

Case Study: Atrial Fibrillation

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Cardiovascular Symposium
September 12, 2009

Medical History

- 55 year old male with paroxysmal atrial fibrillation
- Hypertension
- Mild idiopathic hypertrophic subaortic stenosis
- Obstructive sleep apnea using nightly CPAP
- No history of heart failure, diabetes mellitus, stroke or transient ischemic attack -> CHADS² score of 1
- Moderate alcohol intake with 2-3 drinks/week
- Mild exercise intolerance

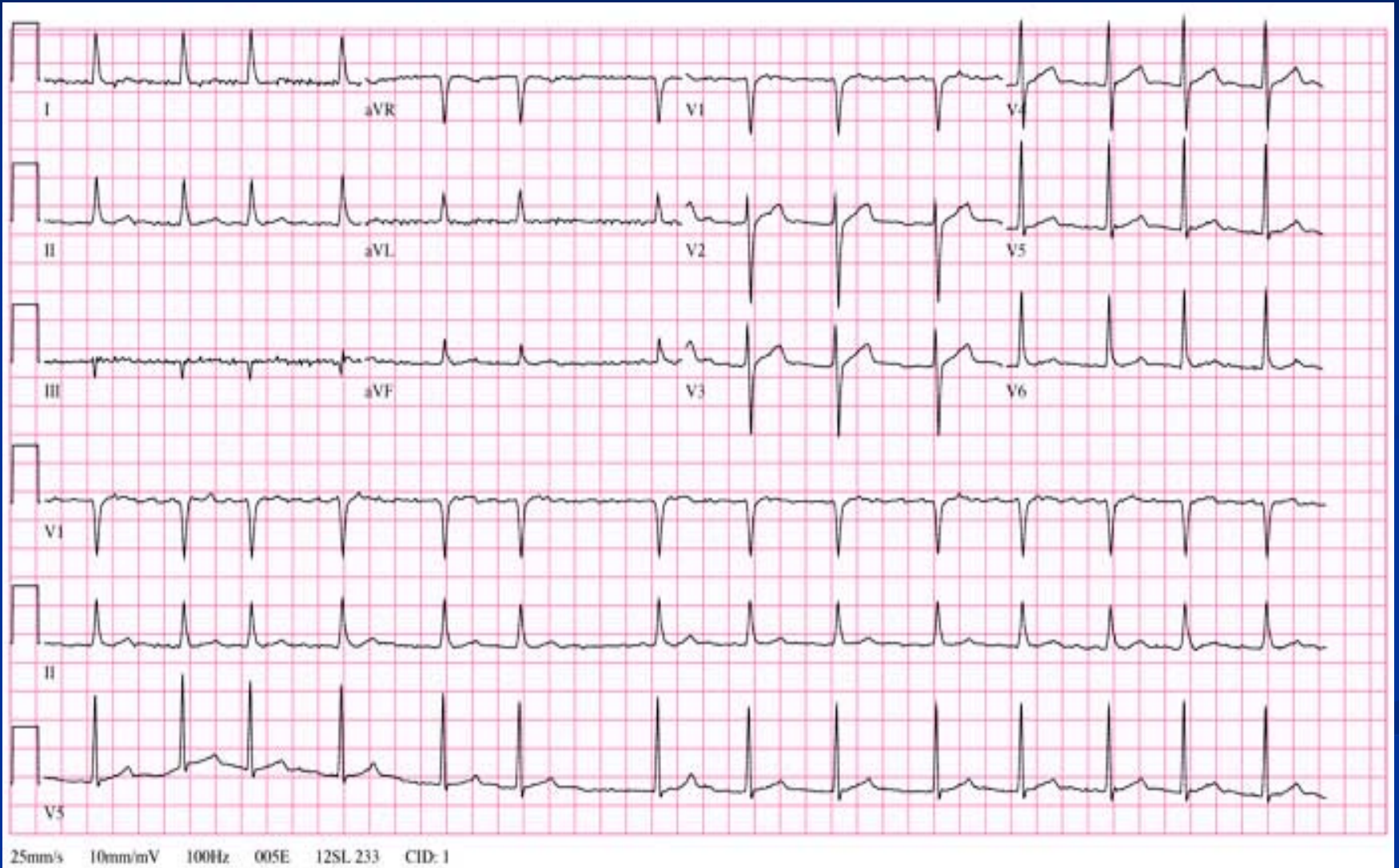
Medical Therapy

- Toprol XL 50 mg daily
- Coumadin 5 mg daily

Physical Exam

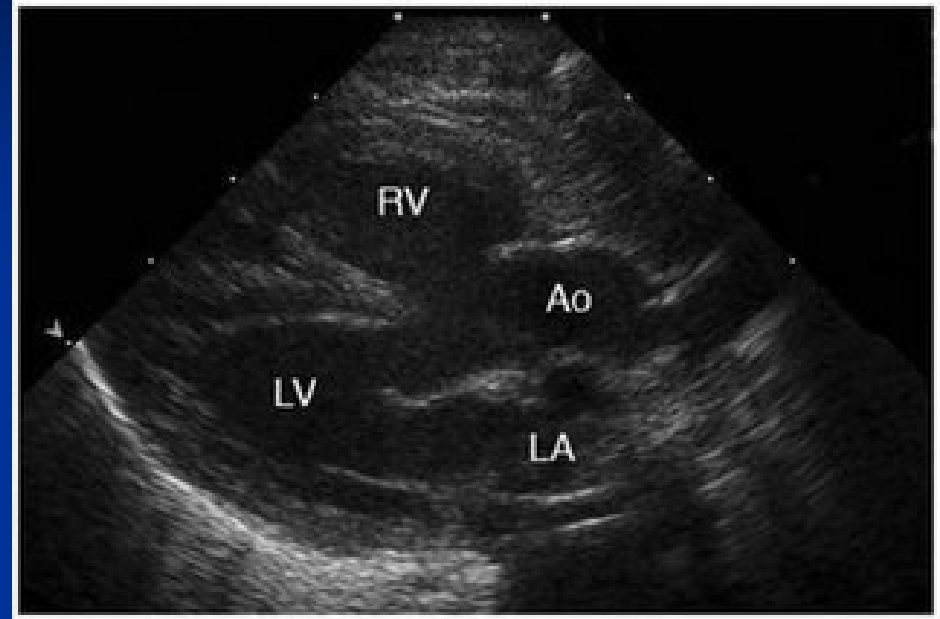
- BMI = 33 kg/m²
- BP = 130/80 Heart rate irregularly irregular 65 bpm
- No JVD or bruits
- 1/6 systolic ejection murmur
- Clear lungs
- No lower extremity edema with equal pulses

Electrocardiogram

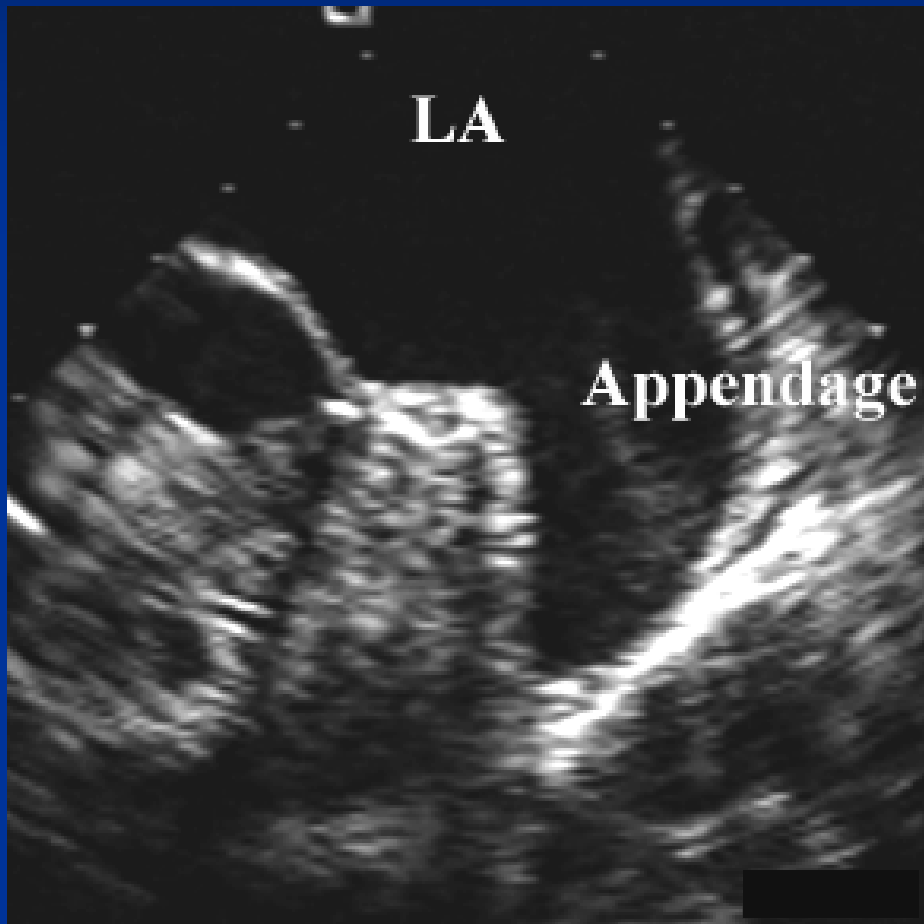


Transthoracic Echocardiogram

- Mildly dilated left atrium
- Mild mitral regurgitation
- Normal LV function
- Mild asymmetric septal hypertrophy with systolic anterior motion and mild LVOT gradient
- Patient was advised to continue Coumadin for 4 more weeks and TEE guided cardioversion was scheduled

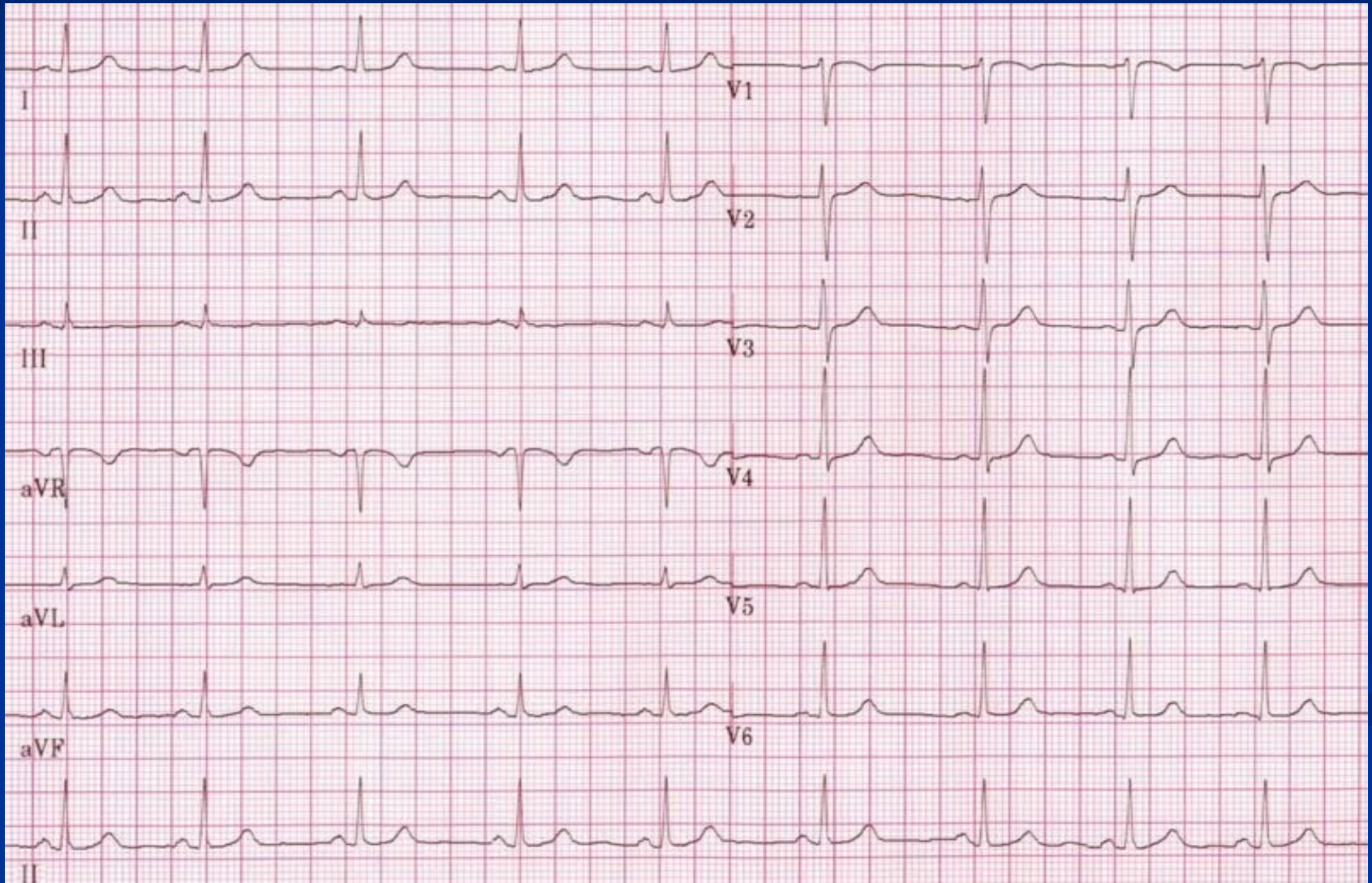


Transesophageal Echocardiogram



- No evidence of intracardiac thrombus
- Mildly dilated left atrium
- Normal LV function
- Patient received 200 J and was successfully cardioverted to sinus rhythm

Post Cardioversion Electrocardiogram



Medical Follow Up

- At initial 6 week follow-up visit, patient states he walks 30 minutes 3-4 times per week and can climb 2 flights of stairs without symptoms
- Off Toprol XL and Coumadin
- At subsequent visits, he resumes alcohol consumption and atrial fibrillation recurs