers is no longer the governing paradigm in the guidelines and should be handled accordingly [3–5]. Reviewing the diverse eligibility criteria for unscheduled elective cardioversion currently recommended by society guidelines around the world (Table A1) [5], a conservative definition of “recent-onset AF” that might win international consent and still carry some clinical utility for emergency physicians would be a 12-h threshold. But until a consensus is reached, the best we can hope for is that researchers avoid using the debated term “recent-onset AF” without providing a definition.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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Appendix A

TABLE A1 | Criteria for cardioversion of nonvalvular^a atrial fibrillation or flutter in haemodynamically stable patients without anticoagulation for at least 3 weeks prior to presentation.

Professional society, first listed (year of guideline)	Atrial fibrillation duration	Inclusion criteria	COR/LOE or GRADE
European Society of Cardiology (2024) [1]	<24 h		Text only and Figure 12 of the ESC guideline
	>24 h and	Transesophageal echocardiography has ruled out intracardiac thrombus	1/B
American College of Cardiology (2023) [2]	<12 h and	CHA ₂ DS ₂ -VAsC score 0–1 or equivalent (i.e., if female, score 1–2) ^b	2b/C-LD
	OR	Cardiac imaging with either transesophageal echocardiography or cardiac CT ^c has ruled out intracardiac thrombus	2b/C-LD
Spanish Society of Emergency Medicine (2023) [3]	<24 h and	CHA ₂ DS ₂ -VAsC score = 0 if male, 1 if female [or CHA ₂ DS ₂ -VA score = 0]	—
Optional ^d	<24 h and	CHA ₂ DS ₂ -VA ≤ 2	—
	24–48 h and	CHA ₂ DS ₂ -VA ≤ 1	—
	OR	Transesophageal echocardiography has ruled out intracardiac thrombus	—
Canadian Association of Emergency Physicians (2021) [4]	<12 h and	No history of stroke/TIA	—
	12–48 h and	No history of stroke/TIA and <2 variables in CHADS-65 algorithm	—
	OR	Transesophageal echocardiography has ruled out intracardiac thrombus	—
Canadian Cardiovascular Society (2020) [5]	<12 h	No recent (<6 month) history of stroke/TIA	Weak recommendation; low-quality evidence
	12–48 h and	CHADS ₂ score 0–1	Weak recommendation; low-quality evidence
	OR	Transesophageal echocardiography has ruled out intracardiac thrombus	Weak recommendation; moderate quality evidence

Note: Adapted from Atzema CL, et al. Comparing Guidelines for Atrial Fibrillation: Focus on Emergency Medicine. *Ann Emerg Med.* 2026; 87 (4): 435–450. Used with permission. CHA₂DS₂-VAsC: Congestive heart failure, Hypertension, Age more than or equal to 75 (2 points), Diabetes mellitus, Stroke/TIA/embolism (2 points), Vascular disease, Age 65–74 years, Sex category; COR, class of recommendation; CT: computed tomography; CHADS-65: Congestive heart failure, Hypertension, Age more than or equal to 75, Diabetes mellitus, Stroke/TIA; CHADS₂: Congestive heart failure, Hypertension, Age more than or equal to 75, Diabetes mellitus, Stroke/TIA [2 points]; GRADE, Grading of Recommendations, Assessment, Development and Evaluation; LOE, level of evidence; TIA: transient ischemic attack.

^aValvular atrial fibrillation includes patients with moderate-to-severe mitral stenosis or any mechanical valve.

^bPatients with left atrial appendage occlusion (LAAO) that are not on anticoagulation have additional considerations including assessment of LAAO adequacy and residual leak, and may require pericardioversion anticoagulation.

^cCardiac CT with delayed contrast-enhanced image acquisition protocol.

^dAdded in an Erratum: risk score used is CHA₂DS₂-VAsC, but the ESC guidelines came out afterward and use CHA₂DS₂-VA.

Appendix References

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