

MANAGEMENT OF ATRIAL ARRHYTHMIAS

Atrial fibrillation doubles mortality risk

Affects 1 in 20 in over 65s. Increase incidence with age

Associations:

- Hypertension
- AGE
- IHD
- Thyroid disease
- Atrial area [enlarged atrium increases risk of developing AF]
- Valve disease [mitral stenosis]
- Amyloidosis
- Family history

Atrial flutter : very good response to endometrial ablation [90% curative]

Management of atrial fibrillation:

Depends if paroxysmal or persistent.

Aim for rate <80 at rest and <120 with moderate exercise

Paroxysmal defined as lasting <7 days

Paroxysmal AF [drugs of choice]:

- Exercise induced = B blocker
- Lone AF = Flecainide
- with heart disease [valve disease previous MI] = Amiodarone

remember to anticoagulate!!!

Persistent lasting >7 days:

Rate vs rhythm control:

<u>Rate control first with persistent AF if:</u> HR>90 (>110 if recurrent onset of AF) asymptomatic in whom antiarrhythmic drugs are C/I unsuitable for cardioversion	<u>Rhythm control first for persistent AF if:</u> Symptomatic Younger Presenting for the 1st time with lone AF with secondary AF
---	--

Drugs to control rate:

- B blocker - Bisoprolol 2.5-10mg OD
 - Ca²⁺ antagonists [diltiazem or verapamil 40-120mg tds]
- IF further rate control needed add in digoxin

ANTICOAGULATE: NNT 37 to prevent one stroke.

Either use [CHADS2](#) or [CHA2DS2-VASc](#) score from European Society of Cardiology guidelines to decide aspirin vs warfarin [click link to visit]. Also summary of what is included in CHADS2 vs CHA2DS2-VASc can be found [here](#)

ABLATION:

Back to work after 2-3 days. Not allowed to drive for 3 days.

Complications <1 in 100 risk of stroke

Types:

- AV nodal ablation: with pacemaker insertion. For older patients – will remain in AF
- Pulmonary vein isolation: Curative in 75% with paroxysmal AF, 50% with persistent AF