

### Frequently Asked Questions About Atrial Fibrillation

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**Q.** How should antithrombotic therapy be handled for a patient with AF who is undergoing stenting for ST-elevation myocardial infarction?

**A.** Heparin therapy is probably the best alternative.

**Q.** Is there an age limit for amiodarone therapy?

**A.** The decision to prescribe amiodarone or any other antiarrhythmic medication is not affected by the patient's age but should be based on the severity of the patient's symptoms.

**Q.** Is there ever an indication for a patient to be on aspirin, clopidogrel, and warfarin?

**A.** This triple therapy has been suggested as a strategy for patients with 2 or more conditions, such as AF and a drug-eluting stent. However, this approach dramatically increases a patient's risk of bleeding, and no prospective randomized trials have supported using this tactic.

**Q.** What is the relationship between chronic obstructive pulmonary disease (COPD) and AF?

**A.** Although sleep apnea has been shown to increase the risk of AF, no data indicating that COPD has any effect are available. Patients who have both COPD and AF and who require  $\beta$ -blocker therapy for rate control should begin treatment at a low dose. The dose should be increased gradually as needed, and breathing should be closely monitored.

**Q.** How effective is dipyridamole therapy in preventing stroke?

**A.** Dipyridamole is not clinically indicated for preventing stroke, and consensus guidelines do not support its use for that purpose.

**Q.** If tachyarrhythmia is found on auscultation in an asymptomatic patient during an office visit, how can it be determined whether this is paroxysmal or persistent AF?

**A.** The diagnosis of AF can be confirmed with ECG during the office visit, but because the patient is asymptomatic, there is no way to determine when the arrhythmia started. After the diagnosis of AF has been made, 24-hour Holter monitoring may help determine whether the AF is paroxysmal or persistent.