

THE AFIB REPORT

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Electrical Cardioversion

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Background

Cardioversion is used to convert a patient experiencing highly symptomatic or persistent atrial fibrillation (AF) to normal sinus rhythm (NSR). Conversion can sometimes be achieved by the infusion of drugs like ibutilide (Covert), dofetilide (Tikosyn) or flecainide (Tambocor) in a hospital setting (chemical conversion). Chemical conversion is most effective if started within a couple of hours of the onset of the episode and becomes less effective as time goes by. In cases where an episode has lasted longer than 7 days drug-induced conversion is not effective and electrical conversion (cardioversion) must be used to regain NSR, either alone or in combination with antiarrhythmic drugs. Cardioversion is also sometimes used instead of drugs in an attempt to convert an AF patient who has just arrived in hospital if the patient suffers severely (fainting, dizziness, breathlessness, etc).

Electrical cardioversion (also known as direct-current or DC cardioversion) is a procedure whereby a synchronized electrical current (shock) is delivered through the chest wall to the heart through special electrodes or paddles that are applied to the skin of the chest and back. The purpose of the cardioversion is to interrupt the abnormal electrical circuit(s) in the heart and to restore a normal heartbeat. The delivered shock causes all the heart cells to contract simultaneously, thereby interrupting and terminating the flutter or AF without damaging the heart. The heart's electrical system then restores a normal heartbeat controlled by the sinus node.

Research has shown that delivering the initial shock with an energy level of 200 to 360 joule is more effective than starting out at a lower level.[1] The procedure is preferably performed in the fasting state with the patient receiving short-acting anesthetic drugs or drugs that produce conscious sedation. Recovery is usually quick and overnight hospitalization is seldom required. Skin burns and ischemic stroke are the most common adverse effects accompanying the procedure. Patients with a low blood serum level of potassium or a toxic level of digoxin may experience life-threatening ventricular fibrillations when undergoing cardioversion. Thus potassium levels should always be checked prior to cardioversion and corrected if necessary.

Prevention of Cardioversion-Associated Stroke

The conversion of atrial fibrillation to NSR results in a transient mechanical dysfunction of the left atrium and the left atrial appendage (LAA) known as "stunning". During stunning, thrombi (blood clots) can form in the left atrium and the LAA. These thrombi are expelled once normal pumping

action is restored and may result in an ischemic stroke or transient ischemic attack (TIA) usually within the first 10 days following cardioversion.

Depending on the time elapsed between the onset of an AF episode and the cardioversion procedure it is also possible that clots may form in the LAA and left atrium. These clots may be dislodged and cause a stroke or TIA once the stronger pumping action inherent in NSR is resumed. It is thus standard practice to postpone cardioversion for 3 to 4 weeks if an episode has lasted longer than 48 hours. During the waiting period, warfarin (Coumadin) adjusted to an INR between 2.0 and 3.0 is administered in order to prevent procedure-associated TIA or stroke. Warfarin is also prescribed for 4 weeks following the procedure.

In some cases it may be possible to safely perform electrical cardioversion without prior anticoagulation even if episode duration exceeds 48 hours. A team of American, Australian and German researchers has found that electrical cardioversion can be performed safely without the 3-week pretreatment with warfarin if a transesophageal echocardiogram (TEE) taken immediately prior to cardioversion shows no signs of thrombi in the left atrium.

The clinical trial involved 525 patients assigned to TEE prior to cardioversion and 509 patients assigned to the conventional 3-week course of warfarin. The average age of the patients was 65 years and most of them had one or more comorbid conditions such as hypertension, or congestive heart failure. All patients had been in AF for at least 48 hours prior to enrolment and 82% were taking one or more antiarrhythmic drugs. The patients in the TEE group underwent TEE, anticoagulation with unfractionated heparin, and cardioversion within 3 days of enrolment, while patients in the conventional group underwent electrical cardioversion between 20 and 40 days after enrolment.

The immediate conversion rate (to normal sinus rhythm) was 82% in the TEE group and 78.4% in the conventional group. The TEE indicated the presence of thrombi in 62 patients and cardioversion was postponed for this group. After 6 months 62.5% of patients in the TEE group who had undergone cardioversion were still in sinus rhythm as compared to 53.9% in the conventional group. The incidence of ischemic (embolic) stroke and TIA (transient ischemic attack) was 1.9% in the TEE-guided group and 0.8% in the conventional group; however, this difference was not statistically significant. The rate of serious bleeding events was significantly higher in the conventional group (7.5%) than in the TEE-guided group (4.4%). Death from cardiovascular causes over the 6-month follow-up period was similar in the two groups at 2% and most were classified as sudden cardiac death not involving stroke or bleeding.

The researchers conclude that TEE-guided electrical cardioversion is a clinically effective alternative to the conventional anticoagulation strategy followed by cardioversion. They point out that the TEE-guided approach may be particularly useful in highly symptomatic, new onset AF and for patients at high risk for bleeding and stroke.[2]

Success Rate for Cardioversion

Although the immediate success rate of electrical cardioversion is quite high at 80 to 90%, the relapse rate is substantial. Researchers at the Mayo Clinic recently reported the results of a study aimed at determining the long-term effectiveness of cardioversion. The study included 351 patients with atrial fibrillation (179 with a first episode) and 126 patients with atrial flutter (78 with a first episode). The patients were all over the age of 60 years and most had hypertension (68%), while 49% had moderate to severe atrial enlargement. Most were on one or more medications including 29% on digoxin, 92% on warfarin, and 53% on ACE inhibitors or angiotensin-converting enzyme inhibitors.

The study participants underwent electrical cardioversion and were then followed-up for a year. At the one-year follow-up 63% of the patients who had been cardioverted after a first atrial flutter

episode remained in NSR. However, only 33% of flutter patients with recurrent episodes remained in NSR.

The results for afibbers were even worse. Only 30% of patients in the new-onset afib group and 35% in the recurrent group were still in NSR after a year. It is interesting that not all atrial flutter patients relapsed into atrial flutter. In patients with recurrent atrial flutter, 39% relapsed into atrial fibrillation. AF patients, on the other hand, almost always (92-95% of cases) relapsed back into atrial fibrillation rather than into atrial flutter. Electrical cardioversion is clearly not very effective for the general afib population and there is no evidence that it is more effective for lone afibbers. However, there is some evidence that effectiveness increases if used together with antiarrhythmic drugs.[3]

A group of cardiologists at the James Cook University Hospital report that pre- and post-treatment with amiodarone greatly improves the chances of staying in NSR after cardioversion. Their clinical trial included 91 patients with persistent or permanent afib scheduled for cardioversion after 6 weeks of warfarin therapy. During the 6-week waiting period 20 patients were randomized to receive amiodarone (200 mg 3 times daily for the first week, 200 mg 2 times daily for the second week, and then 200 mg daily for the remainder of the trial period); 28 patients received sotalol (160 mg twice a day, or 80 mg twice a day if intolerant of the higher dose) and the remaining 29 patients received no antiarrhythmic drug. All patients were given beta-blockers (usually atenolol) or digoxin as required for rate control and all remained on the drug regimen in effect pre-cardioversion for the entire 6-month observation period. During the 6-week waiting period 7 patients in the amiodarone group and 7 in the sotalol group converted spontaneously to NSR and were not given cardioversion. None of the patients not receiving antiarrhythmics converted on their own.

The immediate success rate of cardioversion (patients in NSR at time of discharge from the hospital) was 92% for those in the sotalol group, 81% in the amiodarone group, and 74% in the no-antiarrhythmic group. Unfortunately, the effects of the cardioversion did not last. Six weeks after DCC only 53% of those in the sotalol group, 67% in the amiodarone group, and 42% in the no-antiarrhythmic group were still in NSR. Corresponding numbers at the end of the trial were 39%, 63%, and 16%. The researchers conclude that amiodarone (200 mg a day) is more effective than sotalol (160 mg twice a day) in maintaining NSR after cardioversion. Adverse effects were observed in 4% of the patients assigned to amiodarone and in 11% assigned to sotalol. It is very clear from this clinical trial that electrical cardioversion on its own (without concomitant use of antiarrhythmics) is ineffective in maintaining NSR in persistent and permanent afibbers. Only 16% of converted patients in the no-antiarrhythmic group were still in NSR 6 months after cardioversion. Thus, the message to take away from this trial is that cardioversion without concomitant antiarrhythmic therapy is rarely worthwhile.[4]

Researchers at the Karolinska Institute have found that pretreatment with the beta-blocker metoprolol (time-release version, Toprol XL) significantly improves the success rate for cardioversion. Their study involved 168 persistent afibbers who were randomized to receive metoprolol or a placebo starting at least a week prior to cardioversion (NOTE: only about 15% of the study participants were lone afibbers). On average, the participants were on metoprolol or placebo for 28 days prior to cardioversion and they were also prescribed warfarin (INR 2.1 – 3.0) for at least 3 weeks before and 6 weeks after cardioversion. The starting dose of metoprolol was 50 mg/day with a 50 mg stepwise increase to a target dose of 200 mg once a day.

The participants were checked with an ECG two hours after cardioversion and then every week for 6 weeks, and then 3 and 6 months after cardioversion. During the first 6 weeks, 49% in the metoprolol group and 47% in the placebo group developed afib again and were given a second cardioversion. At the 6-month checkup, 46% of patients in the metoprolol group were still in NSR as compared to only 26% in the placebo group. It is also of interest to note that while 8% of placebo group members relapsed into afib within 2 hours of their first cardioversion, none of the

patients in the metoprolol group did. Beta-blockers are contraindicated for vagal afibbers, so it is not at all certain that pretreatment with metoprolol would be beneficial in this case.[5]

Italian researchers have reported that flecainide and a combination of amiodarone and flecainide are safe and effective in maintaining NSR after cardioversion in patients with persistent afib and hypertension. Their trial showed that flecainide on its own maintained NSR in 88% of patients, while the combination maintained it in 80% at the 6-month check-up. In comparison, only 33% of patients on sotalol or amiodarone alone were still in NSR at the 6-month follow-up. The researchers also found that adding an angiotensin II receptor blocker (losartan, valsartan, irbesartan, candesartan) to the medication regimen was highly effective in maintaining NSR.[6]

It is also possible that an intravenous magnesium infusion may help improve cardioversion efficiency. Researchers at the University of Connecticut have reported that adding 4 grams of magnesium sulfate to a standard ibutilide (Corvert) infusion increases conversion efficiency by a factor of 3. The researchers speculate that the benefits of concomitant use of magnesium sulfate are related to magnesium's ability to increase intracellular potassium concentrations and regulate intracellular calcium concentrations.[7]

Although there were very few lone afibbers in the study group, there is no reason to believe that the addition of magnesium sulfate to the ibutilide protocol would not benefit them as well. Also, if the beneficial effect of magnesium is related to its ability to increase intracellular potassium concentrations and regulate calcium concentrations, then it would seem logical that adding magnesium to cardioversion protocols involving other antiarrhythmics, or even electrical cardioversion, would also be beneficial. Perhaps having a warm bath with plenty of Epsom salt when using the on-demand (pill-in-the-pocket) approach with flecainide or propafenone may improve the odds of a quick conversion.

British researchers report that pretreatment with angiotensin-converting enzyme inhibitors (ACE inhibitors) may help persistent afibbers stay in sinus rhythm after electrical cardioversion. Their study involved 47 patients with persistent atrial fibrillation (AF lasting longer than 48 hours, but less than 6 months) who were scheduled for cardioversion. Patients with left ventricular dysfunction (low left ventricular ejection fraction), valvular heart disease or permanent AF were excluded from the study.

Twenty-four of the patients had been taking ACE inhibitors [enalapril (11), lisinopril (8), and captopril (5)] for at least 6 months before inclusion and continued to do so for the 1-year follow-up. The researchers observed that the patients taking ACE inhibitors required significantly less energy to effect electrical cardioversion (203 joules versus 271 joules on average) than did the controls. There was also a clear difference between ACE inhibitor-treated patients and controls in regard to P-wave duration 1 year after cardioversion (135 ms versus 150 ms). P-wave duration is prolonged in AF patients.

Finally, there was a trend for patients on ACE inhibitors to have fewer hospital admissions for repeat cardioversion during the follow-up period. The researchers noted that the use of beta-blockers was substantially higher in the control group than in the ACE inhibitor group (83% versus 4%). Both groups had similar left atrial size (48 mm and 49 mm). The researchers conclude that ACE inhibitor therapy may be useful in patients with persistent atrial fibrillation.[8]

Other researchers have observed substantial decreases in afib recurrence in patients with left ventricular dysfunction who were treated with enalapril (78% risk reduction) and trandolapril (47% risk reduction).[9]

The results of this study look intriguing, but certainly should be interpreted with caution. The majority of members of the control group (84%) were on beta-blockers, while only 1 patient (4%) in the ACE inhibitor group was taking beta-blockers. It is well established that beta-blockers can increase afib frequency in vagal afibbers. Presumably, there would have been some vagal

afibbers in the control group and these would likely have experienced more episodes than those not on beta-blockers. Thus the lower incidence in hospital readmissions seen in the ACE inhibitor group could equally well stem from the absence of beta-blocker use as from the use of ACE inhibitors. Nevertheless, the findings of less cardioversion energy requirements and a shortening of P-wave duration in ACE inhibitor patients could well be important, but need confirmation in larger trials.

Timing of Cardioversion

Arrhythmia researchers at the University of Michigan have discovered that the timing of electrical cardioversion of afib episodes is all-important in determining the success of the procedure. Their study involved 315 afibbers who underwent cardioversion from 7 minutes to 8 years after the onset of their afib episode. Coronary artery disease was present in 24% of the patients, structural heart disease in 46%, valvular heart disease in 11%, and non-ischemic cardiomyopathy in 11%. Nine per cent were taking class I antiarrhythmics and 28% were being treated with class III drugs.

The researchers found that an immediate recurrence of AF (IRAF) within 1 minute was far more common if the cardioversion was attempted shortly after the episode began rather than after a wait of 24 hours or more. Overall, 20% of the patients experienced IRAF.

<u># of Patients</u>	<u>Episode Duration</u>	<u>Incidence of IRAF</u>
48	less than 1 hour	56%
27	1-24 hours	37%
34	1-7 days	12%
45	1-4 weeks	12%
72	1-3 months	5%
36	3-6 months	10%
40	6-12 months	8%
13	1-8 years	12%

The researchers found that the risk of IRAF depended solely on the duration of the afib episode prior to the attempted cardioversion. Age, gender, structural heart disease, antiarrhythmic drug use, and energy level in cardioversion were not associated with IRAF incidence. They draw some very interesting conclusions from their observations:

- It is likely that the primary cause of IRAF is the continuing generation of ectopic beats in the pulmonary veins which would “reignite” AF as soon as the cardioversion “jolt” is over. The ectopic beat generation from active foci would be most pronounced at the onset of the episode and would gradually decrease as the episode wears on. The following statement is of particular interest, “It is possible that arrhythmogenic pulmonary venous foci are activated by the rapid atrial activity that occurs during atrial fibrillation but that as the duration of atrial fibrillation lengthens, the cellular mechanisms responsible for this arrhythmogenic activity are progressively down-regulated or deactivated.”
- It is very likely that the mechanism underlying IRAF (as above) is different from the mechanism involved in normal early recurrence of afib. Here progressive electrical and anatomic remodeling may play the greater role.
- The findings explain why IRAF is very common in connection with cardioversion performed during electrophysiology studies and ablation procedures.

- The findings also explain why internal cardioversion initiated by an ICD (implantable cardioverter-defibrillator) often results in IRAF if attempted shortly after the onset of the AF episode.

The researchers conclude that the ideal time for cardioversion may be approximately 24 hours after the onset when the risk of IRAF is low, electrical remodeling of the atrium is not pronounced, and when the need for anticoagulation prior to cardioversion has not yet arisen.[10]

It is quite clear from this article that one's chance of a successful cardioversion increases by waiting 24 to 36 hours before attempting it. This, of course, would also give one more time to see if the episode will terminate on its own. Blood clotting in the left atrial appendage and the accompanying risk of stroke is not considered a problem unless the episode has lasted longer than 48 hours. The conclusion that the early stages, at least of an afib episode, are likely fuelled by repeated ectopic activity in the pulmonary veins is also interesting. It underscores the importance of trying to reduce PACs (premature atrial complexes) and, at this point, magnesium supplementation is probably the best way of achieving this. Another intriguing possibility is that ICD wearers may be better off if their ICD is set to attempt to convert an episode after an hour or so rather than as soon as it is detected. Obviously, individual experimentation would be needed to establish this.

The timing of cardioversion is also of great importance when it comes to atrial flutter or fibrillation occurring after a pulmonary vein isolation procedure.

Drs. Fred Morady and Hakan Oral and colleagues at the University of Michigan have observed that the prompt use of electrical cardioversion in ablatees who develop persistent arrhythmia (AF or flutter lasting more than 24 hours) following an ablation may help reverse remodeling and materially reduce the need for a follow-up ablation. Their trial included 215 paroxysmal and 169 persistent afibbers who underwent a segmental PVI with additional lesions as required. Among these 384 patients 24% experienced a persistent arrhythmia (80% AF and 20% flutter) following their procedure. The arrhythmia occurred within 24 hours in 6%, within the first week in 37%, within the first month in 66%, and within the first 3 months in 88% of cases. All patients with persistent arrhythmias were treated with electrical cardioversion and in 52% of cases with antiarrhythmic drugs as well. Cardioversion was performed within 1 week in 34% of cases, within 1 month in 49%, and within 3 months in 75%. Sixteen months after the cardioversion 27% of the patients were in normal sinus rhythm without the use of antiarrhythmic drugs.

The University of Michigan researchers made the rather astounding discovery that patients who had been cardioverted within 30 days of their persistent arrhythmia occurring were 22 times more likely to be in sinus rhythm than were those who had been converted later. Put in another way, 50% of patients who had been cardioverted promptly, i.e. within 30 days were in sinus rhythm 16 months later as compared to only 4% in the group whose cardioversion was delayed by more than a month. This association held true for both patients with post-ablation persistent AF and post-ablation atrial flutter.

The researchers suggest that early restoration of sinus rhythm is likely to prevent progressive atrial electroanatomical remodeling and thus facilitate long-term maintenance of sinus rhythm.[11] This is clearly an enormously important finding and underscores the need to undergo cardioversion as early as possible if persistent AF or flutter develops after a PVI.

Inflammation and Cardioversion

Researchers at the Mayo Clinic have found that a high blood level of C-reactive protein (CRP), a marker of systemic inflammation, prior to cardioversion is associated with a greater probability of afib recurrence within one month. The researchers studied 17 patients with atrial flutter and 50 patients with persistent afib. They measured CRP level just prior to cardioversion and observed that the average level in patients who remained in sinus rhythm after cardioversion (6.0 mg/L)

was significantly lower than the level (10.7 mg/L) in patients who reverted to afib or flutter within one month after cardioversion. They conclude that high CRP levels prior to conversion double the risk that the cardioversion will not result in maintenance of NSR beyond the first month (after adjusting for other relevant factors such as age, gender, and medications used prior to cardioversion). About two thirds of the patients cardioverted had no recurrence within the first month. The researchers conclude that anti-inflammatory medications may help retain NSR after cardioversion and that measuring CRP prior to cardioversion may provide valuable information as to the likelihood of the cardioversion being successful beyond the first month.[12]

Several other studies have uncovered an association between elevated levels of the inflammation marker C-reactive protein (CRP) and atrial fibrillation (AF). Inflammatory markers, mainly CRP, have been related to the risk of developing AF, the persistence of AF (paroxysmal, persistent, permanent), recurrence after cardioversion, and left atrium enlargement.

A recently reported study carried out by a group of Greek researchers included 60 patients with persistent afib between the ages of 61 and 75 years, 60% of whom were men. The participants were free of valvular heart disease, congestive heart failure, prior heart attack, and thyroid dysfunction, so were a relatively healthy group although not classified as lone afibbers. A significant exclusion criteria was that the patients could not have been taking antioxidants or multivitamins. They had their CRP level measured prior to direct current cardioversion and were given amiodarone after the conversion (200 mg/day x 3 during first week, 200 mg/day x 2 during second week, and 200 mg/day thereafter). Patients who did not convert or who reverted back to AF within an hour were excluded from further follow-up.

The researchers found a clear correlation between CRP level and the percentage of patients who remained in sinus rhythm over the 3-year follow-up period. In the group of patients with a CRP level less than 0.43 mg/dL (4.3 mg/L), 45% were still in sinus rhythm at the end of 3 years. The corresponding figures for CRP levels between 0.43 and 0.8 mg/dL and CRP level greater than 0.8 mg/dL were 13% and 17% respectively. The researchers conclude that baseline CRP levels can be used to estimate the likelihood of persistent afibbers remaining in sinus rhythm after undergoing a successful electrical cardioversion.[13]

This study adds to the evidence of a close association between inflammation, as measured by CRP level, and the risk and persistence of AF. Although it is not entirely clear whether inflammation causes AF or AF causes inflammation, it would seem prudent for afibbers to maintain their CRP levels as low as possible. This can be achieved by regular supplementation with such natural anti-inflammatories as Zylflamend, beta-sitosterol, bromelain, curcumin, boswellia, Moducare, quercetin, and fish oil.

Italian researchers at the University of Brescia have confirmed that pre-cardioversion CRP level is indeed an important predictor of the likelihood of remaining afib-free after an electrical cardioversion. Their study involved 106 patients (74 men and 32 women) with new-onset, persistent lone AF who underwent cardioversion with a biphasic defibrillator using 150 to 200 J according to the weight of the patient. All study participants had an ECG one week following the procedure and a Holter monitor evaluation 1 and 6 months following cardioversion. All patients left the hospital in normal sinus rhythm. At the 1-week examination, 20% had reverted to AF and this percentage rose to 43% at the 6-month examination.

The researchers observed a strong correlation between elevated CRP (high sensitivity C-reactive protein) and the risk of afib recurrence. The average CRP level among afibbers experiencing recurrence was 5.8 mg/L (0.58 mg/dL), while it was only 0.9 mg/L (0.09 mg/dL) among the 60 patients who did not experience recurrence. NOTE: Ignoring CRP levels above 10 mg/L (an indicator of acute inflammation) did not change these numbers significantly. Among study participants who reverted to AF within the first week, 86% had an elevated CRP level; the corresponding number for patients reverting by 6 months was 92%. There were no statistically

significant differences between patients who remained in sinus rhythm and those who did not as far as the following variables are concerned:

- Age
- Presence of diabetes
- Presence of hypertension
- Duration of AF
- Left ventricular ejection fraction
- Fibrinogen level
- Left atrial diameter
- White blood cell count

The Italian researchers point out that ACE inhibitors and statin drugs have been found to have anti-inflammatory properties, that fish oils reduce risk of post-operative AF, and that methylprednisolone reduces the risk of post-cardioversion AF recurrence by decreasing CRP levels. They conclude that pre-cardioversion CRP levels predict the risk of relapse and that patients with high levels may benefit from therapy with antiarrhythmics prior to and after cardioversion.[14]

Other Factors Affecting Cardioversion Success

In the 2nd virtual LAF Conference in January 2003, the role of **aldosterone** in the initiation of AF episodes was discussed in considerable detail.[15,16] This was followed by an article in the March 2004 issue of *The AFIB Report* further elucidating the role of aldosterone in lone atrial fibrillation (LAF). Dr. Patrick Chambers also discussed the role of aldosterone in his article "P Cells and Potassium" published in the March 2005 issue of *The AFIB Report*. It is likely that aldosterone exerts its negative effects through one or more of the following mechanisms:

- Inflammation and fibrosis (tissue scarring and thickening);
- Increased tendency to blood clotting;
- Impaired fibrinolysis (impaired blood clot digestion and removal);
- Sodium retention;
- Potassium and magnesium loss;
- Disturbance of ANS balance;
- Increased activity of catecholamines (norepinephrine and epinephrine);
- Decreased heart rate variability;
- Increased production of reactive oxygen species (ROS), especially superoxide;
- Decreased production of nitric oxide (NO) and accompanying endothelial dysfunction.

A group of Polish researchers has just reported that a decrease in aldosterone level is associated with the maintenance of normal sinus rhythm (NSR) following a successful cardioversion. Their clinical trial involved 45 patients with persistent non-valvular AF and normal left ventricular ejection fraction and 20 matched control subjects with no evidence of AF. The average age of the patients was 59 years and 81% were men. Twenty percent of the group had LAF. The 45 patients were scheduled for electrical cardioversion (CV) after having been in persistent afib for an average of 12 weeks. Plasma aldosterone levels were measured 24 hours prior to CV and again 24 hours after. The baseline aldosterone level was 152 pg/mL in the afib group and 130 pg/mL in the control group (p=0.11).

Forty-three of the initial 45 patients left the hospital in NSR and were examined again 30 days later. At this examination 24 patients (56%) were still enjoying sinus rhythm, while the remaining 19 (44%) had reverted to persistent AF. The Polish researchers noted that while there was no significant difference in aldosterone levels 24 hours prior to CV and 24 hours after in the group that reverted to AF (126 pg/mL vs. 118 pg/mL), there was a sharp decrease from 176 pg/mL to 101 pg/mL in the group that maintained NSR 30 days after CV (p=0.003).

They conclude that a rapid drop of more than 13 pg/mL following CV predicts sinus rhythm maintenance with 87% sensitivity and 64% specificity. They speculate that a largely unchanged aldosterone level after cardioversion may reflect more advanced disease of the atria with enhanced expression of angiotensin converting enzyme (ACE) and local activation of aldosterone excretion. They found no correlation between baseline aldosterone levels and sinus rhythm maintenance 30 days following cardioversion.[17]

This study further emphasizes the crucial role of aldosterone in the genesis of atrial fibrillation and supports the evidence that ACE inhibitors, angiotensin receptor blockers (ARBs), or aldosterone antagonists may increase the chance of maintaining NSR following a cardioversion.

Brain natriuretic peptide (BNP), a cousin of atrial natriuretic peptide (ANP), is a hormone released from the walls of the ventricles when stretched such as during unusually strenuous activity. It is stored as a prohormone within secretory granules in the ventricles and is secreted as an N-terminal fragment, N-terminal pro-brain natriuretic peptide (nt-pro-BNP), and the smaller active hormone BNP. BNP has effects similar to those of ANP, that is, it decreases sodium reabsorption rate, renin release, and aldosterone release; it also increases vagal (parasympathetic) tone and decreases adrenergic (sympathetic) tone. Because nt-pro-BNP is easier to measure than BNP it is often used as a marker for BNP.

It is well established that BNP and nt-pro-BNP levels are elevated in heart failure and that the degree of elevation is directly proportional to the seriousness of the failure. However, researchers at the Massachusetts General Hospital have reported that lone afibbers also have elevated nt-pro-BNP values even when in sinus rhythm. Their study involved 150 participants with lone atrial fibrillation (LAF) and 75 afib-free controls matched according to age, gender, race, and ethnicity. The majority of participants (81%) were men, the average age at enrolment was 54 years, and the average age at first diagnosis was 45 years. The demographics of the study group thus closely mirrors that of the much larger groups involved in our own LAF surveys and, once again, puts "paid" to the still widely held notion that afib is solely a disease of old age, which it clearly is not. At the time of enrolment 130 afibbers had the paroxysmal variety, while 20 were in permanent AF.

Blood samples were obtained from all participants at enrolment. The researchers found that the median level of nt-pro-BNP was significantly higher among lone afibbers (even when in sinus rhythm) than among controls (166 versus 133 fmol/mL or 48 pg/mL versus 39 pg/mL); they also observed that nt-pro-BNP levels were higher in afibbers with permanent LAF than in those with paroxysmal LAF (55 pg/mL versus 45 pg/mL), and that afibbers with high nt-pro-BNP levels at study entry were more likely to progress to the permanent version than were those with lower levels (57 pg/mL versus 47 pg/mL). There were no significant differences in ANP levels between afibbers and healthy controls, but ANP levels in afibbers who later developed hypertension were significantly higher than in those who did not (1090 versus 470 pg/mL). The researchers speculate that BNP may be involved in sustaining fibrillatory rotors through its potentiating effect on vagal nerve impulses transmitted from the brain.[18]

Polish researchers investigated a group of afibbers with hypertension or coronary heart disease and found that BNP levels rise during an afib episode and tend to return to normal following a successful cardioversion. The decline in BNP level was quite significant with a drop from 95 to 28 pg/mL in paroxysmal afibbers and a drop from 75 to 41 pg/mL in persistent afibbers.[19]

In January 2010 Dr. Qi-xian Zeng and colleagues at the Shandong Communication Hospital in Jinan, China confirmed that patients with atrial fibrillation have elevated levels of both BNP and ANP when compared to healthy controls and that these levels decrease significantly after a successful cardioversion. The study included 100 consecutive patients with paroxysmal or persistent AF and 20 healthy controls. About half the patients had coronary heart disease or hypertension, but none had heart failure. Prior to their scheduled cardioversion (chemical using amiodarone or propranolol) all patients had their blood levels of BNP and ANP measured. The

cardioversion was initially successful in 60 patients, but 18 experienced recurrence within 24 hours and were, together with the 40 patients not successfully cardioverted, classified as permanent afibbers.

Thus, 24 hours following the cardioversion 42 patients (42%) were in normal sinus rhythm (NSR), while 58 were still in afib. Both BNP and ANP levels decreased significantly immediately following the cardioversion with BNP levels dropping from an average of 162 pg/mL to 124 pg/mL and ANP levels declining from 200 pg/mL to 164 pg/mL. Both BNP and ANP levels were significantly higher in the 16 patients who relapsed into AF within 24 hours of being cardioverted than among those who remained in NSR (BNP of 180 versus 132 pg/mL and ANP of 188 versus 138 pg/mL).

The 42 patients still in NSR after 24 hours were followed for an additional 500 days. At the end of this period, 26 were still in NSR corresponding to an overall 500-day success rate of 26% for the 100 patients originally undergoing cardioversion. The average baseline BNP value for those who remained in NSR for 500 days was 122 pg/mL as compared to 147 pg/mL for the patients who relapsed during the 500 days. Corresponding numbers for ANP were 129 and 153 pg/mL. In comparison, BNP and ANP values for healthy controls were 81 and 100 pg/mL respectively.

The Chinese researchers conclude that baseline BNP and ANP levels can be used to predict the likely outcome of cardioversion and that afibbers with a BNP level of less than 138 pg/mL have a good chance of being successfully converted.[20]

In contrast to the findings of the Chinese researchers, Polish researchers recently reported that, while baseline ANP levels are substantially higher among persistent afibbers than among healthy controls, there was no correlation between the maintenance of sinus rhythm during 30 days after electrical cardioversion and baseline ANP level. They did confirm that ANP levels decreased significantly after a successful cardioversion.[21]

Thus, it would appear that, while a low baseline BNP is likely associated with better cardioversion outcome, a similar correlation with ANP is in doubt.

Conclusions

Electrical cardioversion is commonly used to convert atrial fibrillation and atrial flutter to normal sinus rhythm. Although the immediate efficacy of the procedure is acceptable, especially for recent onset atrial flutter, the long-term effectiveness of the procedure is poor. Cardioversion is usually not attempted without prior anticoagulation if an episode has lasted more than 48 hours, but there is emerging evidence that it can safely be performed beyond this time limit if a transesophageal echocardiogram (TEE) shows no evidence of clots in the left atrium or left atrial appendage. The most common side effects of cardioversion are skin burns (from the electrodes) and ischemic stroke or transient ischemic attack (TIA). Low serum potassium levels and toxic levels of digoxin prior to the procedure can result in life-threatening ventricular arrhythmias, so potassium levels should always be checked and, if necessary, adjusted prior to cardioversion.

The success rate of cardioversion can be improved by pre- and post-procedure administration of beta-blockers or antiarrhythmics, and it is possible that a magnesium infusion may be beneficial as well. There is evidence that the timing of cardioversion is important with the procedure being carried out 24 to 36 hours from the onset of an episode being optimal. The timing of cardioversion following a pulmonary vein isolation procedure is also critical with substantially better results being reported if the procedure is carried out within 30 days of relapsing into AF.

There is a close association between the presence of systemic inflammation and cardioversion success. Patients with high levels of C-reactive protein (CRP) prior to cardioversion are significantly less likely to remain in sinus rhythm than are those with lower levels. Similar

associations have been found for high pre-procedure levels of aldosterone and brain natriuretic peptide.

It would appear that patients with AF or flutter can improve their chance of cardioversion success by ensuring adequate serum levels of magnesium and potassium and low levels of CRP prior to the procedure. There is also evidence that pre- and post-treatment with beta-blockers or antiarrhythmics may improve long-term outcomes.

A fellow afibber's experience with cardioversion

Although electrical cardioversion (ECV) is usually a fairly uneventful and painless procedure when performed by properly trained and skilled personnel it can be quite an ordeal when skill and expertise is lacking. The following report by Shannon, a long-time poster on the afibbers.org Bulletin Board, bears this out.

I have had a total of 17 cardioversions and most of them have been successful and uneventful. However, the last one I had felt like someone simultaneously dropped a 480 volt power line across my chest and hit me square on the top of the head with a large sledgehammer!

NOT something I would wish on anyone to experience. The key thing for anyone going in for an Emergency Room ECV (note: you aren't at all likely to have such an experience with an EP or Cardiologist doing the ECV) is to either make sure just before they inject the anesthesia that they insure you are fully out before pushing the button.

That last ER doc in the small Arizona country hospital ER who blasted me was clearly unfamiliar and nervous when administering the Propofol and was pushing it in way too slow as he took about 3 plus minutes to push in only 90mg to 100mg of Propofol when I had told him I typically need 120mg for dreamland to happen for me. With some 20 Propofol-only anesthesia's overall under my belt at this point, I knew pretty much how this works for me, but he didn't listen.

I started to close my eyes in hopes it would start to take and he immediately told the nurse manning the Zapper machine to " Go ahead and push the button" and I was just trying to yell "No I'm still awake" when the world exploded and I levitated half a foot off the bed! It was quite a jolt to say the least.

However, dont let this one isolated experience make anyone afraid of an ECV. Every other time it was perfectly fine! But just don't be shy in telling them you want Propofol anesthesia with either a nurse anesthesiologist on hand, if not a regular anesthesiologist, however a nurse anesthesiologist will be perfectly fine in an ER. Or else, insure the Doc administering it is very familiar with administering Propofol and that they have a respiratory therapist on hand as required. Also, ask him to confirm you are truly out by touching your eye lids or pricking your toes, shoulders or lightly slapping your cheeks before he or she pushes the button and you will not feel or know a single thing and will be wide awake and feeling clear but mellow within 5 to 8 minutes after the zap.

It really is an easy procedure and it can be highly effective, but just don't let it become a crutch for too long for continuing to postpone getting a more lasting fix done in the form of a good ablation. I'm not sure if after getting a good number of ECVs, if it might start to encourage more scarring or fibrosis in the heart? Maybe so, but I'm not sure about that.

Prior to an ECV it helps if you have an anti-arrhythmic on board and particularly if you are well repleted with Magnesium and Potassium too before you go into the ER. I would always give myself 2 grams of Intramuscular Magnesium injections whenever I would trigger into a flutter and drink a quick slug of Potassium Gluconate before going in and I never once needed a second shock to convert me.

In fact, I could always convert at around 75 joules, and likely could have gone even lower, but so often the ER docs would still insist on setting it at anywhere from 100 joules to 150 joules. This was particularly true with the last guy in spite of what I had told him. This guy felt a little threatened that I knew a bit about what was going on and how this worked for me and apparently needed to assert his authority by using a much bigger jolt than I needed and with too small a dose of Propofol pushed in much too slowly to take proper effect with this very short acting drug.

Afterward, I yelled that I was awake and why did he push the button, while the two nurses were mortified at witnessing what just happened, this ER doc then stammered : "But you were slurring your words" as the laughably poor rationale for why he had the nurse push the button. When the absurdity of that statement finally sunk in to him he then immediately tried to blame the poor nurses saying that if they had not been talking to me during the Propofol infusion I would have surely been fully anesthetized! I can assure you that when Propofol is properly administered they could fire off a 21 gun salute with 105mm Howitzer cannon's surrounding your bed and you would still be blissfully oblivious ...

In any event, you are the patient and don't be afraid to speak up and remind them to confirm that you are fully out before they push the button and it will all be fine.

Shannon

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