Controlling persistent atrial fibrillation

Sir,

The recent review of rate or rhythm control in persistent atrial fibrillation by Boos and colleagues1 favours a rate control strategy in patients with NYHA > II symptoms or LVEF < 40%. However, there is a lack of evidence on how atrial fibrillation should be managed in these patients.2,3 In the trials reported by Boos et al., mean ejection fraction was either not reported or > 50%, diuretic use was low, and few patients had an established diagnosis of heart failure according to guideline criteria.4

The prevalence of atrial fibrillation (AF) in heart failure ranges from 10%–50%, depending upon the severity of symptoms (NYHA class).2,3 AF may cause or exacerbate heart failure symptoms, and is associated with a worse prognosis.5–8

Patients with AF and heart failure may have more to gain from restoring atrial contraction ('atrial kick') than those without significant ventricular dysfunction. Studies have shown improvement in exercise capacity (including 6 min walk distance), peak oxygen consumption and cardiac output following cardioversion.8–10 It is likely to be more difficult to cardiovert and maintain sinus rhythm in patients who have heart failure, and therefore a much more aggressive policy in terms of preparation for cardioversion, and for maintenance of sinus rhythm, is likely to be required. However, there is evidence that aggressive treatment with ACE inhibitors,11,12 beta-blockers,13 angiotensin receptor blockers14,15 and amiodarone16,17 may reduce the propensity to develop atrial fibrillation, and may even restore sinus rhythm without having to resort to electrical means. It is likely that aldosterone antagonists will show similar benefits. Most of these treatments also improve the symptoms of heart failure, and are therefore justified or mandated in this population.

Patients with heart failure were poorly represented in trials comparing rate control versus rhythm control of AF, and as they may gain more by having sinus rhythm restored, it is inappropriate to conclude which strategy should be preferred. In addition to AF-CHF, the CAFÉ-II study aims to randomize 400 patients to an aggressive strategy of cardioversion versus rhythm control in the Humberside region (population 1.5 million) of the UK. The results of these studies should be awaited before making confident predictions that may be incorrect.

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**Temporary cardiac pacing**

Sir,

While it is undoubtedly true that some consultants in General (Internal) Medicine may not feel competent to perform emergency cardiac pacing by the transvenous route,1,2 there is, in my experience, a lingering expectation among some consultant cardiologists that their non-cardiologist colleagues will respond affirmatively to the suggestion 'Why don't you pace him yourself?' The dilemma of the continuing demand for emergency pacing versus the shrinking pool of competent juniors can best be resolved by training specialist nurses to the required level of expertise. Already, in gastroenterology, suitably trained nurses perform endoscopies. By analogy, there is no reason why nurses in cardiology cannot be trained to fill the service gap.

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