

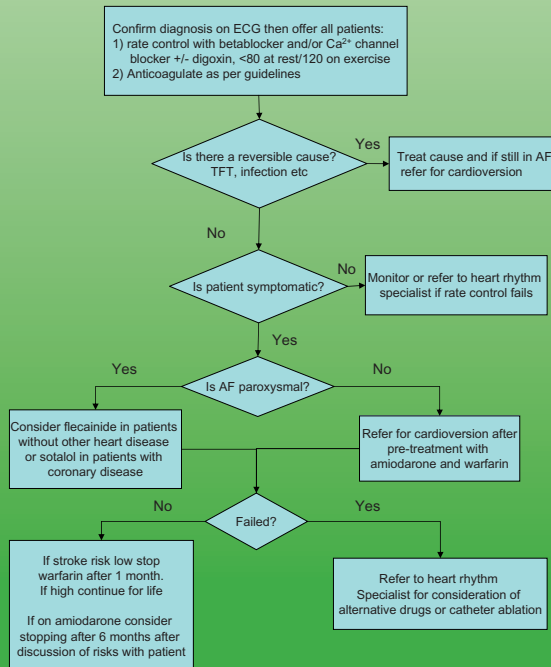
Dangers of amiodarone

Amiodarone has very important side-effects, especially if used for a long time. It can damage the skin, thyroid, eyes, brain, nervous tissue, liver and lungs. It may cause allergic responses in those sensitive to iodine. It has an increased risk of causing damage over time, because of accumulation. It has a half-life of 3 weeks, and therefore even when stopped may stay in the body for a further 6 months.

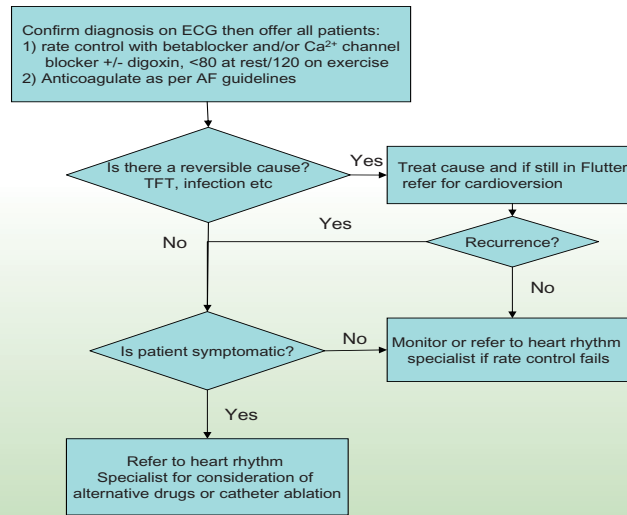
Catheter ablation

Many patients with paroxysmal and persistent AF are eligible for a catheter ablation approach to maintain sinus rhythm. This takes between 2-4 hours, can be done under sedation, and targets the irritable trigger areas in the left atrium particularly the 4 pulmonary veins. Overall success rates are 80% for paroxysmal and 60% for persistent AF, although many patients need 2 procedures. There is a 2% risk of a serious complication in the procedure including stroke, perforation of the heart and damage to the pulmonary veins. Catheter ablation is only done by cardiologists with heart rhythm training – trained cardiac electrophysiologists.

Is my patient suitable for cardioversion?



What to do with a patient with atrial flutter



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



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TEN TOP TIPS FOR ATRIAL FIBRILLATION

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What is the impact of AF?

500,000 patients in the UK have atrial fibrillation, (AF), AND the incidence is rising at 5% per annum. AF consumes 1% of the NHS annual budget, (£1bn). AF is associated with more than 575,000 UK hospital admissions, causes another 95,000 admissions per annum. AF roughly doubles the risk of death in both sexes, independent of age group. Health care costs of AF are 9- to 23-fold greater than in those without. One-in-four stroke patients is admitted in AF. Elderly patients, in particular, may have asymptomatic AF, and have a high stroke-risk.

Atrial flutter

Atrial flutter is allied to AF and also causes stroke. It is a common cause of admissions with 50,000 new cases each year in the UK. Atrial flutter commonly leads to recurrent admissions and as it can easily be cured by catheter ablation this should be considered for first line treatment.

Diagnosis

NICE guidelines require an ECG diagnosis of AF, but this is time-consuming in primary care. Thirty QOF points are available for pulse-check, ECG-confirmation and establishment of appropriate anticoagulation. AF is paroxysmal (if an episode lasts less than 7 days), persistent (greater than 7 days and cardioversion is being considered) or permanent (chronic) if cardioversion has been ruled out, and a patient is to be managed in long-term AF.

Stroke prevention

The need for warfarin should be considered in all AF patients. Scoring systems or flow charts are used to assess whether warfarin, aspirin or nothing is needed as blood thinning treatment.

Patients who have, for example:

- mechanical heart valves
- mitral valve stenosis (narrowing)
- aneurysm of the left ventricle need treatment with warfarin independent of the presence of AF.

Other patients are scored according to whether they have:

- diabetes: 1 point
- heart failure: 1 point
- age 75 years or more: 1 point
- treated high blood pressure: 1 point
- Previous stroke/TIA: 2 points

Patients with a score of 2 or more need Warfarin.

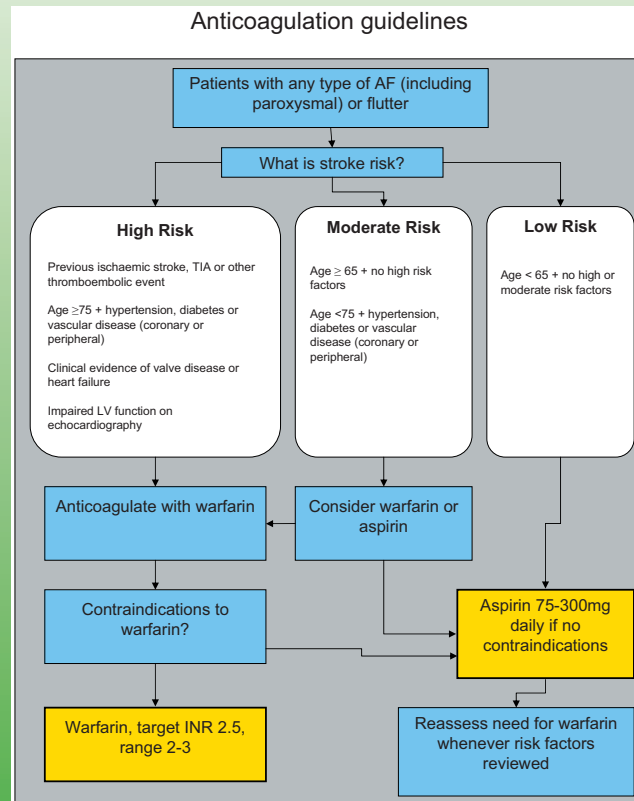
Patients with a score of 1 should be further assessed:

- coronary artery disease
- aged 65 to 74
- female gender
- history of thyroid overactivity

Patients with a score of 1 plus one or more of these other factors probably need warfarin, others need aspirin.

Patients with a score of 0 do not need warfarin but may need aspirin if these other factors risk are present (see above).

Instead of using this scoring system a flow chart (such as that below) can be followed.



Adapted from National Collaborating Centre for Chronic Conditions. *Atrial fibrillation: national clinical guideline for management in primary and secondary care*. London: Royal College of Physicians, 2006

Permanent Diagnosis AF

For some patients long term AF is accepted. The main elements of treatment are stroke prevention and appropriate control of heart rate at rest and with exercise. Digoxin does not control the heart rate during exercise in AF so beta-blockers and calcium antagonists that increase the time taken for the AV node to recover are usually needed. Occasionally, patients with poor rate-control need a pacemaker and ablation of the AV-node.

Cardioversion

Direct-current cardioversion may be attempted in patients with symptomatic persistent AF despite good rate control and in appropriate patients where there is a perceived benefit of being in sinus rhythm. Cardioversion is usually successful initially but less so long term. It can be done quite safely by trained specialist nurses as a day case procedure. It is useful to give a drug such as amiodarone for 2 months prior to cardioversion to improve success. All patients must be adequately anticoagulated with warfarin for at least 3 weeks prior to and 1 month after cardioversion.

Paroxysmal AF

Paroxysmal AF (PAF) is often much more troublesome than Permanent AF and is a common cause of admission to hospital. The aim of treatment is suppression of AF episodes. The stroke risk in PAF is the same as any other type of AF and warfarin or aspirin should be prescribed.

Suppressing AF

In patients with PAF and a normal heart, flecainide, propafenone or sotalol are the drugs of choice, but they are not innocuous. BNF recommends commencement under the supervision of a hospital consultant, ideally a cardiologist with an interest in heart rhythm care, (cardiac electrophysiologist). Patients should combine flecainide or propafenone with a rate control drug such as a beta-blocker or Ca²⁺ channel blocker if atrial flutter is suspected. In patients with known or suspected heart disease, amiodarone is the best drug for suppressing PAF.