SOURCES OF FURTHER INFORMATION

NHS inform

www.nhsinform.scot
Telephone: 0800 22 44 88 (8am–10pm)

NHS inform is the national health and care information service for Scotland. It includes a section on heart conditions with information and links to resources to support patients with heart disease.
www.nhsinform.scot/illnesses-and-conditions/heart-and-blood-vessels

There is also a section providing advice on healthy living for physical and mental wellbeing.
www.nhsinform.scot/healthy-living

Arrhythmia Alliance

www.heartrhythmalliance.org/aa/uk
Telephone: 01789 867 501
Email: info@heartrhythmalliance.org

Unit 6B, Essex House, Cromwell Business Park, Chipping Norton, OX7 5SR

The Arrhythmia Alliance is a coalition of charities, patient groups, patients, carers, medical groups and allied professionals working together to improve the diagnosis, treatment and quality of life for all those affected by arrhythmias.

British Heart Foundation

www.bhf.org.uk
Telephone: 0131 555 5891
Heart Helpline: 0300 330 3311
Email: bhfhi@bhf.org.uk

The Cube, 43a Leith Street, Edinburgh EH1 3AT

The British Heart Foundation (BHF) is a national heart charity and the largest independent funder of cardiovascular research in the UK. The BHF provides vital support, information and care for patients and their carers. It provides forums to listen to, engage and influence both patients and key stakeholders.

Chest Heart & Stroke Scotland

www.chss.org.uk
Telephone: 0131 225 6963
Advice Line Nurses: 0808 801 0899
(9.30am–4.00pm, Mon–Fri)
Email: admin@chss.org.uk

Third Floor, Rosebery House, 9 Haymarket Terrace, Edinburgh, EH12 5EZ

Chest Heart & Stroke Scotland is a health charity set up to improve the quality of life for people in Scotland affected by chest, heart and stroke illness, through medical research, influencing public policy, advice and information and support in the community. It helps to co-ordinate self-managed peer support groups throughout Scotland which provide a range of activities to support people affected by chest, heart and stroke illness.

CredibleMeds®

www.crediblemeds.org

CredibleMeds® is a website run by the Arizona Center for Education and Research on Therapeutics with a mission to foster the safe use of medicines. It maintains the CredibleMeds® website and the QTdrugs lists of drugs that have a risk of QT prolongation and cardiac arrhythmias under a contract with the US Food and Drug Administration Safe Use Initiative to support the safe use of medications.

This Quick Reference Guide provides a summary of the main recommendations in **SIGN 152 Cardiac arrhythmias in coronary heart disease.**

Recommendations **R** are worded to indicate the strength of the supporting evidence. Good practice points ✓are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**.

This QRG is also available as part of the SIGN Guidelines app.

Available from Android Market

Download on the App Store

Healthcare Improvement Scotland

SIGN

SIGN 152 • Cardiac arrhythmias in coronary heart disease

Quick Reference Guide *September 2018*

Evidence

ARRHYTHMIAS ASSOCIATED WITH CARDIAC ARREST

Adjunctive therapies in the peri-arrest period

R Intravenous adrenaline/epinephrine should be used for the management of patients with refractory VT/VF.

R Intravenous amiodarone should be considered for the management of patients with refractory VT/VF.

R Therapeutic hypothermia should not routinely be administered to patients in the prehospital or inhospital setting after cardiac arrest.

R Atropine should be used in the treatment of patients with symptomatic bradycardia. When atropine is ineffective consider intravenous administration of further positively chronotropic agents before transvenous pacing is instituted.

R Patients with polymorphic VT should be treated with intravenous magnesium sulphate (2 g over 10–15 minutes; 8 mmol, or 4 ml of 50% magnesium sulphate). QT-interval-prolonging drugs, if prescribed, should be withdrawn. If present, hypokalaemia should be corrected by potassium infusion.

ARRHYTHMIAS ASSOCIATED WITH ACUTE CORONARY SYNDROME

Atrial fibrillation

R Class Ic antiarrhythmic drugs should not be used in patients with AF in the setting of ACS.

R Patients with AF and haemodynamic compromise should have urgent synchronised DC cardioversion or be considered for antiarrhythmic and rate-limiting therapy using:

- intravenous amiodarone

or

- digoxin, particularly in presence of severe LV systolic dysfunction with heart failure.

R Patients with AF with a rapid ventricular rate, without haemodynamic compromise but with continuing ischaemia should be treated with one of:

- intravenous beta blockade, in the absence of contraindications
- intravenous verapamil where there are contraindications to beta blockade and there is no LV systolic dysfunction
- synchronised DC cardioversion.

R Patients with AF without haemodynamic compromise or ischaemia should be treated with rate-limiting therapy, preferably a beta blocker, and be considered for chemical cardioversion with amiodarone or DC cardioversion.

Ventricular arrhythmias

R Patients who have VF or haemodynamically significant VT more than 48 hours after infarction should be considered for an implantable cardioverter defibrillator.

R All patients with ST-elevation acute coronary syndrome should undergo assessment of LV function for risk stratification at least six weeks following the acute event.

ARRHYTHMIAS ASSOCIATED WITH CHRONIC CORONARY HEART DISEASE/LEFT VENTRICULAR DYSFUNCTION

Rate control

R Rate control is the recommended strategy for management of patients with well-tolerated atrial fibrillation.

R In patients with permanent AF or persistent AF following a rate-control strategy and a resting heart rate >110 bpm, appropriate rate-control therapy should be instituted with an initial target of resting heart rate <110 bpm.

R Ventricular rate in AF should be controlled with beta blockers, rate-limiting calcium channel blockers (verapamil or diltiazem), or digoxin and combination therapy may be required.

Catheter ablation for AF

R Ablation and pacing should be considered for patients with AF who remain severely symptomatic.

R Patients with highly symptomatic paroxysmal atrial fibrillation resistant to one or more antiarrhythmic drugs and little or no comorbidity should be referred to an arrhythmia specialist for consideration of ablation.

Ventricular arrhythmias

R Revascularisation should be considered in patients who have had sustained VT or VF.

R Patients surviving the following ventricular arrhythmias in the absence of acute ischaemia or treatable cause should be considered for ICD implantation:

- cardiac arrest (VT or VF)
- VT with syncope or haemodynamic compromise
- VT without syncope if LVEF ≤35% (not NYHA IV).

R Patients with a primary-prevention ICD should have a single therapy zone programmed at a detection rate of 200 bpm.

ARRHYTHMIAS ASSOCIATED WITH CORONARY ARTERY BYPASS GRAFT SURGERY

R Patients who are referred for cardiac surgery and who have a history of atrial fibrillation (paroxysmal or persistent) should routinely be considered for surgical ablation as a concomitant procedure.

PSYCHOSOCIAL ISSUES

R Psychosocial implications for people experiencing cardiac arrhythmias should be considered by all healthcare staff throughout assessment, treatment and care.