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Pharmacist's Letter
Hospital

Compare Rate Control Options for Acute Atrial Fibrillation

Questions are coming up about how to choose a rate control med for acute management of atrial fib.

Continue to address and treat underlying triggers (anemia, sepsis, etc)...and evaluate options to manage symptoms.

Cardioversion is still the go-to if patients are unstable due to atrial fib...such as with chest pain, low BP, or shock.

And now data suggest that rhythm control may be preferred long-term for patients with onset of atrial fib in the last year who are at high CV risk.

But rate control is still the first step to acutely reduce symptoms for stable patients in atrial fib with rapid ventricular rate.

Aim for a heart rate less than 110 beats per minute, or lower if symptoms persist.

Generally start with an IV beta-blocker (metoprolol, etc) or nondihydropyridine calcium channel blocker (diltiazem, etc).

Diltiazem seems to work more quickly and lowers heart rate a bit more than metoprolol. But recent data suggest that either is similarly effective at getting to goal heart rate within 2 hours.

Tailor the choice. For example, lean toward a beta-blocker for a patient with known heart failure with reduced ejection fraction.

Or consider amiodarone as a rate control option for ICU patients. But be aware, it may lead to unintended cardioversion.

Evaluate acute and chronic anticoagulation needs for ALL patients with atrial fib. Start by assessing risks for stroke (diabetes, hypertension, etc) and bleeding (prior GI bleed, etc).

For example, anticoagulate most patients before cardioversion and for 4 weeks after...regardless of atrial fib duration.

And typically use long-term anticoagulation for patients with multiple stroke risks.

Use our resource, *A-fib: Focus on Pharmacotherapy*, for rate and rhythm control meds, guidance about anticoagulation around cardioversion and for long-term use, and more.

Key References:

-Eur Heart J. 2021 Feb 1;42(5):373-498
-Crit Pathw Cardiol. 2022 Sep 1;21(3):105-113
-Am J Emerg Med. 2022 Jan;51:248-256

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