



atrialfibrillationassociation

www.afa.org.uk

Providing information, support and access to established, new or innovative treatments for Atrial Fibrillation

Frequently Asked Questions



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Glossary

Aortic Plaque

The aorta is the main blood vessel from the heart and carries blood to the rest of the body. It ends as it divides into two at the level of the naval to form the arteries that supply blood to the legs. This can develop narrowings called 'plaques' which can cause problems with the circulation. This would be included in the diseases under the heading of Peripheral Vascular Disease.

Abdominal Aortic Aneurysm

This is often abbreviated to AAA. This is where the main blood vessel from the heart becomes swollen (dilated) in the segment in the abdomen. This can lead to rupture which is a serious problem. If the swelling is identified it is often kept under observation until such a time that the risk of replacing the swollen blood vessel balances with the risks of rupture.

Angina

This is also known as Ischaemic Heart Disease (IHD) or Coronary Artery Disease (CAD). This is a pain or ache in the chest on activity, which settles at rest. The pain is caused by cramp of the heart muscle due to poor circulation.

Diabetes

This is a condition where your body no longer controls its blood sugar as well as it should. Although many think of diabetes as requiring injections of insulin, most cases of diabetes are treated with diet and medication.

Heart Failure

This is also known as Congestive Cardiac Failure (CCF) or Left Ventricular Systolic Dysfunction (LVSD). This is where the heart muscle has been damaged and does not work as well as it should. This tends to make you breathless, even when lying down, and is generally treated with 'water tablets' amongst other medications.

High Blood Pressure

This is also known as Hypertension. This is a problem where the pressure in your circulation is higher than it should be. Although high blood pressure causes no symptoms it can lead to heart disease and strokes. It is treated with improvements in lifestyle and medication.

MI

This stands for Myocardial Infarction but is better known as a heart attack. This is where the muscle of the heart is damaged by a blockage in the circulation.

Peripheral Vascular Disease

This is better known as 'poor circulation' and generally has symptoms of cramping of the legs when walking and the cramp settling quickly when you rest. It is caused by narrowing of the arteries of the legs. Often people are seen by a vascular surgeon to see if the narrowings can be opened or bypassed.

Stroke

This is also known as a Cerebrovascular Accident (CVA). This is where the brain is damaged permanently by an interruption in its circulation. This can occur due to a blockage or a bleed into the brain.

TIA

This stands for Transient Ischaemic Attack, also called a 'mini stroke'. This is where the circulation to the brain is interrupted very briefly so although you develop the symptoms of a stroke, there is no permanent damage to the brain and a complete recovery is always achieved. The occurrence of a TIA requires a rapid review.

Valvular Heart Disease

This is where the small tissue valves in the heart develop problems. This is either by becoming narrow (stenosis) so the heart has to work harder to push the blood through the valves or by leaking back along the direction of flow so the heart has to work harder to pump the leaked blood again.

Section 1 - Atrial Fibrillation

1. What might have caused my Atrial Fibrillation?

Atrial Fibrillation is very common and the number of individuals that are affected is increasing. There is no question that there is a clear age-related incidence of Atrial Fibrillation. This would therefore imply that there is a powerful element of 'wear and tear' involved in the development of this heart rhythm abnormality. Undoubtedly there are other influences such as high blood pressure and there is also a familial aspect to it. If a close family member has had Atrial Fibrillation then the likelihood of other individual members having that condition is increased.

It has been a tradition in medicine to look for other specific causes of Atrial Fibrillation. Some patients for example, have an underlying problem with the thyroid gland. When a patient first presents with Atrial Fibrillation, it is important that the doctors check the level of the thyroid hormones in the blood through a simple blood test. In most patients this is not the cause but it is important that it is checked.

Some patients do have an underlying problem with the structure of their heart. Accordingly all individuals with Atrial Fibrillation should have an echocardiogram to look at how the heart is in terms of its size and its function.

It is rare that patients with Atrial Fibrillation have the rhythm as a first presentation of coronary artery disease. It used to be that a coronary angiogram was considered when looking into other ways for coronary artery disease in patients presenting with Atrial Fibrillation. That is now not the case for most patients. Unless there is a particular reason to think an individual may have coronary artery disease, doctors in general would not look specifically.

2. Why do I have Atrial Fibrillation? I am quite fit and healthy in all other ways.

Individuals who are fit and healthy can develop Atrial Fibrillation. In these individuals who have Atrial Fibrillation two factors may be at play. One is the influence of genetics and the other the influence of exercise. It's increasingly apparent, particularly in young individuals, that a family history can be a common feature. It's also become apparent in those who lead particularly healthy lifestyles and visit the gymnasium on a very

regular basis, and participate in exercise to a very high level, then the risk of Atrial Fibrillation might in fact be enhanced if they are otherwise predisposed.

Doctors would previously refer to Atrial Fibrillation occurring under the sorts of conditions where no other heart disease was observed as lone atrial fibrillation. However, awareness of the presence of lone Atrial Fibrillation has increased over time and its incidence may also be increasing.

3. What symptoms do you normally get during an episode of Atrial Fibrillation?

Experienced physicians who meet patients with Atrial Fibrillation are surprised by the substantial variability in the way they are aware of their fibrillation. Some patients have very rapid Atrial Fibrillation and get very few symptoms; others have infrequent short bursts of paroxysmal atrial fibrillation and get quite debilitating symptoms.

The sorts of symptoms individuals experience include an awareness of the heartbeat, a general feeling that things just aren't right in the chest. The rare individual might suffer some chest discomfort and some get dizziness and more rarely a feeling that they might faint. If Atrial Fibrillation is more persistent then a general exhaustion and debilitation might well be present. Some people with paroxysmal Atrial Fibrillation are aware of the heart beat being irregular with a general non-specific awareness that things are just not quite right during an attack and then there is substantial debilitation for a prolonged period afterwards which may extend well into the next day.

There are a group of individuals who don't experience any symptoms from Atrial Fibrillation. They simply present to their doctor and are found to have fibrillation that may be either persistent or paroxysmal. Those people are said to have 'silent Atrial Fibrillation'. In the occasional patient some other medical consequence will arise from their fibrillation such as, in its most extreme presentation a stroke and then they will be found to be in atrial fibrillation and this will be presumed to be the cause of that other medical issue.

4. Where can I access information and advice about Atrial Fibrillation?

There are a number of sources available on the web that will help to guide you to ask the right questions when your Atrial Fibrillation is being managed.

The AFA website: www.afa.org.uk provides information which will help you understand your treatment and make sure you get the very best treatment.

5. My Atrial Fibrillation seems worse at night. Is this normal?

Classically, two patterns of Atrial Fibrillation were described. One was the so-called adrenergic pattern in which attacks of Atrial Fibrillation occurred on exercise, the other pattern was the so-called cholinergic pattern in which Atrial Fibrillation would often occur at rest in bed at night. Of course, many patients presented both patterns and what is now apparent is that most patients manifest neither pattern uniquely.

Having said this, an account of Atrial Fibrillation starting at night is not uncommon. When an individual describes this pattern, one of the useful investigations may be an ambulatory ECG monitor (24 hour tape). Some of these patients are seen to have slow heart rates at night which may predispose to the onset of fibrillation and under these conditions the implantation of a pacemaker may allow one to control the symptom very efficiently without much drug therapy or without an Atrial Fibrillation ablation, although these should also be considered, possibly as adjunctive therapies in conjunction with a pacemaker.

In summary although this pattern of Atrial Fibrillation is not seen in everyone, it is not uncommon.

6. I have been diagnosed with Atrial Fibrillation. Is it likely that my children will also develop Atrial Fibrillation?

Atrial fibrillation is a common condition and is widely regarded as being multi-factorial. That is, many factors are involved in determining the expression of the condition in a particular individual.

All diseases are determined by both intrinsic (and often, therefore, genetic) and extrinsic (usually environmental) influences. In Atrial Fibrillation the relative importance of intrinsic and extrinsic factors changes as we get older. In young people presenting with Atrial Fibrillation, genetic factors may be

more powerful in terms of their influence on the expression of the disease than in older people. Of course, Atrial Fibrillation is an age-related condition and the very fact of aging itself may be the determinant of Atrial Fibrillation in a particular individual simply combined with other factors that may have developed during their lifetime, such as the appearance of blood pressure or obesity.

Accordingly, the impact of the expression of Atrial Fibrillation in an individual, and the likelihood of this appearing in their children, will be determined by things like the age of appearance in the parent and other co-factors such as other environmental influences. For example, the amount of alcohol consumed or participating in an extreme amount of exertion.

My general view in discussion with patients is that, because of this multiplicity of influences, patients with Atrial Fibrillation should not be particularly concerned about the risk for family members. In very few individuals is there a single major genetic determinant. It is rather the influences of chance that will determine the expression in those in succession in that family. Accordingly, the chance of your children having Atrial Fibrillation may be marginally higher than those who do not have an affected parent. However this is not something that should particularly concern you or them as we can do little to influence events. Should Atrial Fibrillation appear then appropriate referral and management should be embarked upon as it would if there was no family history. This general position may change with the advent of personalised medicine and predictive testing but it is what we have for the time being and works well within the bounds of what can be achieved.

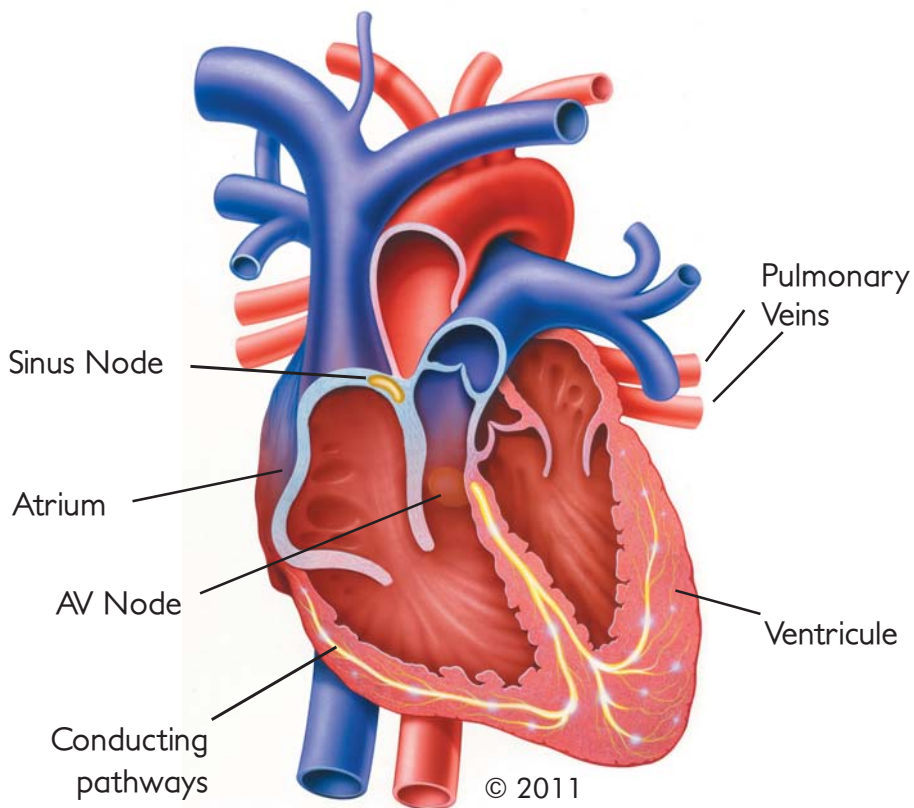
7. Why does my Atrial Fibrillation come and go when others have it persistently?

The pattern of the Atrial Fibrillation and the way it affects individuals differs. In some people the attacks go on for short spaces of time then spontaneously revert to a normal rhythm. That is usually called 'paroxysmal Atrial Fibrillation'. The reason that the attacks terminate spontaneously as they do is often unclear.

In some people on the first occasion they present, for example, to a General Practitioner, they will be found to be in Atrial Fibrillation which is there all the time. This is generally referred to as 'persistent Atrial Fibrillation'. This might have

started in some patients as paroxysmal Atrial Fibrillation that has now become persistent. In some, however, that transition has been so rapid that it has not been noticed and the individual has simply presented. In some patients an attack will just start and never cease and that again is referred to as being persistent. Research is going on at the moment to try and work out why it is that paroxysmal becomes persistent in some individuals and not in others.

See AFA Fact Sheet 'Atrial Fibrillation'



Section 2 - Diagnosis

1. I have been diagnosed with Atrial Fibrillation, what investigations would the doctor generally conduct on my first visit?

If you have Atrial Fibrillation then a doctor will first take your medical history, asking you questions and trying to establish what symptoms have been a result of the Atrial Fibrillation. They would also be trying to identify any cause. An examination would then be taken, keeping a particular eye on your blood pressure to see if there is any evidence of fluid overload caused by heart failure. They would listen to the heart to see if they can hear any murmurs that might indicate that there are problems with the heart valves and obtain an electrocardiogram (ECG) which will provide the diagnosis. In a formal sense, Atrial Fibrillation cannot be diagnosed without conducting such an electrical ECG recording.

In selected patients, a Holter recording is taken as a secondary test, which is an ECG recording made over a period of 24 hours from a portable device. This test would not be indicated in all patients.

Once an ECG recording has been obtained and the history considered, then in most individuals appropriate treatment can be decided upon.

2. What are the main objectives that the doctor should discuss with me in regard to the management of my Atrial Fibrillation?

There are three main issues that the doctor should consider. The most important thing is the risk of stroke. Stroke arises in patients with atrial fibrillation usually as a result of what is called 'thromboembolism'. What happens under these circumstances is that a clot is formed in the heart. This arises because the atrial chambers are not properly expelling blood and there is the potential for 'sludging up' of blood and 'stasis', the 'damming back' of blood that may lead to clot formation.

For reasons that we do not fully understand, the clot can occasionally break free and in the occasional unfortunate individual, this can result in a stroke.

The second strategic consideration is symptom control. The main issue with Atrial Fibrillation in terms of its day-to-day impact is on 'quality of life', and this can vary quite substantially in individual patients. For some

this has little impact upon their quality of life and in others the impact can be devastating. There is no obvious and direct relationship between the ECG appearances representing the electrical disruption of the rhythm and the extent to which individuals get symptoms.

The final issue the doctors should consider is the potential impact the Atrial Fibrillation is having upon heart function in general. It might be that Atrial Fibrillation has emerged with relatively few symptoms but has over a period of time lead to damage to the main pumping chambers of the heart, the ventricles. Accordingly an echocardiogram should be obtained to see if that has indeed occurred. It might be that more aggressive treatment is required in individuals where some impact upon heart function is observed. The overall impact upon heart function in patients with atrial fibrillation is still under discussion and in most patients there is no discernable and obvious immediate impact upon heart function. However, it is possible over the years that in some individuals, heart damage can occur and that should be kept in mind.

3. I have persistent Atrial Fibrillation. I have recently presented to my doctor. What are the key issues that should be considered in my case?

If you have recently been found to have persistent Atrial Fibrillation most opinion would indicate that we should try to get you back to normal rhythm. This should not be immediately applied because if one tries to correct the rhythm in patients who have been in Atrial Fibrillation for an uncertain period of time, that can increase the risk of thromboembolic events and may well precipitate a stroke.

Accordingly, the right course of action is for the doctor to start the individual on Warfarin, thin the blood and at the same time give a drug such as a beta-blocker (but not Sotalol), Digoxin or a calcium channel blocker (Verapamil or Diltiazem). The reason to add these latter drugs is to slow the response of the ventricle to the Atrial Fibrillation, which should help the symptoms to some extent in the short term. The reason for the Warfarin is to allow clot risk to be reduced and also allow the doctor to plan for a cardioversion that would normally be done once an individual is stable on these drugs.

With the first presentation with Atrial Fibrillation, Warfarin should not be started in conjunction with drugs like Amiodarone or Sotalol. The reason is that these drugs might lead to the restoration of normal rhythm at a point that the Warfarin has not yet had time to act and this could lead to a stroke.

Once the Warfarin has been in place for about six weeks and the blood tests have been satisfactory (the international normalised ratio (INR) has been maintained around 2.5 for that period), then a cardioversion should be conducted.



Section 3 - Stroke and Risk

1. Will having Atrial Fibrillation increase my risk of other conditions?

The main problem with Atrial Fibrillation is the risk of clot formation and the precipitation of stroke. It is obviously the most feared consequence and therefore after discussion and once appropriate tests have been completed, a proper judgment needs to be taken as to whether Aspirin or Warfarin should be started.

The other problem with Atrial Fibrillation is that in the occasional patient it appears to cause heart failure and that again should be carefully considered in individuals. The echocardiogram is extremely powerful in guiding consideration and treatment of that possibility.

2. I have high blood pressure and Atrial Fibrillation. I have found that I am unable to tolerate Warfarin and I wonder if there is anything else available to reduce my risk of stroke?

In general terms, Warfarin is an extremely well tolerated drug and for the vast majority of patients, it is tolerated. However, there is a sub-set of patients who, for a variety of reasons, some of them rather non-specific (tiredness, tummy upset etc.), find they are unable to tolerate Warfarin.

The only widely available drug that has been shown to significantly reduce the risk of stroke in the context of Atrial Fibrillation is Warfarin. The newer agents currently undergoing review should provide similar protection against the risk of stroke. However for the time being, Warfarin is the drug of choice. In general terms, use of Aspirin is now being looked upon with increasing ambivalence in those with Atrial Fibrillation. Clopidogrel might provide some benefits but this would not compare to those available with Warfarin.

One option that is possibly useful in those with a risk of stroke and intolerance of Warfarin, is the use of a left atrial occlusion device. This is usually a catheter-based procedure not dissimilar to ablation from a patient's perspective. The procedure is now available at several regional cardiac centres in the United Kingdom and in selected patients, may become the approach of choice.

See AFA Fact Sheet 'Blood Thinning'

Section 4 - Treatment

1. How is Atrial Fibrillation treated?

Drugs are currently the most usual treatment for Atrial Fibrillation, and have the aim of alleviating symptoms and reducing the likelihood of stroke. Commonly prescribed medicines include Warfarin, Sotalol, Flecainide, Amiodarone, and beta-blockers. For many patients, these drugs do not reduce symptoms or provide side effects that may actually prove to be worse than the symptoms arising directly from the Atrial Fibrillation. Physicians may also elect to perform an electrical cardioversion, a procedure in which high-voltage current is delivered through metal paddles positioned on the chest wall. Cardioversion will often “shock” the heart back into its regular rhythm.

For patients undergoing surgery for other types of heart disease, including coronary surgery or mitral valve repair, an additional procedure called surgical ablation may be performed to treat Atrial Fibrillation. The surgical procedure involves making multiple, strategically placed incisions, or lesions, in the upper chambers of the heart. These lesions are intended to isolate and stop the abnormal electrical impulses that cause Atrial Fibrillation, thereby restoring the heart to normal sinus rhythm (NSR). For many patients not needing surgery, a less-invasive procedure called catheter ablation is now thought by many specialists to be the most appropriate treatment. In 2006, the National Institute for Health and Clinical Excellence (NICE) issued a guidance document that supports catheter ablation for patients with Atrial Fibrillation who are not adequately treated with drugs. According to the NICE guidelines, catheter ablation can successfully cure atrial fibrillation in up to 80% of patients and reduce mortality by more than 50%.

2. I have been found to have Atrial Fibrillation and have few symptoms. Do I actually need any treatment?

In individuals who do not have any obvious or intrusive symptoms due to Atrial Fibrillation, then the decision as to how to treat them usually revolves around the containment of issues that may emerge due to thromboembolism. The main question may therefore be should Aspirin or Warfarin be started? That will be something that would need to be discussed with the doctor once the basic tests have been completed, particularly the echocardiogram. It might be that if there is other evidence of cardiac damage, that in addition to an anticoagulant, then drugs that would stop the heart being damaged over time

may be needed. In the long term, this could include treatments such as ACE inhibitors that may provide long term 'cardioprotection'. In addition, blood pressure has been found as a triggering cause of Atrial Fibrillation and if found then that would need to be controlled. In general terms, most patients who have Atrial Fibrillation will receive some treatment even if it is only Aspirin.

3. Are there any treatments that can be applied to cure me of Atrial Fibrillation?

For many individuals the treatment of choice is radio-frequency ablation, however it is not clearly established as a viable treatment option in many patients with Atrial Fibrillation.

Radio-frequency ablation is particularly effective in patients with paroxysmal Atrial Fibrillation where cure rates of 80% are achieved. In patients with persistent Atrial Fibrillation cure remains more elusive, although there are developments such as the use of special catheters that may be applicable to treat these groups of patients.

The question of ablation is something you should raise with your doctor. Should you decide to take this further, then it is important that the specialist considering doing the ablation has considerable experience of the technique. There are concerns with regard to the safety of the technique that may itself cause stroke and also potential damage to structures around the heart, particularly the oesophagus. The decision to proceed to have an ablation is something that is very individual based on the impact on quality of life, the perceived relative risks and benefits of that procedure and upon the discussion with a physician prior to embarking upon the procedure.

4. Can I make Atrial Fibrillation better without medication or without having an operation?

The question relates to the capacity of lifestyle modifications to improve both symptoms and objective measures of Atrial Fibrillation. With paroxysmal Atrial Fibrillation, it may well be that interventions such as decreasing alcohol intake, losing weight and generally increasing fitness and controlling blood pressure, are capable of controlling atrial fibrillation. However, other permissive influences, such as age, may also be pushing the fibrillation forward and in those who manifest with Atrial Fibrillation, it is unusual to find that single dominate lifestyle interventions will make the fibrillation better to the extent that no other

actions are necessary. Even if a lifestyle modification approach is considered as the first line strategy for symptoms, then this should not change a pro-active medical approach in measures to reduce the risk of stroke.

Having said this, it would be encouraged that there are lifestyle modifications in all patients with Atrial Fibrillation, as these are likely to lead to a better overall outcome in terms of quality of life and prognosis of whether or not other interventions are applied.

See AFA booklet 'Atrial Fibrillation, Patient Information'



Section 5 – Medication

1. I have paroxysmal Atrial Fibrillation. What drug treatments are available to help alleviate my symptoms?

There are three types of drug that are used for what is called 'rhythm control' in patients with Atrial Fibrillation. In many ways the simplest drugs to use are what are termed as beta-blockers. These interrupt the action of adrenaline and stimulatory nerves on the heart. Some of the beta-blockers are relatively simple such as Atenolol and Metoprolol and others are somewhat more complex such as Sotalol. Sotalol is complex in that it also has direct electrical actions on the heart. The problems with beta-blockers are that in many patients they can cause tiredness, mood upset and in both men and women may be sexually disruptive. Some patients however tolerate beta-blockers extremely well and it is effective in the management of their Atrial Fibrillation. Some individuals, for example, those who have already got a slow pulse, may not be suitable for beta-blockers and therefore they cannot be used. Some patients are totally intolerant of beta-blockers usually because the drugs completely undermine their quality of life.

The second category of drugs that the doctor might suggest for the control of Atrial Fibrillation is called class Ic drugs. There are two drugs in this category. The one that is most commonly used in the United Kingdom is called Flecainide. Flecainide is usually extremely well tolerated and can be highly effective in the suppression of Atrial Fibrillation. In the first few days after it is started, there may be symptoms of dizziness and blurred vision but that generally resolves. A small number of individuals cannot take it at all. In another group the Atrial Fibrillation can be organised by the addition of Flecainide and this can lead to it being conducted to the ventricles quite rapidly. Accordingly, Flecainide should be started with some caution. Occasionally Flecainide is started in conjunction with a beta-blocker or alternatively a drug like Verapamil or Diltiazem, which will slow the response to the ventricle should organisation in the atria occur. The other drug in this category is called Propafenone. This has many of the features of Flecainide but in addition it also has some beta-blocking action. There are no particular advantages (or disadvantages) in starting Propafenone in place of Flecainide. In patients who have hearts that are damaged in other ways, for example, who have coronary artery disease or have an abnormal echocardiogram, then Flecainide or Propafenone may not be suitable for them.

The third type of drug used for the treatment of Atrial Fibrillation is called Amiodarone. Amiodarone has the enormous advantage of being effective, but the problem is its side effects. Most patients will suffer some side effects from Amiodarone. All patients get what is called photosensitivity, which is an undue sensitivity to the effects of sunlight. This can lead to burning of the skin, which in some individuals can be really quite devastating. All patients should be warned about this side effect and should take care in any form of sunlight. The use of barrier creams in exposed sun areas and the use of hats, particularly in the summer, should be applied in all patients.

Amiodarone causes other side effects that can have major effects on individuals such as causing under-or over-activity of the thyroid gland. In view of this, individuals need regular monitoring of the thyroid through blood tests usually carried out by the GPs clinic.

There are many other side effects, some of which are quite common, such as sleep disturbance and nightmares and again may well necessitate stopping that treatment. There are also some life-threatening side effects of which the most impacting arises through lung damage. Anybody on Amiodarone who starts to notice coughing or shortness-of-breath should be alert to the idea that the Amiodarone is a potential cause and if this is found to be the case the drug should be stopped immediately.

Again, as is the case with many issues with Atrial Fibrillation, there is enormous variability, however, and many patients will tolerate Amiodarone very well and find that with it they can have their quality of life restored to near normal.

2. Who can prescribe Dronedarone?

Dronedarone is the recently available anti-arrhythmic agent. One of the points with new drugs is that issues related to efficacy, tolerability and even adverse effects could emerge in the early phases of their clinical use. It is therefore generally advised that new drugs are used just by specialists so that if signals of problems emerge in the population they can be spotted early and action taken.

Dronedarone, being a new drug, is in that early phase of its use in the community. Accordingly, specialist prescription by cardiologists is felt to be appropriate at this time. In general terms, doctors, who are not specialists in Atrial Fibrillation, would not feel particularly comfortable using a drug with which they lack familiarity and are happy that Atrial Fibrillation specialists

prescribe the new drug after proper consideration of all the other treatment options that are available. It might be that general physicians would seek the view of a cardiologist before suggesting the prescription of Dronedarone. General cardiologists might also seek the specialist view of a consultant electrophysiologist/heart rhythm specialist before, again, embarking upon the prescription of this drug.

As Dronedarone becomes increasingly used, one can anticipate a situation in which other doctors that might first include general physicians, physicians with an interest in medicine in the elderly as well as rhythm specialists would be more comfortable prescribing this drug. In the longer term its widespread use by primary care physicians might also be possible.

3. I have Atrial Fibrillation and would like to know how often my doctor should review the drugs that I am taking.

Regarding Atrial Fibrillation and frequency of assessment, one could divide the background to the advice into three phases. There is the initial phase of recognition of the condition and its characterisation with the determination of the treatment plan. The second phase would be the initiation and assessment of therapy. Then the third phase would follow entry into a period of stability (after the period of intense treatment modification is at an end) and the individual has returned to a new steady state. It is likely at this point quality of life will have been much improved and Atrial Fibrillation might have been completely suppressed.

In the first and second phases of the management of the condition, relatively regular reviews by the doctor is normally the order of the day. Once the main treatments have been deployed, then a follow up at 6 or 12 months is usual. At the end of that period, if symptoms are controlled and appropriate anti-thrombotic plans are in place, follow up may not be required on a regular basis.

In my practice, in those with persistent patterns of Atrial Fibrillation in whom a rate control strategy, for example, has been embarked upon, then I would propose in correspondence copied to the patient that they would be followed up in three to five years with a further echocardiogram to look at the structure of the heart and assess medication in the light of symptoms and other more objective observations.

See AFA booklet 'Drug Information for Atrial Fibrillation'

Section 6 – Cardioversion

1. What is an electrical cardioversion?

Electrical cardioversions are applied to people with persistent (not paroxysmal) Atrial Fibrillation. The individual is first given Warfarin and adjusted into the right (therapeutic) range (to make sure there is no clot in the heart) and is then given a general anaesthetic. Pads are placed on the chest and an electric shock is given across the heart whilst the patient is asleep. In many patients this will restore normal rhythm. In those whom the Atrial Fibrillation has been relatively short-lived, the normal rhythm may be restored for a considerable period of time. In fact they may stay in normal rhythm well into the future. In those who have had Atrial Fibrillation for longer or who have structurally damaged hearts as indicated by echocardiography, the rhythm might go back to Atrial Fibrillation quite quickly thereafter.

If the first cardioversion has worked but Atrial Fibrillation has emerged sometime thereafter, then a repeat cardioversion may be planned. Under those conditions and in addition to Warfarin an anti-arrhythmic drug may be started and applied in conjunction with a cardioversion to increase the chance of the normal rhythm being maintained over time. The drug that is usually used is Amiodarone because that is the most effective. It might be that after a period of time the Amiodarone can be stopped providing the heart has been maintained in normal rhythm.

See AFA Fact Sheets, 'Cardioversion' and 'Medical Cardioversion'



1. I understand that after a while Atrial Fibrillation may be harder to treat successfully with ablation and that in general terms drugs have usually been tried first. When is the best time to seek advice from a specialist?

The management of Atrial Fibrillation is evolving. The recent guidance from the European Society of Cardiology (committee chaired by Professor Camm) indicates that the ablation of Atrial Fibrillation can now be considered as a potential first line therapy for those with Atrial Fibrillation who have a structurally normal heart. This is a somewhat new position with the general feeling in the community previously being that individuals would have had to fail anti-arrhythmic therapy before being considered for radio frequency ablation. The possibility now that one could proceed to ablation without even trying an anti-arrhythmic drug is thereby raised and therefore early advice from a specialist may well be advisable in many cases with symptomatic Atrial Fibrillation.

If a person has significantly symptomatic Atrial Fibrillation then they should seek an opinion from a heart rhythm specialist at an early stage. This will allow you to discuss the full range of possibilities in terms of management at the outset of your experience of the condition. This gives the individual patient who suffers Atrial Fibrillation the knowledge and confidence that allows them to proceed comfortably through the earlier stages of the assessment and management of the condition. Whether early intervention in Atrial Fibrillation to stop the attacks at an early stage leads to a decreased number of events later on and makes it easier to treat successfully with ablation is not, in a formal sense, fully known at this time. However, there is an argument for early intervention in appropriate cases.

See AFA booklet, 'Catheter Ablation for Atrial Fibrillation'



Section 8 – Procedures

1. Will I eventually need a pacemaker?

There are three areas where pacemakers have been used in Atrial Fibrillation.

The first use of pacemakers in Atrial Fibrillation is in those individuals who have Atrial Fibrillation and are also found to have a slow pulse. The slow pulse may be observed because it has caused symptoms such as collapse or it may be seen, for example, on an electrocardiogram or, for instance on ambulatory electrocardiogram. The addition of the pacemaker to the treatment in a patient under those conditions can be extremely valuable e.g. it may allow the use of other drugs that would then suppress other symptoms of Atrial Fibrillation in the context of paroxysmal Atrial Fibrillation.

In some patients with paroxysmal Atrial Fibrillation pacemakers can be beneficial. It is now generally felt by most experts however that the only patients in whom this would be effective long-term are in those who also have evidence of slow heartbeats. However, it may well facilitate the overall management of patients with Atrial Fibrillation particularly if they are elderly where ablation treatments might be considered unduly risky.

The final use of pacemakers is in patients with persistent Atrial Fibrillation in whom the ventricular chambers are being bombarded extremely rapidly by the Atrial Fibrillation. In those patients in whom drugs have previously been tried to try and stop these rapid ventricular responses then a pacemaker may be implanted. Once this is in place, or even at the same time, then the junction between the upper chambers and lower chambers can be easily disconnected by passing a catheter into the heart and applying energy to disrupt that connection - this is termed 'ablation of the atrio-ventricular (AV) junction'.

This overall procedure is colloquially referred to as a 'pace and ablate' procedure. It has been in use for almost 30 years and has proven to be highly effective in many patients. If that procedure is completed then the pulse might feel entirely regular and almost certainly the quality of life would be increased if it has been applied to the patient under the right situation. Warfarin is likely to have to continue however, as the atrial chambers, which are the usual source of clot, will still be beating erratically and Warfarin will be required to stop the clot forming.

See AFA Fact Sheet, 'Pace and Ablate'

Section 9 – Health and Exercise

1. I have recently developed Atrial Fibrillation. Is it safe for me to carry on attending my keep fit classes and jogging twice a week?

In an individual developing Atrial Fibrillation the first step in terms of getting a management plan is proper medical assessment. Once that's been achieved and appropriate medication has been prescribed and/or interventions have been embarked upon, then physicians would generally encourage patients to return to full and normal activities. The general attitude of heart specialists is for individuals to return to normal lifestyles and maintain general cardiovascular fitness. Such a programme will provide the maximum long-term advantage to patients.

Accordingly, we would want individuals to attend keep fit classes, pursue fitness to the best of their capabilities and if they were able to go out jogging, this would also be encouraged. The maintenance of normal weight, joint flexibility and muscular strength is important to global fitness.

In the vast majority of patients, exercise is unlikely to have an adverse influence on the expression of Atrial Fibrillation. Accordingly, it's certainly safe in the majority of patients for exercise to continue and most doctors would encourage this for most of their patients affected by Atrial Fibrillation.



MEMBERSHIP APPLICATION FORM

Membership is free, however donations are gratefully received. Cheques should be made payable to AFA.
If you are interested in receiving further information, becoming a volunteer or fundraiser, please do not hesitate to contact us.

<p>PLEASE PRINT -</p> <p>Patient <input type="checkbox"/></p> <p>Title: Mr / Mrs / Miss / Ms / Dr _____</p> <p>Full Name: _____</p> <p>Address: _____ _____ _____</p> <p>Postcode: _____</p> <p>Daytime Telephone no: _____</p> <p>Evening Telephone no: _____</p> <p>E-mail: _____</p> <p>Date of Birth: _____</p>	<p>Carer <input type="checkbox"/></p> <p>Name: _____</p> <p>Tel: _____</p> <p>Email: _____</p> <p>Address: _____ _____ _____</p>	<p>Patient Diagnosed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Diagnosis: _____</p> <p>If Diagnosed by whom:</p> <p>GP <input type="checkbox"/> Cardiologist <input type="checkbox"/></p> <p>Geriatrician <input type="checkbox"/> Paediatrician <input type="checkbox"/></p> <p>Name: _____</p> <p>Hospital/Medical Centre: _____ _____ _____</p>
<p>Tick box if happy to receive newsletters and updates from AFA <input type="checkbox"/></p>		

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Acknowledgements:

AFA would like to thank the GPs, cardiologists and nurses who help develop and review AFA booklets. Particular thanks is given to Dr Andrew Grace and Dr Matthew Fay for their work on this booklet.

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Please remember these are general guidelines
and individuals should always discuss
their condition with their own doctor.

