

Key points in PAF:-

- ◆ ECG-diagnosis of PAF is important, and incentivised in the primary care QOF
- ◆ An underlying cause is found in about 50% of patients, but “lone AF” is commoner in lower age-groups
- ◆ Echocardiography is required where there is a history of structural heart disease or the 12-lead ECG is abnormal
- ◆ “AF-begets-AF”, and PAF will progress to chronic AF in most cases
- ◆ Treatment should aim to suppress PAF for symptom-control and for reduction of long-term risk
- ◆ Amiodarone and flecainide are the most effective drugs for suppressing PAF, but amiodarone is too toxic for long-term use, and flecainide should not be used after Q-wave MI or in other important structural heart disease
- ◆ B-blockers are a good choice for exercise-induced PAF, but of little benefit otherwise
- ◆ Anticoagulation for PAF should follow anticoagulation guidelines for chronic AF
- ◆ RFCA for PAF should be considered for any symptomatic patient under 70 after failure of two drug trials, (including refusal of amiodarone)
- ◆ Permanent pacing of the atrium may suppress PAF

