



AF – Rate vs Rhythm Control

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Favouring rate control

Persistent AF
Less symptomatic
Age >65
HTN
No hx HF
Previous failure of antiarrhythmics
Patient preference

Favouring rhythm control

PAF or new AF
More symptomatic
Age <65
No HTN
HF clearly exacerbated by AF
No previous failure of antiarrhythmics
Patient preference

Rhythm Control

Normal LV function - flecainide, sotalol, amiodarone
EF >35% - amiodarone, sotalol
EF <35% - amiodarone

Rate Control

Betablockers
CC blockers
Digoxin

Causes of AF

Cardiac - HTN, valvular disease, CAD, CHF, cardiomyopathy, genetic, post cardiac surgery, sick sinus.
Non-cardiac: hyperthyroidism, sepsis, alcohol, OSA, COPD, stimulants

Drugs

Metoprolol

Pros: first-line in patients with comorbidities - CAD, HF, LV dysfunction. Generally well tolerated
Cons: dizziness, fatigue; caution elderly (falls); can mask hypoglycaemia (caution DM)

Diltiazem/verapamil

Pros: preferred young patients (less fatigue), preferred asthma/COPD, less effective control HR in exercise
Cons: constipation; avoid after MI or HF

Digoxin

Pros: can be added to BB or CCBs if not controlling rate; good for sedentary patients or LV dysfunction
Cons: Not first line; less effective than BB/CCB; toxicity and side effects possible; drug interactions, caution in renal failure, assoc with incr risk all-cause mortality

**Amiodarone**

Pros: Most effective (60-70% at 1year), better at preventing AF than sotalol or propafenone, rate and rhythm controlling properties, can be used in renal dysfunction or HF

Cons: serious side effects, drug interactions (esp warfarin), loading dose and titrating schedule required, long half life 26-100 days

Sotalol

Pros: rate and rhythm controlling properties, 30-50% efficacy 1 year

Cons: pro-arrhythmic properties, CI in CrCl <40, bradycardia common in elderly, avoid in women >65 taking diuretics or have renal impairment (risk TdP)

Flecainide

Pros: 30-50% efficacy 1 year, can be used for pill-in-pocket strategy in structurally normal hearts (200-300mg)

Cons: should be coupled with AVN blocker (BB or CCB) as risk VT, CI in structural heart disease, can have serious cardiac SEs (arrest, arrhythmia, AVN block)