

THE AFIB REPORT

Your Premier Information Resource for Lone Atrial Fibrillation!

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Editorial

It is now 12 months since the first issue of The AFIB Report saw the light of day. Originally it was intended as an addition to International Health News, but recently it became clear that the amount of research, which needed reporting, warranted its own free-standing publication. When I began writing The AFIB Report I had great faith that the problem of LAF would be solved within a relatively short period. This was obviously overly optimistic particularly in light of the fact that the problem was first recognized in 1870.

Nevertheless, I believe we have made great progress. Our surveys have given us all a much clearer idea of what we are dealing with and what triggers the episodes. The LAF Forum and Bulletin Board have served admirably as gathering places and information exchanges, and have helped many new afibbers with a sense of hope while at the same time clearing up much of the confusion surrounding LAF. The AFIB Report has pulled together much of the research concerning LAF and will continue to do so.

In this issue we continue with our discussion of supplements that may be useful to afibbers. It is pretty clear that there are more supplements that may help vagal afibbers than there are for adrenergic, mixed or chronic types. I have the adrenergic type and have found that dissolving 12.5 mg of atenolol (Tenormin) under the tongue and then swallowing it with a glass of water will very often prevent an episode if I feel stressed and "on the verge".

We also begin in this issue a series of articles written by afibbers who have found effective ways of coping with LAF. The first, by Frank McCabe, is a real success story. Frank used to have an episode almost every night upon going to bed. He has now gone a full year without a single episode!

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I personally have found the anti-inflammation protocol very helpful. It has reduced my number of episodes and time spent in fibrillation by at least half. I believe results (fewer and shorter episodes and less ectopic beats) became apparent within the first 6 weeks of being on the protocol. If it has not worked within 2 months it is probably not likely to work. I have now discontinued the protocol, but fully expect the improvement to last. I debated whether to carry on with it, but decided that too little is known about the long-term effects of curcumin and Moducare to take them for more than a couple of months. I will keep you posted on my progress.

*Yours in health – and sinus rhythm!
Hans*

SUPPLEMENTS FOR AFIBBERS – Part II

F. Magnesium

Magnesium is extremely important in ensuring a steady heart beat and overall heart health[73-79]. Magnesium and potassium calms the heart and oppose the action of sodium and calcium that excites it. About 99% of the body's magnesium is found in tissues and bones and the heart tissue is particularly rich in this vital mineral. Only 1% of the body's magnesium stores is found in the blood so a regular blood test is a very poor indicator of your magnesium status. Ideally you would measure the magnesium level in your heart tissue to see if you are deficient, but this is not terribly practical. Fortunately, researchers at the Cedar-Sinai Medical Center in Los Angeles have discovered that there is a direct correlation between heart tissue magnesium level and the concentration found in epithelial cells scraped from under the tongue or from between the gums and the upper and lower lips[80]. Trace Elements Inc. (www.traceelements.com) can do the magnesium testing and can also recommend a physician in your area who can do the cell scraping. Thirteen per cent of the respondents to the original LAF survey have had their intracellular magnesium levels measured and 83% of them were deficient.

There is considerable medical evidence that a magnesium infusion can prevent or stop arrhythmias[73,77-79]. At least 10% of the survey participants found weekly or monthly magnesium infusions useful in preventing episodes. The evidence supporting the use of oral magnesium supplements as a means of correcting a deficiency is sparser. The Cedars-Sinai researchers reported a 10% increase in intracellular magnesium levels after six months of supplementation with 365 mg/day of elemental magnesium[80]. Although our survey did not support a beneficial effect of magnesium there is lots of anecdotal evidence of the benefits to afibbers of supplementing with magnesium. Magnesium aspartate, gluconate or citrate are probably the best choices as the cheaper and more common magnesium compounds (magnesium oxide and magnesium carbonate) are poorly absorbed. Magnesium absorption tends to decrease as body stores are replenished so there is little chance of overdosing; nevertheless, patients with end-stage renal disease should not supplement with magnesium[81]. It requires vitamin D for optimum absorption so it is important to get adequate unprotected sun exposure daily or to take a vitamin D-3 supplement when using oral replenishment of magnesium[81].

So the bottom line as far as magnesium is concerned is:

- Consider having your intracellular tissue level of magnesium determined and if deficient correct it;
- Talk to your doctor or naturopath about having weekly or monthly magnesium infusions for a while to see if this will decrease the frequency and severity of your episodes;
- Take an oral magnesium supplement. I have settled on three capsules of magnesium/potassium aspartate that provides me with 300 mg of elemental magnesium and 300 mg of elemental potassium on a daily basis.

G. L-carnitine

Carnitine is a vitamin-like compound which is intimately involved in the transport of fatty acids into the mitochondria, the body's energy producing cells. It is extremely important for heart health and supplementation has been found useful in the treatment of many forms of heart disease including angina, congestive heart failure, heart attack, and arrhythmias[82-84]. Carnitine has been found particularly effective in reducing the incidence of ventricular premature beats in heart attack patients[85,86].

Carnitine is extremely safe and no adverse effects have been reported in human clinical trials. It appears to work synergistically with coenzyme Q10[87]. The recommended daily dosage is between 1500 and 4000 mg in divided doses[82].

H. Taurine

Taurine is a sulfur-containing amino acid that is particularly abundant in the skeletal and cardiac muscles. It is safe and effective in the treatment of many cardiovascular conditions. Research has shown that supplementing with 3 to 6 grams daily reduces cholesterol levels[88,89]. Taurine also protects the heart from calcium imbalances and subsequent heart damage[90]. It can lower blood pressure and stimulate heart muscle contraction and is especially effective for congestive heart failure patients[91-93]. There is ample evidence that taurine can prevent cardiac arrhythmias by modulating the in and outflow of potassium from heart muscle cells[94]. Animal experiments have shown that taurine and magnesium taurate are effective in preventing or shortening the arrhythmias often accompanying heart surgery[95,96]. I have not come across any clinical studies concerning taurine and LAF so it is uncertain whether it would have any benefits for lone afibbers. However, it is not likely to do any harm. Usual recommended dosage is 500 mg three times a day.

I. Fish oils

Fish oils have been found useful in the treatment of several inflammatory diseases including asthma, arthritis, and inflammatory bowel disease. They (eicosapentaenoic acid and docosahexaenoic acid) also have a direct effect on the central nervous system and can block the entry of sodium and calcium ions into vascular smooth muscle cells. This effect, combined with the anti-inflammatory effect, may explain why fish oils help prevent ventricular arrhythmias and sudden cardiac death[97,98]. Dr. U.N. Das, MD a world-renowned expert on essential fatty acids emphasizes that it is important to ensure the availability of adequate amounts of arachidonic acid and di-homo-gamma-linolenic acid (a metabolite of GLA, gamma-linolenic acid) in the diet in order to obtain the full benefits of fish oils as preventers of arrhythmias[97].

There is no clinical evidence that fish oil supplementation prevents lone atrial fibrillation and indeed, our recent LAF survey found no such protective effect. Nevertheless, supplementation is a valuable addition to the program for afibbers because of its effectiveness in stroke prevention.

A 1995 study concluded that men who ate fish 5 or more times per week had a 40% lower risk of having a stroke than did men who ate fish less than once a week. Researchers at the Harvard Medical School and the Brigham and Women's Hospital now report that the benefits of fish consumption are even more spectacular for women. Their just completed study involved 79,839 female nurses who were between the ages of 34 and 59 years at the start of the study in 1980. After 14 years of follow-up a total of 574 strokes had occurred in the group. Most of the strokes (303) were ischemic (caused by a blood clot). There were also 181 hemorrhagic strokes (caused by a ruptured artery) and 90 strokes of undetermined origin.

After adjusting for age, smoking and other cardiovascular risk factors the researchers concluded that women who ate fish once a week lowered their risk of having a stroke of any kind by 22% and those who consumed fish 5 or more times per week reduced their risk by 52%. They ascribe the protective effect of fish consumption to the commensurate intake of fish oils (omega-3 fatty acids). They estimate that women whose intake of fish oils is 0.5 gram/day or more have a 30% lower risk of suffering a stroke than do women whose intake is below 0.1 gram/day. There was no evidence that women with a high fish or fish oil consumption have an increased risk of hemorrhagic stroke. The researchers believe that the protective effects of fish oils are due to their ability to inhibit platelet aggregation, lower blood viscosity, suppress the formation of leukotrienes, reduce fibrinogen levels, and reduce blood pressure levels and insulin resistance. They also note that the beneficial effects of fish consumption were substantially more pronounced among women who did not take aspirin on a regular basis[99].

Fish oil can be a double-edged sword though. Some fish like swordfish, tuna, shark, king mackerel, and red snapper can have mercury levels exceeding the current US standard of 1.0 ppm. Many more species exceed the New Zealand limit of 0.5 ppm. Salmon usually has very low levels of mercury. If you plan on supplementing with fish oil it is a good idea to ask the manufacturer to certify the maximum level of mercury found in their product and obtain a statement that they use molecular distillation to remove impurities from their product. I asked Pronova, a major Norwegian producer of fish oils, for certification. They stated that their fish oils are molecular distilled and are certified to contain less than 0.1 ppm of mercury (10 times lower than the allowable limit). The actual mercury content of their products is even

lower at 0.01 ppm or less. Pronova oils are used in the manufacture of such brands as Coromega, Omacor and Pikasol.

J. Hawthorn

Extracts from the leaves and flowers of hawthorn (*Crataegus laevigata* and *Crataegus oxyacantha*) are widely used and officially recognized in Germany for the treatment of hypertension and a variety of heart-related ailments. Hawthorn extracts are effective in the treatment of cardiac insufficiency (congestive heart failure) and can counteract a feeling of pressure and tightness in the heart region. It is also effective in the treatment of arrhythmias caused by an excessively slow heart beat (bradycardia). Studies have shown that hawthorn extracts are effective in reducing the incidence of angina attacks and in reducing cholesterol levels and blood pressure[100-103].

I have not come across any clinical evidence in the literature indicating that hawthorn is useful in the prevention or treatment of atrial fibrillation (rapid, irregular heart beat). Hawthorn is positive inotropic in its effect on the heart muscle; in other words, it stimulates heart muscle contractions and causes the heart rate to increase[100]. This may be of benefit in the case of vagal afibbers, but could be detrimental for adrenergic afibbers. This is pure speculation on my part though. Nevertheless, it may be worthwhile for vagal afibbers who usually begin their episodes when going to bed to try a cup of hawthorn tea an hour before bedtime. Hawthorn is best taken as a tea and there are no known side effects associated with commonly prescribed doses[100].

K. Avena sativa

The potential benefits of *avena sativa* (oat straw) in preventing LAF episodes in vagal afibbers was discovered quite by accident by Frank McCabe a vagal afibber living in Ireland. He found a marked reduction in ectopic (premature) beats and a complete disappearance of the fear of another episode after supplementing with 3 capsules/day of a homeopathic formulation of *avena sativa* sold under the trade name of Vigorex Forte. I have tried it myself, but found it too stimulating as I have the adrenergic variety.

Avena sativa is the Latin name for oats and the remedy is extracted from oat straw (tops or leaves). It is totally safe and has no known side effects. It has been used in folk medicine for a very long time to treat nervous exhaustion, arthritis, rheumatism, insomnia, and in general, to strengthen the nervous system[104]. More recently it has been touted as an aid to increase libido. As I recall there is some evidence that it can increase testosterone levels. This could be of benefit to some vagal afibbers especially if they tend to be very physically active. Strenuous exercise is known to reduce testosterone levels fairly significantly.

The product Frank uses and I tried is available in health food stores or on the Internet at <http://www.4vigorex.com>. Don't be turned off by the emphasis on the sexual aspects on the website. I guess this is what sells though! The usual recommended dosage is 3 capsules a day.

L. Red pepper

Red pepper (cayenne, *Capsicum frutescens*, capsaicin) is a powerful stimulant of the heart and circulatory system[105]. Recent research has shown that part of its effect is due to the fact that it shifts the balance of the autonomic nervous system by increasing the activity of the sympathetic branch[106,107]. This is certainly not a good thing for adrenergic afibbers, but it may be just the ticket for vagal afibbers. Taking a capsule or two of cayenne pepper (available in health food stores) with dinner may be enough to prevent vagal type episodes during the digestive period following the evening meal. Please note that this idea is pure speculation on my part and not supported by any clinical evidence that I know of. If anyone tries it please let me know the results. I can't evaluate it myself as I have the adrenergic variety.

The tranquilizer lorazepam (Ativan) has also been found to decrease parasympathetic (vagal) activity significantly while increasing heart rate by about 8% (6 beats per minute)[108]. This change in autonomic system balance may be enough to prevent vagal episodes that begin after going to bed. Again, this is just speculation on my part so if you try it please let me know the outcome. A one-half milligram tablet taken an hour before bedtime might do the trick.

M. Pancreatic enzymes

The parasympathetic (vagal) branch of the autonomic nervous system is dominant during digestion and when lying down. This is why vagal afibbers tend to begin their episodes during digestive periods, when going to bed, during sleep or just before arising. Effective digestion is highly dependent on a good supply of enzymes produced in the pancreas. Many people are unable to produce enough pancreatic enzymes and as a consequence suffer from abdominal bloating and discomfort, gas and indigestion. Supplementation with pancreatic enzymes replenishes the body's supply. The proteases found in pancreatic enzymes are useful in preventing tissue damage during inflammation[109,110]

What has all this got to do with LAF? - Possibly quite a lot. Researchers at the University of Michigan Medical Center have discovered that the production of pancreatic enzymes is entirely controlled by the parasympathetic branch[111]. This means that if more enzymes are called for a more active vagal response is required. The effect of this higher vagal tone probably extends to the heart and could conceivably result in the initiation of a vagal episode. Supplementing with pancreatic enzymes would reduce the need of the pancreas to produce them and might therefore reduce vagal tone.

Add to this the proven anti-inflammatory effects of pancreatic enzymes and it is clear that they could be a very important supplement for lone afibbers. I have found the prescription medication Cotazym to be highly effective and have incorporated it into my anti-inflammatory protocol.

N. Probiotics

Probiotics is an umbrella term used for beneficial bacteria such as *Lactobacillus acidophilus* and *Bifidobacterium bifidum* found in the human intestine. Probiotics help insure the health of the colon and are important factors in overall health and specifically in immune system health[112]. Recent research carried out in Finland concludes that supplementation with probiotics is highly beneficial in both the prevention and treatment of autoimmune diseases, inflammatory diseases, and allergies[113]. They are an integral part of my anti-inflammation protocol.

OTHER SUPPLEMENT PROTOCOLS

In addition to the above-mentioned supplements there are 3 specific supplement protocols that may be useful.

The Hoffer Protocol

Dr. Abram Hoffer, MD, PhD, a world-renowned psychiatrist practicing in Victoria, BC, believes that an excess of adrenochrome in the heart muscle is the cause of atrial fibrillation. Excessive mental, emotional or physical stress causes an outpouring of norepinephrine and epinephrine (adrenalin). The adrenalin, in turn, is oxidized to adrenochrome in the myocardium[114,115]. There is also some indication that adrenochrome is involved in inflammatory reactions such as rheumatoid arthritis[116]. Dr. Hoffer found that niacin (vitamin B3) counteracts the effects of adrenochrome and has successfully treated several atrial fibrillation patients with the following protocol[114]:

- Niacin – 1000 mg three times a day after meals
- Folic acid – 5 mg three times a day after meals
- Coenzyme Q10 – 100 mg three times a day with meals
- Vitamin B12 – 1 mg sublingual tablet a day
- Vitamin B6 – 250 mg a day
- L-lysine – 500 mg three times a day
- L-carnitine – 500 mg twice a day
- Magnesium – 500 mg a day (as citrate)
- B complex (50 mg) – with breakfast

Dr. Hoffer recommends the use of pure, crystalline niacin as the timed-release form may cause liver problems. He also suggested to me that, in the case of lone atrial fibrillation, the protocol would probably only be useful for afibbers with the adrenergic variety[117]. In any case, the protocol should not be undertaken without medical supervision. I tried it myself back in 1997, but unfortunately, it did not resolve my LAF.

Detoxification Protocols

DMPS (sodium dimercaptopropane sulfonate) and DMSA (dimercapto-succinic acid) are the two drugs of choice for mercury detoxification. They are not officially approved for this purpose, but are approved for the removal of lead, another heavy toxic metal. DMPS is usually administered via a slow intravenous injection while DMSA is taken orally. There is an on-going controversy as to which one is most effective. DMSA is claimed to be able to cross the blood brain barrier so theoretically should remove mercury from the brain. DMPS though may be quicker acting, but tougher on the body overall. Neither DMPS nor DMSA should be administered until ALL amalgams have been removed from the mouth. DMPS definitely and DMSA possibly get into the saliva and actually begin dissolving the mercury from any remaining amalgams – not a good idea! Both DMPS and DMSA need to be administered by a physician or naturopath trained in their use. Close monitoring of mercury levels in the urine is a must.

Natural detoxification is based on the use of intravenous vitamin C infusions and oral supplementation with various sulfur-containing compounds. Sulfhydryl groups (sulfur) bind very strongly to mercury and the resulting compounds are eliminated in the urine or feces. MSM (methyl sulfonyl methane) and alpha-lipoic acid (thioctic acid) are both good mercury binders. NAC (n-acetylcysteine) also works, but may tend to spread the mercury around before eliminating it. Most natural detoxification programs also include chlorella or seaweed, which also tend to mop up mercury.

Because the detoxification protocols all remove other metals it is essential that any regimen includes supplementation with vitamins (especially B, C and E) and minerals (especially selenium, zinc and magnesium).

Effective detoxification is absolutely essential if an amalgam removal program is to be successful, but it is a bit complicated. So for this reason it is best carried out with the guidance of an experienced naturopath or holistic physician.

The Anti-inflammation (Larsen) Protocol

In my own experience this protocol is the most effective for eliminating LAF – at least the adrenergic variety. The details of this protocol are given in the September 2001 issue of The AFIB Report.

A Roller Coaster Ride to Freedom from the Tyranny of Afib

by Frank McCabe (frankamccabe@eircom.net)

The roller coaster ride started when I was skiing in Cervinia in 1984. On a complete whiteout morning near Monte Rosa I skied into a ravine in order to avoid a woman who fell right in front of me. I landed headfirst and my right thumb was bent all the way back tearing all the ligaments. Determined not to miss my week of skiing I got a local doctor to mould the cast around the ski pole and skied for the rest of the week.

When I got back to Concord, Mass. John Blute who is a brilliant hand surgeon mildly cursed me for getting to him a week later, but he did a brilliant job. Going into surgery I said to John this must be a routine procedure for him and he responded sharply there was no such thing as a routine surgery.

How right he was. Thirty minutes after the local anaesthetic wore off the pain reached a high threshold and I suddenly passed out. When I woke up I was surrounded by a raft of doctors, technicians, and

nurses and with one doctor pounding on my chest. I, of course, was in complete denial that there was anything wrong with me as I had intended to go back to work later in the afternoon. After one night in intensive care and no changes in the enzyme tests I was released the following morning on condition that I would have a follow-up cardiac investigation.

Diagnosis: Lone Atrial Fibrillation

All the tests (Thallium scans, Ultrasound, etc.) proved negative and the Lahey Clinic cardiac team's evaluation was that I had a VASO VAGAL episode. Yes, my first experience with control system problems and this word vagal became an ever-increasing part of my life over the next twenty years.

Four years later I took a vacation in Barbados from a very stressful VP level job in the computer industry, a world where everyone is an overachiever. After consuming multiple high-test Cokes I jumped in for a swim and World War III broke out in my chest with my heart beating in a way I never experienced before. I took a couple of coffees and went into denial until the following morning after not having slept. I called a local doctor and she told me I was in arrhythmia. That really got my attention. The medical staff in St Elizabeth's hospital in Barbados confirmed it was atrial fibrillation. I was put on intravenous Verapamil and it converted to sinus rhythm after 10 hours.

Further evaluation and tests in the Lahey Clinic a week later confirmed the diagnosis of lone atrial fibrillation. The recommendation at the time was not to take drugs and hopefully another episode would not occur.

More Episodes

The next episode was two years later after a hectic business day and a late night dinner with the usual wines, etc. Immediately after falling asleep I woke up again with World War III beating inside my chest. I went to the nearest emergency room and was put on intravenous atenolol (Tenormin), which dropped the pulse from 170 to about 120 bpm. Six hours later the heart went back into sinus rhythm.

The frequency of episodes started to increase, but they always converted in a hospital setting using drugs. Typically the conversion process would start at around midnight and sinus rhythm would be restored in the early afternoon.

I started taking 25 mg of atenolol. It brought about no change in the frequency of episodes, but had the positive impact that when an episode would occur the heart rate would only rise to 130 rather than 170 bpm as in the past. Another change I discovered was that if I took an additional 50 mg of atenolol at home (rather than going to the hospital) during an episode the pulse level average would drop to an acceptable 100 bpm and conversion to sinus rhythm would occur within six to fourteen hours. I am convinced that the beta-blocker did not accelerate the conversion it simply reduced the pulse rate and the anxiety level.

Another decision I had to face was "Should I take Coumadin?" The literature tends to recommend it after 60 years of age if you experience atrial fibrillation. I made the decision to take 175 mg of coated aspirin daily instead based on some studies I looked at. This was a hard call, but I am happy with my decision.

In 1995 while on an assignment in Oregon I had an episode that did not convert in 48 hours. I was finally getting really concerned especially when Dr. Gibson, a great caring cardiologist, said that the medical fraternity did not fully understand LAF and what could prevent it with certainty.

Having discussed options at length Dr. Gibson put me on a cocktail of Lanoxin (digoxin), Rythmol and atenolol. It took a few days to settle down and for a period of a couple of months I was free of AFIB episodes. BUT AT A PRICE, the side effects were quite unpleasant - low energy, very low pulse rate, negative effects on adrenaline response. I also found it very difficult to adjust to the feeling of the modified pulse. I found it difficult to fall asleep as the pulse rate dropped to 40 bpm and felt totally unnatural.

The frequency of AFIB episodes was now about monthly, but what made it unpleasant was the fact that it tended to occur within minutes of falling asleep and the frequency of PACs (premature atrial contractions) and PVCs increased sharply. I felt that any one of these PACs could trigger an episode.

After a really bad period where I had three episodes in three days (during a bout of prostatitis) the cardiologist put me on a monitor for four days and it captured a couple of AFIB episodes. However, it threw up one vital piece of information. The episodes occurred immediately on falling asleep and, on both occasions, were preceded by a PAC.

As I looked back on events at that time I realised that despite taking ever more aggressive drugs the frequency of AFIB was increasing. It was also clear that the medical community had not successfully characterised AFIB and had no real answer to lone atrial fibrillation other than trial and error.

My Search Begins

At this point I started to spend most evenings on the Internet and I started trying everything possible to avoid as many known trigger points as possible such as avoiding caffeine, alcohol, stressful situations where possible (easier said than done), avoiding sleeping on my left hand side and taking up yoga (which helped). It is questionable how helpful all of this was as the frequency of episodes was still increasing.

I spoke to research people in the Massachusetts General Hospital in Boston, the Cleveland Clinic and Dr. Cox's team in Washington and came to the conclusion that the maze procedure was still experimental and only for severe, life-threatening cases or where the patient could not deal with AFIB mentally anymore. I also came to the conclusion that ablation procedures only worked for atrial flutter and did poorly for atrial fibrillation.

I was exploring the mercury issue when I contacted Hans Larsen on his web site. Hans was extremely helpful. On our first phone call he made a profound statement that LONE AFIB IS A PROBLEM OF THE AUTONOMIC NERVOUS SYSTEM AND NOT A HEART PROBLEM.

The Mercury Connection

As mercury is one of the heavy metals that could negatively affect the central nervous system it became my major area of focus. It was a real roller coaster ride. For every article that indicated that this could be a culprit there were other convincing articles that indicated the contrary. Every single cardiologist and dentist I spoke to indicated that it was impossible that amalgam in the teeth could cause atrial fibrillation.

Around that time Hans Larsen found a piece of research done in Canada that showed that amalgam (silver) fillings constantly leach out mercury. Up to this point the dental community was adamant that amalgam could not leach out mercury under any circumstance.

This renewed my determination to completely explore the mercury connection. It took me nearly a year before I found a dentist that I had complete confidence in and who fundamentally understood the process needed to successfully remove amalgam fillings without causing further mercury toxicity.

At the same time I came across a retired dentist in London, Dr. Levinson, who was devoting the rest of his life to this research. He did a number of tests including muscle tests that confirmed I was seriously allergic to mercury. The most important test was measuring the galvanic current between each of my teeth. The typical readings were 7 microamps. Dr Levinson's theory was that the typical current in the brain is measured in picoamps (one billionth of an amp) whereas in a mouth with dissimilar metals the currents were similar to mine, i.e. 7 microamps (7 millionth of an amp). The proximity of such high currents could cause capacitance effects, which conceivably could negatively affect the central nervous system. Personally I believe there are two factors at work here and the combination of the two is potentially one of the major causes of lone atrial fibrillation.

Amalgam Removal

The dentist who I decided to go ahead with the removal of all my amalgam fillings was Dr. Marc Mortiboys outside London. He had all the equipment and processes that completely met the rigorous protocols for safe mercury removal:

- Detox program before removal
- Charcoal tablets on the day of removal
- Separate air supply plus mask
- Eyes covered with damp cloths
- Higher levels of water flow to lower drilling temperature
- Rubber dam
- Dental assistant constantly vacuuming debris
- Detox program for months afterwards.

I had rationalised at this point that I would hopefully see some improvement six months later as mercury has a long half-life in the tissues.

As I was having dinner later that evening I suddenly got this extraordinary high feeling. As I had not been drinking I initially could not figure it out. Then I realised that the PACs and low-level atrial flutter that I often experienced had virtually disappeared and my energy level was way up.

This feeling stayed with me for weeks. I then gave up taking Rythmol cold turkey and continued taking atenolol. This triggered an AFIB episode within days. Once again I appeared to be on a roller coaster. It was only later that I realised that beta-blockers (atenolol) can precipitate AFIB in vagal type afibbers.

I asked my very caring cardiologist to try a different drug and we tried Sotalol and immediately I experienced three episodes in 48 hours. I reverted to Rythmol and atenolol (I had previously dropped Lanoxin). Again it was only later I realised that Sotalol acts as a beta-blocker, which can be a major cause of AFIB in vagal types like myself.

The Final Bridge

I had the electrical current measured again in my mouth. While the currents on average were reduced I had a high current between a large gold alloy bridge and the other teeth.

This was a really big decision for me as to whether I should remove a structurally powerful and expensive gold bridge and replace it with a plastic, less-structurally strong one at great expense. I made the decision to go ahead. As the dentist was removing the bridge he found some residual mercury under the bridge that he drilled out.

Once again I had the electrical currents in my mouth checked out and they were all at zero amps.

Finally I was beginning to get real confidence that at least I was removing mercury from the equation. During all this time I took detoxification remedies like seaweed, charcoal, etc. (before, during and after the removal) to help detox any residual mercury in the tissues. I had a number of conversations with experts like Dr. Huggins from Colorado to get advice on the best, conservative means of detoxification.

For the next six months I never had a single episode of AFIB or any PVCs or PACs. However, I continued to be nervous going to bed at night wondering if I would wake up with an episode.

I saw Vigorex Forte (a homeopathic remedy) in a health shop and as I always experiment I took it to see if it would have any effect on the mental component. Whether it acted as a placebo or not, the fear of further episodes disappeared immediately.

Incidentally, at an earlier time when I was having frequent episodes of AFIB, I tried hypnosis based on the logic that there was a strong mental component to the episodes, if one was predisposed. In my case it did not appear to help.

I am now one year completely free of all forms of arrhythmia and all concerns and fears of atrial fibrillation have disappeared. All I can say with certainty is that for ten years my life was almost ruled by atrial fibrillation and now it has disappeared from my life. Which of the interventions I made caused this breakthrough I honestly cannot say - I will let the reader be the judge.

Finally I would like to acknowledge the great help and encouragement of Hans Larsen without whose support I would not have gotten to this point.

I just hope my experience will encourage others to find the path to success that works for them. My advice to them is Keep the Faith and you will find the solution – if you pursue it relentlessly.

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