Atrial Fibrillation Ablation Instructions

Patient Name:

Procedure Date:

Arrival time:

We want to thank you for choosing the University of Virginia Health for your procedure. Your care and well-being are important to us. We are committed to providing you with the best possible care using the latest technology. This handbook should be used as a guide to help you through procedure and answer questions that you may have. Please give us any feedback that you think would make your experience even better.

Contact Information

Your Care Team

Physician:

Nurse Practitioner:

RN Care Coordinator:

IMPORTANT PHONE NUMBERS:

Heart Center Centralized Scheduling (Monday - Friday, 8 am - 5 pm): 434-243-1000

Daytime Emergency Number (Monday - Friday, 8 am - 5 pm): 434-243-1000. Ask for the "RN Care Coordinator" associated with your physician.

Evening and Weekend Emergency Number: 434-924-0000. Ask the operator to page the "Fellow on call for the Electrophysiology" Service.

Procedure Scheduling Office: 434-982-1818

Lodging Arrangements/Hospitality House: 434-924-1299 / 434-924-2091

Parking Assistance: 434-924-1122

Interpreter Services: 434-982-1794

Billing Department: 434-297-5416

Medical Record Requests: 434-924-5136

Your medical information is available to you in UVA Health MyChart. You can either sign up on-line or download MyChart App on your smartphone or your tablet

https://mychart.healthsystem.virginia.edu/Mychart/Signup

Questions about the Visitor Policy?

Please Visit:

https://uvahealth.com/patients-visitors/visiting-patient

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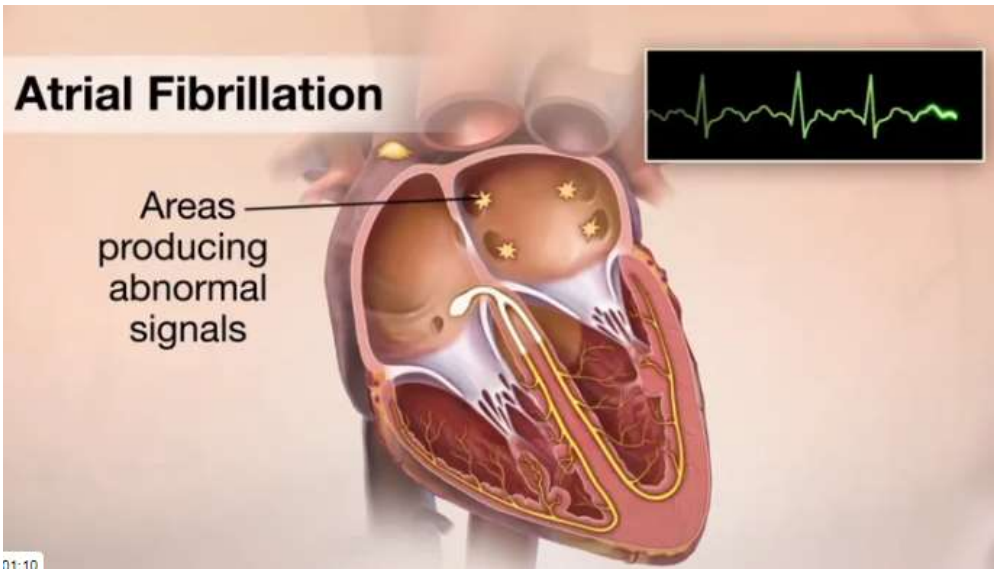
UNDERSTANDING ATRIAL FIBRILLATION (AFib)

What is Atrial Fibrillation (AFib)?

Atrial fibrillation is the most common type of abnormal heart rhythm (arrhythmia), characterized by an irregularly irregular rhythm. According to CDC, it is estimated that 12.1 million people in the United States will have AFib in 2030. People of all ages can get AFib with no medical problems though it is most often found in older people with other risk factors such as high blood pressure, coronary artery disease or heart failure, valvular heart disease, lung disease, thyroid disease, diabetes, excessive alcohol or caffeine intake, smoking, sleep apnea, and obesity.



Snapshot from the Heart Rhythm Society website (https://upbeat.org)

How do people get AFib and what are the signs and symptoms of AFib?

Although AFib is not usually life threatening, it can cause stroke and other problems such as heart failure (as your heart cannot pump blood out to your body as it should). AFib may start suddenly with or without any trigger (pain, acute illness/surgery, excessive caffeine or alcohol, dehydration, anxiety, stress, etc) and stop on its own, or it may become persistent if unrecognized and untreated. Some people with AFib do not feel any symptoms while some people can tell as soon as it occurs. Common signs and symptoms of AFib include fatigue/weakness, palpitations, shortness of breath, decline in activity tolerance, chest discomfort, dizziness/lightheadedness, and passing out.

How is AFib diagnosed?

AFib is diagnosed with an ECG (electrocardiogram), Holter monitor, mobile cardiac monitoring, event monitor, or implantable loop recorder that show electrical activity of your heart. Your doctor may order other tests such as ultrasound, CT, or MRI of your heart, or stress test to further evaluate your heart structure and function.

What are the treatment options for AFib?

Once you are diagnosed with this AFib, one of the first things that your cardiologist (rhythm specialist/electrophysiologist) will need to discuss with you is the need for blood thinning therapy. When your heart does not pump efficiently in atrial fibrillation, it increases risks of having a stroke. There is a 5-fold increase for stroke in patients with AFib. There are a number of factors that increase your risk of stroke including age, high blood pressure, diabetes, heart failure or heart attack/disease, vascular disease, prior stroke/TIA, and female gender. Your cardiologist will discuss about your risks of having a stroke based on this as well as risk factors for bleeding and may recommend starting a blood thinner (i.e. Warfarin/Coumadin, Apixaban/Eliquis, Rivaroxaban/Xarelto, Dabigatran/Pradaxa, Edoxaban/Savaysa).

Once you decide on treatment to prevent blood clots/stroke, your cardiologist will discuss about treatment options for AFib include medications, cardioversion, and/or catheter ablation.

Medications to consider are rate lowering agents such as beta-blockers or calcium-channel blockers as well as anti-arrhythmic agents that suppress AFib. Sometimes your doctor may want to try either one or both to best treat your AFib. Cardioversion is a medical procedure to put you back in normal rhythm using low energy shock when medication therapy is not enough to restore normal rhythm or when you are unstable in AFib with rapid heart rates. Lastly, a catheter ablation involves using a small tube that goes into your blood vessel through your groin to get to your heart to find the area in the heart that cause AFib and delivers either heat or cold to heart muscle to put tiny scars on it which will block the signals that cause AFib. This is usually done under general anesthesia. Typically patients stay overnight in the hospital as the procedure itself typically takes at least 3-4 hours and patient is placed on 4 hours of bedrest after the procedure. Your blood thinner will be resumed after the procedure to prevent any clot formation from the procedure.

What to expect prior to your procedure

- You will be contacted by your RN Care Coordinator for date and time for your procedure. Usually you are asked to come to our clinic prior to your procedure for pre-procedure work up including clinic visit, blood work, and/or CT scan to evaluate your heart anatomy and rule out any clots in your heart chambers. Your RN Care Coordinator will communicate with you regarding pre-procedure instructions via phone call and letter/MyChart.

- Your pre-procedure instruction letter will include date/time for your pre-procedure clinic visit and/or CT scan or TEE (Transesophageal echocardiogram) with detailed instructions. If you are scheduled for CT scan as your first appointment for pre-op work up, you go to the Radiology Department (1st floor of the Main Hospital). After you are done with your CT scan, go to the Primary Care Complex to register for your pre-procedure visit and blood work. Please get your labs drawn once you register for your pre-procedure visit appointment. Lab is located right across the registration office (1st floor, Primary Care Complex). If you are scheduled for TEE, it's usually after your pre-procedure visit and blood work and you will need to have a ride as you will receive sedation medication for this procedure.

- Once you come up to the 2nd floor of Primary Care Complex, you will arrive at Cardiology Clinic. Once you check in at the Front Desk, you will be escorted to one of the exam rooms for pre-procedure visit with our nurse practitioner (NP). During pre-procedure clinic visit, nurse practitioner will review your history, medications, and procedures in details before you sign the consent form for your procedure. Bring your weight log to this visit so that nurse practitioner can document your weight in your chart. AFib Questionnaire forms will be collected on the day of procedure.

- You may need to hold some of your medications prior to procedure. This includes medications to control your heart rate and/or rhythm, diuretic (water pill), some of blood pressure medications, any herbal supplement, and blood thinner. Please follow the instructions as provided in your pre-procedure instruction letter.

- You will need to arrange your ride at discharge as we recommend you do not drive for at least 3 days to allow the groin sites to heal up.

- If you need assistance with work excuse/FMLA form, please contact your care team prior to your procedure.

What to expect on the day of procedure

- Follow the instructions regarding diet. You are asked to not to eat any solid food for at least 8 hours prior to your arrival time. You may have clear liquids (water, black coffee or tea with no dairy products, apple juice) until 2 hours prior to arrival time.

- You may take your usual morning medications with sips of water no later than 2 hours prior to your arrival time. Please follow the pre-procedure instruction letter regarding medications to hold.

- Arrive at the front door of the main hospital on Lee Street located directly across from the Lee Street Garage. Greeters are available to help you. Register at the OR & Procedure Check-In Area, located on the 2nd floor. Plan to arrive 15 minutes early to complete any paperwork. Remember to bring your Photo ID, Insurance card (s), and, if applicable, Pharmacy/Prescription card (s) with you to your appointment.

- You will be escorted to one of the rooms in Cardiac Transition Unit (CTU) to prep you for the procedure. It usually takes little over an hour. During this time, you will meet many of our team members who will help you get ready for the procedure.

- Procedure usually takes about 3-4 hours or so. Once the procedure is over, your physician will update your family/significant other registered as emergency contact. You will be placed on 4 hours of bed rest and will be closely monitored by our team. Once you are stable to return to CTU to complete your bed rest and potentially spend the night, your family member/significant other can come meet you in CTU.

- If you spend the night, you will be evaluated by nurse practitioner in the following morning to make sure you are stable to go home. We advise you against driving for at least 3 days after the procedure so we ask you to arrange your ride beforehand. Tentative discharge time is between 9 and 10 am.

What to expect after your discharge

- You may be quite tired for a few days after the procedure. Some people feel aching muscles in their arms, legs or back because they were lying in the same position for many hours during and after the procedure. You may notice bruising in the groin areas where the catheters (tubes) were inserted. These bruises should resolve in a few weeks. If the bruises get larger, or you notice new bleeding or oozing after you go home, you should call your doctor or go to the nearest Emergency Room (ER).

- Sometimes, in the first 6-8 weeks or up to 3 months after the procedure, you may feel your heart start to go into Afib, but then it stops and stays in normal rhythm. This is normal, and often referred to as "*startup beats*." It simply means that the Afib wants to "startup" but the barrier or scar created by the procedure has worked to stop the AF. This usually goes away or you become used to it and no longer feel it.

- Other patients may have a *few brief episodes* of Afib after the procedure. This is often related to the irritation of the heart tissue from the procedure itself. This does not necessarily mean that the procedure failed. It is important that you contact your care team to let them know if you have multiple episode of Afib. It is not an emergency, but if the AF lasts longer than 12 hours, the doctor may want to consider treatment including medication change or electrical cardioversion to put you back into normal rhythm.

Other common issues following the procedure include:

- Chest pain/discomfort that can occur or worsen with a deep breath. This may be pericarditis (irritation/inflammation of the outside lining of the heart as a result of the ablation procedure. This can be treat with the medication called “Colchicine.” Sometimes your doctor may recommend OTC Ibuprofen 400 mg every 4 to 6 hours as needed.

- Shortness of breath. This is usually due to the inflammation of the heart tissue and/or fluid retention as you received IV fluids given during the procedure. This may occur 2 to 3 days after you are discharged home. Often this is treated with diuretics or "water pills." We recommend you monitor your daily weight prior to your procedure and resume it following discharge until your weight returns to your baseline (pre-ablation weight). If you have persistent or worsening shortness of breath, please let your doctor know.

- New onset or worsening gastroesophageal reflux (GERD). This can be related to possible irritation of your food pipe (esophagus) from the procedure as this is often located right behind your left top chamber where the ablation was performed. Your doctor may prescribe the medication (i.e. Protonix) to treat this condition if indicated. This can also be treated with OTC Nexium, Prevacid, Prilosec, or Pepcid for 4 weeks. If you develop difficulty swallowing, vomiting, coughing up blood, and fever, please call your Nursing Care Coordinator as listed above immediately.

- Issues related to General Anesthesia: Patients often report sore throat, hoarseness, fatigue, headache, worsening migraine, visual disturbances, constipation, and musculoskeletal discomfort after ablation. Patients may also have urinary retentions, bloody urine, hesitancy, and frequency from the use of Foley catheter (a catheter which drains your bladder).

Puncture Site Care (Right and/or left femoral veins (groin)):

- A lump the size of a quarter is not abnormal and will get smaller with time. If the lump gets larger call your primary care physician or your cardiologist.
- Bruising at the site is normal. The bruise will go through many color changes. It may take several weeks to go away completely.
- Soreness will go away within a few days.
- If you develop bleeding or sudden swelling at the groin puncture site: lie down, apply direct pressure above the site. If unable to stop the bleeding call 911 or have someone drive you to the closest emergency room.
- Numbness and tingling of the affected extremity should be reported to your primary care physician.
- Keep the puncture site clean and dry. Remove dressing 24 hours after your procedure. You may shower after 24 hours. Gently wash the catheter site with soap and water. If the site oozes or bleeds slightly, place a small bandage over it to protect your clothes. Once the site has stopped oozing, you may leave it uncovered.
- Acetaminophen/Tylenol 325mg, take 1-2 tablets every 4-6 hours as needed for pain control

Activity Restrictions after the Procedure:

You should take it easy for the first 5 days after the procedure. This includes:

- No pushing, pulling or lifting more than 10 lbs (approximately a gallon of milk)
- No exercise
- No tub bath, swim, or sauna
- Avoid excessive stair climbing
- Avoid excessive bending at the waist or stooping

- No driving for at least 3 days after your procedure.
- Back to work: discuss with your provider regarding when it is best for you to return to work prior to your procedure. Please turn in any FMLA paperwork or other paperwork needed prior to your procedure as well.

After 5 days, you may gradually resume your normal activities and exercise regimen.

Medications:

- **Continue your home blood thinner.** This is important as your heart maybe irritable after the procedure and your risk for clotting remains high even with restoration of normal sinus rhythm. You can further discuss about duration of your ongoing blood thinner therapy at follow up in our clinic and will be determined based on your medical history, not based on the success of the ablation.
- Continue other home medications as prescribed

Diet:

You may eat your usual (heart healthy) diet when you get home.

- Choose heart healthy fats including unsaturated fats found in foods such as olive and sunflower oils, avocados, nuts/nut butter, and Omega-3 fats which are found in certain fish such as salmon, tuna, trout, and in walnuts and flaxseed.
- Eat at least 5 servings of fruit and vegetables a day.
- Make at least half of your grains whole (bread, rice, pasta, cereal, etc)
- Eat 2-3 servings of fish per week.
- Low sodium (no more than 2,000 mg/day). Add little or no salt to food you prepare.
- Avoid foods high in trans-fat (also called partially hydrogenated fat).
- Avoid fried foods and sugary baked goods.

Follow Up:

- Follow up with your PCP in 1-2 weeks after discharge, as needed
- If you are on Warfarin (Coumadin), we want you to follow up with your PCP with repeat INR check in 5 days as your Warfarin dosing may need to be adjusted based on your INR level. We will send a Warfarin referral form to your PCP.
- Follow up with your physician/nurse practitioner in clinic in 3 months or sooner if needed. If you have an existing cardiac device such as a pacemaker or ICD, your device visit will be coordinated with this visit. If you have an implantable loop recorder (ILR), we will schedule your device remote transmission the day prior to your clinic visit.

Frequently Asked Questions About AFib

1. **What are common triggers for AFib?**
   While AFib can occur without any identifiable cause, some people feel they develop this AFib with certain activities. Examples include alcohol, stress (physical or emotional), acute illness (cold, flu, pneumonia, or GI bug) or surgery, alcohol, caffeine, lack of sleep, anxiety, certain cough, cold, allergy medications, missing medications to control your heart rate/rhythm, surgery, or extreme endurance exercise. Initially AFib can be triggered and it may not last long. However, if it's left untreated, it will progress to become persistent AFib as we all know AFib begets AFib and at that point controlling this triggers may not stop your atrial fibrillation.

2. **Am I going to have a heart attack or die from AFib?**
   IF you have underlying blockages in your artery that supplies blood to your heart muscle, it raises risk of developing atrial fibrillation as it creates stress to your heart. AFib is usually not life-threatening condition but can lead to stroke or heart failure if your AFib occurs at really rapid rates for some time. There is an increased risk of death associated with atrial fibrillation primarily due to embolic stroke (clot that blocks the artery in the brain). This is why we emphasize on the importance of blood thinner therapy.

3. **Can I take Aspirin instead of anticoagulants (Eliquis, Pradaxa, Xarelto, Warfarin, Savaysa)?**
   2019 Updated Clinical Guideline suggest that aspirin is no longer recommended for patients with AFib for stroke prevention. Current guideline support use of direct-acting oral anticoagulants (blood thinner) such as Warfarin (Coumadin), Apixaban (Eliquis), Dabigatran (Pradaxa), Rivaroxaban (Xarelto), and Edoxaban (Savaysa) based on your risk factors (age, female gender, high blood pressure, coronary artery disease/heart attack, heart failure, diabetes, vascular disease, history of stroke/heart attack), not based on duration/chronicity of your AFib.

4. **Can I come off of blood thinner after AFib ablation?**
   Risk of clot formation increases after the ablation and it's usually recommended to continue your blood thinner for 3 months following your ablation. The decision to stop your blood thinner beyond that point is based on your risk factors as mentioned above, not on the clinical outcome of your procedure. Make sure you discuss about ongoing blood thinner therapy at your follow up visit.

5. **Can I come off of any meds for heart rhythm or heart rate control after ablation?**
   Whether to come off of any of your heart medication after ablation should be carefully discussed as it certainly pose a risk of recurrent AFib or increased heart rates. Depending on complexity of your AFib and procedure outcome, your doctor may want to consider adjusting your medication

6. **Can AFib be cured?**
   As of today, there is no cure for AFib though there are many treatment options available nowadays to treat AFib. Goal of care should be focused on improving symptom management and minimize AFib burden.

7. **I feel fine with no AFib episode… why do I need to come back for a follow up appointment?**
   It is great that you remain in normal sinus rhythm. It is also important to ensure that current treatment regimens are still best for you and some tests might be necessary (blood work, ECG) depending on your cardiac history. It is also important to review your risk factors for AFib and work on risk factor modification to help you stay in normal rhythm as long as possible.

8. **Can I have more than one ablation if AFib returns?**
   Some people develop recurrent AFib "early," "late," or "very late" after their first ablation. It is because the areas that were previously ablated heal up instead of scarring and re-connect for AFib to come back, or you develop new spot(s) to cause AFib. Success rate with 2nd ablation is usually higher than first one.

9. **Where can I get more information about AFib on-line?**
   American Heart Association (https://www.heart.org)
   Mended Hearts (https://mendedheart.org)
   Heart Rhythm Society (https://www.hrsonline.org)
   StopAfib.org (https://www.stobafib.org)