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Pill-in-the-Pocket Cardioversion

Patients with Paroxysmal Atrial Fibrillation (also referred to as AFib or AF) i.e. AFib that comes and goes often ask their doctor whether it might be possible to take a medication only at the time that they get AFib, in order to restore the normal rhythm, rather than taking it all the time to ward off attacks which might only occur rarely. In fact it is not unusual for patients to forget to take medication when they have the normal rhythm and when they suddenly develop AFib, they then remember to take the medicines and often, do so at a higher dose than normal. This is not recommended without full discussion with the physician to ensure that it can be safely done.

Only some patients are suitable for the 'Pill-in-the-Pocket' method of treatment. They should:

- be able to recognize the onset of the AFib
- have attacks that happen no more frequently than at weekly or preferably monthly intervals
- have no significant underlying heart disease
- have no disabling symptoms during an attack (fainting, severe chest pain or breathlessness)
- only use this medication if the patient has symptoms less than 24 hours (if longer may cause a clot in the heart with possible complications)
- be on beta-blockers or rate limiting calcium channel blockers for at least 30 minutes prior to taking the "pill in the pocket" (if not already taking these) or may lead to potentially dangerous rate/rhythm problems
- consider the addition of an anticoagulant if sinus rhythm is not gained within 24 hours or other clinical indications suggest its value

The usual way to begin treating a patient in this way is by asking the patient to report to the nearest Emergency Room (ER) as soon as possible after the onset of an attack. The patient will have been given a letter to inform the ER staff about the procedure. A routine 12-lead EKG should be performed to check the rhythm and the general state of the heart. The patient should then be connected to an EKG monitor from which recordings can be taken if needed. The patient will be rested and given the appropriate dose of the antiarrhythmic drug which has been selected for use. This is taken with a small sip of water and the patient then lies down and relaxes, perhaps reading or watching the TV. The staff keep an eye on the situation and the EKG monitor is alarmed to alert the ER staff of any change of the rhythm. From time to time the blood pressure is taken.

In some cases the technique does not work and the patient is discharged after about four hours, often after being given medication to control the heart rate and with an appointment to see the physician in charge. In most patients the AFib does convert to sinus rhythm and the patient is allowed home after an hour of additional EKG monitoring. Provided that the technique was shown to be effective and safe (no abnormal rhythm has developed and the blood pressure has been stable), the patient is then allowed to self administer the same dose of the same medication whenever AFib re-occurs remembering to take a beta-blocker or rate-limiting calcium channel blocker at least 30 minutes beforehand otherwise a potentially dangerous rate/rhythm may occur. Progress is monitored in the out-patient department and in conjunction with the family physician.

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