Ninety Good Minutes

Atrial fibrillation, already the most common dysrhythmia, will become even more common in years to come. Accountable care organizations, now common, will become ubiquitous. The shift in healthcare expenditure onto patients, a common process already, will become the rule. The convergence of these three forces will compel emergency physicians to manage atrial fibrillation without hospitalization at every reasonable opportunity. While the same goes for many other diagnoses, ranging from exacerbations of chronic heart failure to acute treatment of pulmonary embolism, atrial fibrillation is one of the most rewarding and fun to treat and street. One reason is the diagnosis is made with a simple 12 lead electrocardiogram, as opposed, for example, to the confusing array of testing that often precedes the diagnosis of pulmonary embolism. With a sheet of paper, the patient, nurse, and doctor all know what the problem is. With a quick CHA²DS²-VASc score, and monotherapy oral anticoagulants, the instant medical opinion about need for anticoagulation is also straightforward (although patient adherence, not so much). That leaves one basic and one derivative question: First is the question of rate-only or rhythm control; and then the derivative, if rhythm control, by which method. Prior to the multicenter, randomized trial by Scheuermeyer and colleagues in this month’s AEM, we had precious little evidence to offer patients about whether one method was better than the other for rhythm control. As a practitioner who has used an outpatient outpatient atrial fibrillation treatment protocol at my institution for two years now, I have been unable to advise patients on any specific merit of chemical versus electrical cardioversion. No good advice meant no reassurance. As a result, for reasons that are unclear to me, the stale magnetism of indecision somehow drifted the conversation back to "...well, if you prefer, we can always just control your heart rate and deal with the electrical abnormality later when you follow up with the specialist cardiologist, as long as we treat you with an anticoagulant." And with that, about 30 percent of patients bailed on rhythm control, and left the emergency department still in atrial fibrillation. Scheuermeyer et al empowers the evidence-based offering: "We have two equally safe and effective options to get you back into normal heart rhythm. The fastest is to put you to sleep and use electrical energy. This will probably get you out of here and back home 90 minutes faster than the other method."

Best wishes,
Jeffrey A. Kline, MD
Editor-in-Chief, Academic Emergency Medicine