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Harry's Case Study



It's been a long journey. Now I've unwound my memory I can see that my first atrial fibrillation experience was in 1983 – six days in hospital with an unexplained arrhythmia as a result of what they described as a physical break-down. In the following three years I had bouts of ectopics and arrhythmia at various times. To me, all this was associated with stress and the consultants again didn't name an arrhythmia. Then things receded with only the occasional flare-up for the following ten years.

Low BP

For a few years up to 2000 I increasingly began to feel woozy and light-headed when rising – thankfully no fainting but a drop in BP and an increase in heart-rate. Postural orthostatic tachycardia or other neurological disorders were suggested. The neurological specialist refused to refer me for heart tests even though my research indicated the problem could be cardiac in origin. I persisted and argued my point and eventually he agreed to a 24 hour monitor and there they were: AF, tachycardia, bradycardia and 1st degree heart block!

The wait and see years

The diagnosis was paroxysmal (intermittent) AF. So it was a thankful goodbye to the obstinate neurologist and hello to the first of the cardiologists as well as ongoing tests of various kinds, monitoring and eventually medication - *Bisoprolol*, *Clopidogrel* and *Atorvastatin*. I saw my first electrophysiologist (EP) in 2004 and he suggested the anti-arrhythmic *Flecainide* rather than ablation at that time, whilst noting that would change in a few years. I declined *Flecainide* due to my slow heart rate (sometimes three to four second gaps between beats) at night.

Condition was then monitored by cardiologists, and then a second EP who suggested on balance of risk vs. symptoms it was still too early for a PVI ablation. During this period and unnoticed by me my PAF had changed to AF 24/7 by early 2006. As I tolerated the AF reasonably well and my heart rate was controlled he eventually discharged me back to my GP in 2006 with *Bisoprolol* and *Clopidogrel* to wait and see developments.

Symptoms worsened

Within a year it often felt like a bag of fighting monkeys in my lower left chest and other symptoms became more pronounced and debilitating. I also now felt cut off from specialist care so I had another 7-day holter monitor test and echocardiogram, this time arranged by my GP. I asked for a referral back to cardiologists in 2008 and my GP was only too happy as he felt the consultant was best placed to manage my condition. We set objective to keep heart rate in normal range, so *Bisoprolol* dosage increased yet again. At my request I was referred to my third EP – diagnosis was now persistent long standing AF with a slow ventricular response, meaning heart rate was still well controlled.

New outlook for long-term persistent AF

The new EP was prepared to undertake a PVI ablation, explaining that it would probably require two, maybe three ablations to achieve a long-term symptom free condition – this was the target rather than an actual ‘cure’. He was and still is of the firm opinion, that long term persistent AF is not permanent AF until such time as it is established that normal heart rhythm cannot be restored. Long term persistent AF is therefore as much a candidate for a PVI ablation as PAF and recent onset persistent AF. At no time were budgetary factors mentioned, it seemed to be purely a clinical decision as he was confident that my quality of life could be improved by this means.

The route to PVI ablation

Not totally straightforward. The first step was *Warfarin* therapy, then three months of *Amiodarone* therapy before an internal cardioversion in July 2009, to test if normal heart rhythm did indeed feel better than my by now usual state of rate controlled AF. It did, albeit only lasting a few days before AF crashed back in. Then came a delay caused by occasional flashes of pain in chest – were they cardiac? An angiogram revealed coronary artery disease (70% occlusion of one vessel) so heart MRI was necessary to determine if pains were ischemic (cardiac). They weren't and they have greatly reduced since the last ablation.

So, after more than four years of AF 24/7, the first ablation was done in March 2010 but unfortunately I reverted to AF after less than four weeks. For the second ablation in June 2010 he used the Hansen Robotic system that provides greater precision and supported it with three months of post-procedure *Amiodarone* therapy. Now in early 2011 I remain in normal rhythm and mostly symptom free – I feel so much better than before that I wish I hadn't prevaricated for as long as I did about having it done.

Lessons learnt

I have been fortunate – despite my initial reservations I found both ablations remarkably pain free and at all times I felt I was in the hands of a very skilful, professional and knowledgeable team. Furthermore, all this was done on the NHS. My GP was highly supportive, the first EP was a pioneer of PVI ablation techniques in UK, the second a leading expert in AF ablations, who left to set up a centre of excellence in another health authority region and the third is a rising light in one of the foremost centres in UK. He has great experience of and interest in ablating long-standing persistent AF.

However, I have also helped myself. Firstly I learnt to live with my AF, not to give in to it but to work around it and ignore it whenever possible, whilst making sure I received adequate treatment and care. To achieve this it is necessary to research and understand AF so you can speak to medical professionals without fear and with confidence – in my experience most now respond positively to this approach and engage with the patient in achieving the best outcome possible. List your questions in advance and make notes at all appointments. Above all, both parties should put it in writing, so what is agreed and any actions proposed are clear and understood. Finally, be kind to the consultant's secretary, she can often prove to be your best friend.