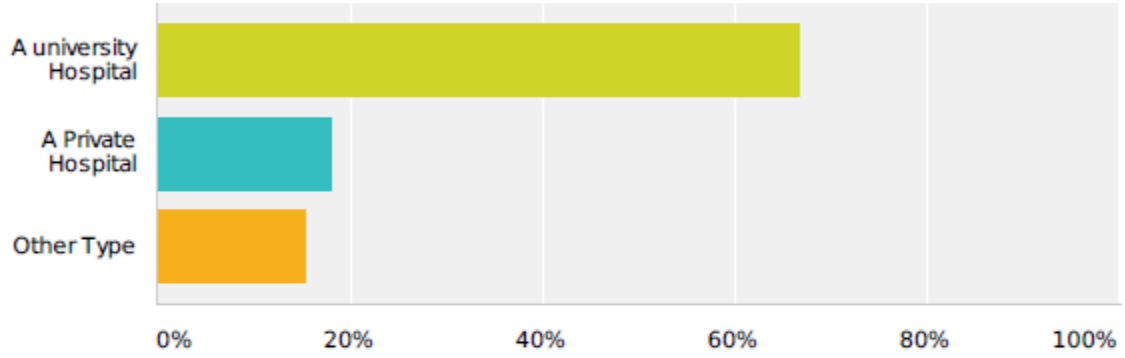
EP WIRE : European Use of Prophylactic Antiarrhythmic drugs for Atrial Fibrillation

Q1 Is your Institution :

Answered: 39 Skipped: 0

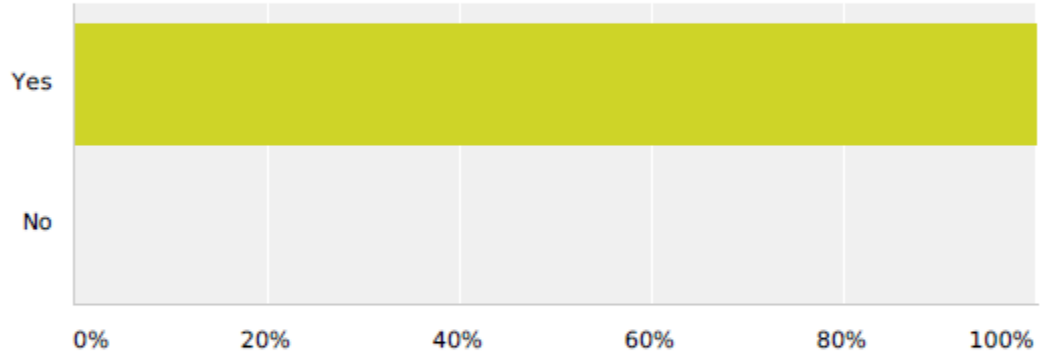


Answer Choices	Responses	
A university Hospital	**66.67%**	26
A Private Hospital	**17.95%**	7
Other Type	**15.38%**	6
Total		39

Institution name (33)

Q5 Would you be comfortable if we acknowledge your centre in the Europace Journal and on the Website ?

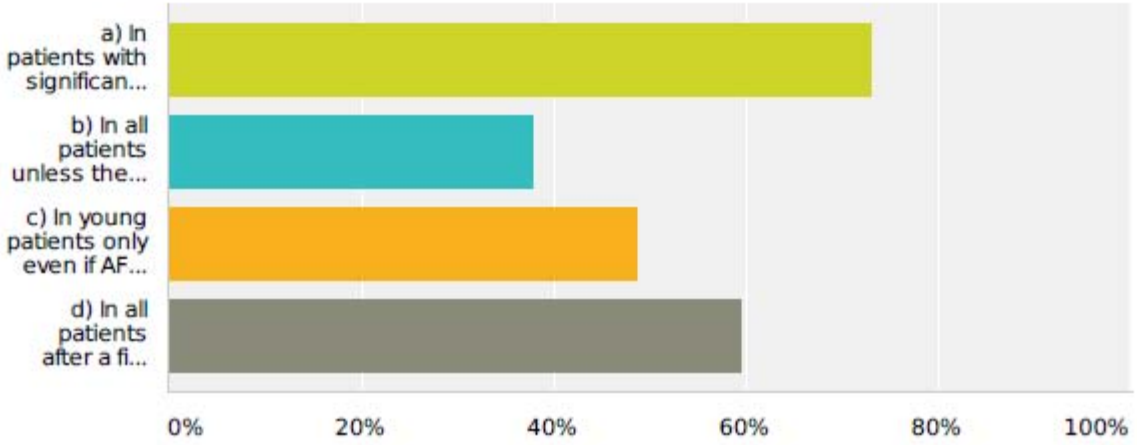
Answered: 39 Skipped: 0



Answer Choices	Responses	
Yes	**100%**	39
No	**0%**	0
Total		39
Other (please specify) (0)		

Q6 In which patients do you prefer rhythm control once you have achieved rate control for AF? (multiple answers possible)

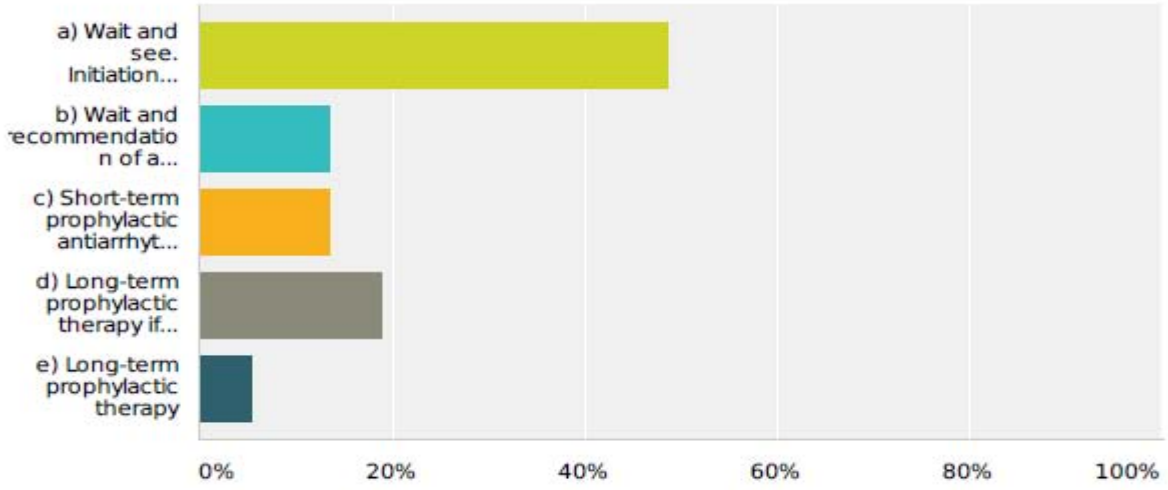
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) In patients with significant AF-related symptoms despite rate control	**72.97%**	27
b) In all patients unless the risk of recurrence is expected to be very high (e.g. significantly dilated left atrium)	**37.84%**	14
c) In young patients only even if AF is well tolerated	**48.65%**	18
d) In all patients after a first detected episode of AF since all patients deserve at least one attempt to restore sinus rhythm.	**59.46%**	22
Total Respondents: 37		

Q7 What is your routine approach regarding prophylactic antiarrhythmic drug therapy after successful conversion in patients who had a first detected episode of AF?

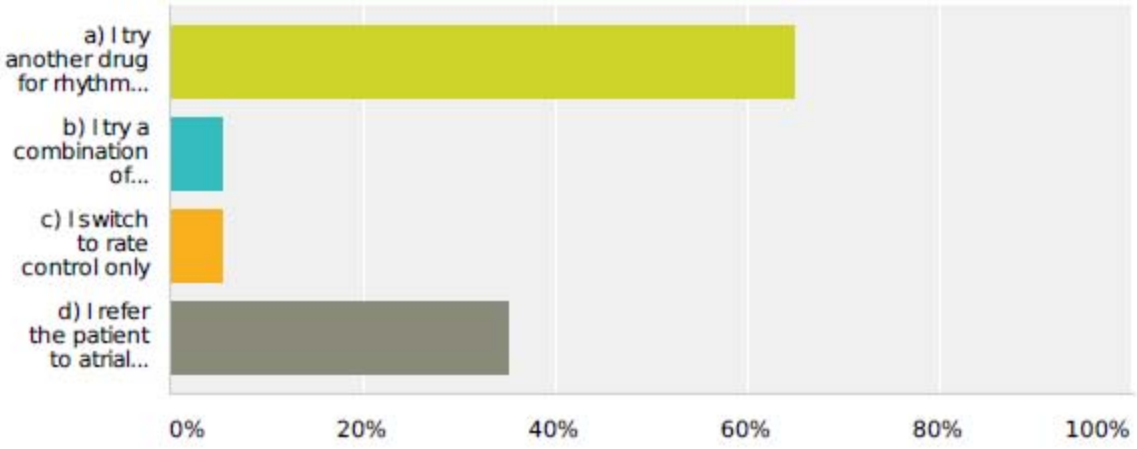
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Wait and see. Initiation of antiarrhythmic therapy only after one or more recurrences.	**48.65%**	18
b) Wait and recommendation of a pill-in-the-pocket therapy in case of a second episode	**13.51%**	5
c) Short-term prophylactic antiarrhythmic therapy (e.g. 4-8 weeks)	**13.51%**	5
d) Long-term prophylactic therapy if the patient is considered to carry a high risk for recurrence (dilated left atrium etc) but not if the recurrence risk is considered low	**18.92%**	7
e) Long-term prophylactic therapy	**5.41%**	2
Total		37

Q8 If you make an attempt at rhythm control and the first drug fails, what do you do next?

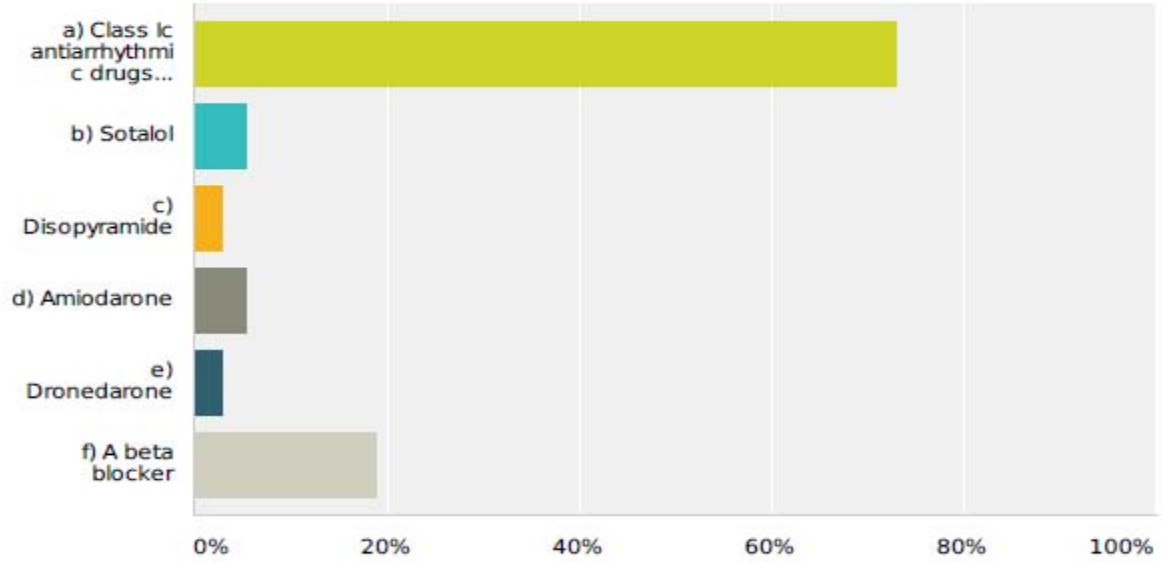
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) I try another drug for rhythm control	**64.86%**	24
b) I try a combination of antiarrhythmic drugs	**5.41%**	2
c) I switch to rate control only	**5.41%**	2
d) I refer the patient to atrial fibrillation ablation	**35.14%**	13
Total Respondents: 37		

Q9 What is your preferred first-line drug for patients without structural heart disease?

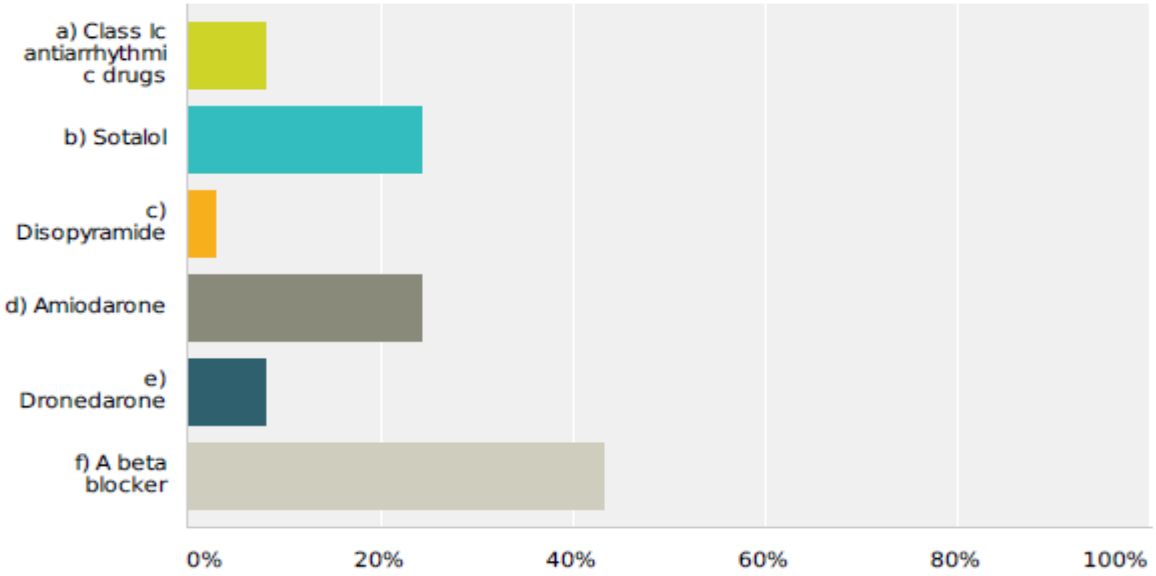
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Class Ic antiarrhythmic drugs (flecainide, propafenone etc)	**72.97%**	27
b) Sotalol	**5.41%**	2
c) Disopyramide	**2.70%**	1
d) Amiodarone	**5.41%**	2
e) Dronedarone	**2.70%**	1
f) A beta blocker	**18.92%**	7
Total Respondents: 37		

Q10 What is your preferred first-line drug for patients with hypertension and left ventricular hypertrophy?

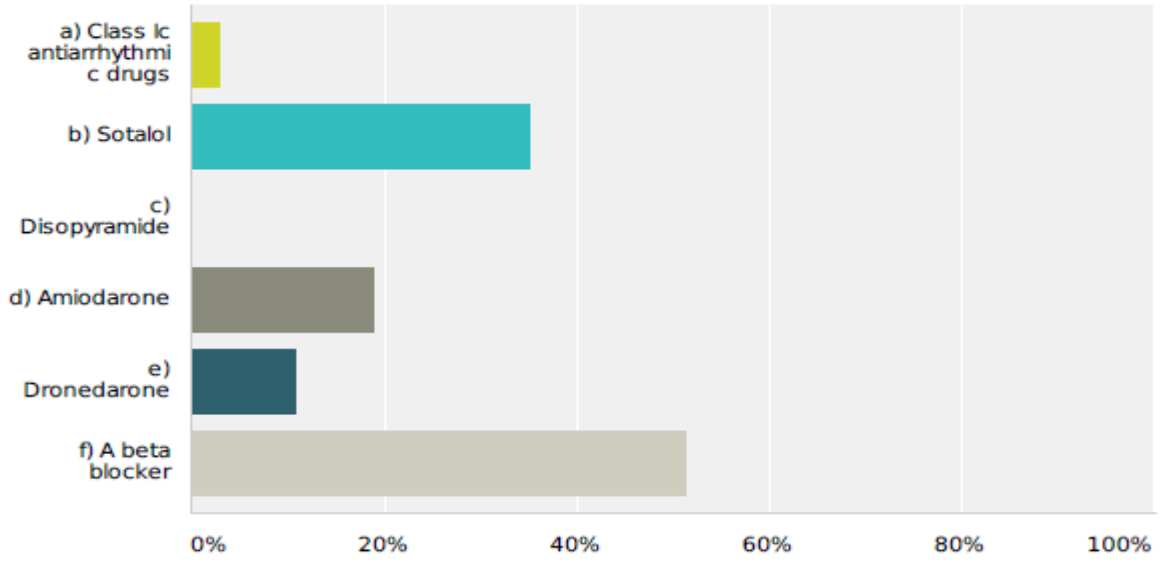
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Class Ic antiarrhythmic drugs	**8.11%**	3
b) Sotalol	**24.32%**	9
c) Disopyramide	**2.70%**	1
d) Amiodarone	**24.32%**	9
e) Dronedarone	**8.11%**	3
f) A beta blocker	**43.24%**	16
Total Respondents: 37		

Q11 What is your preferred first-line drug for patients with coronary artery disease and normal left ventricular ejection fraction?

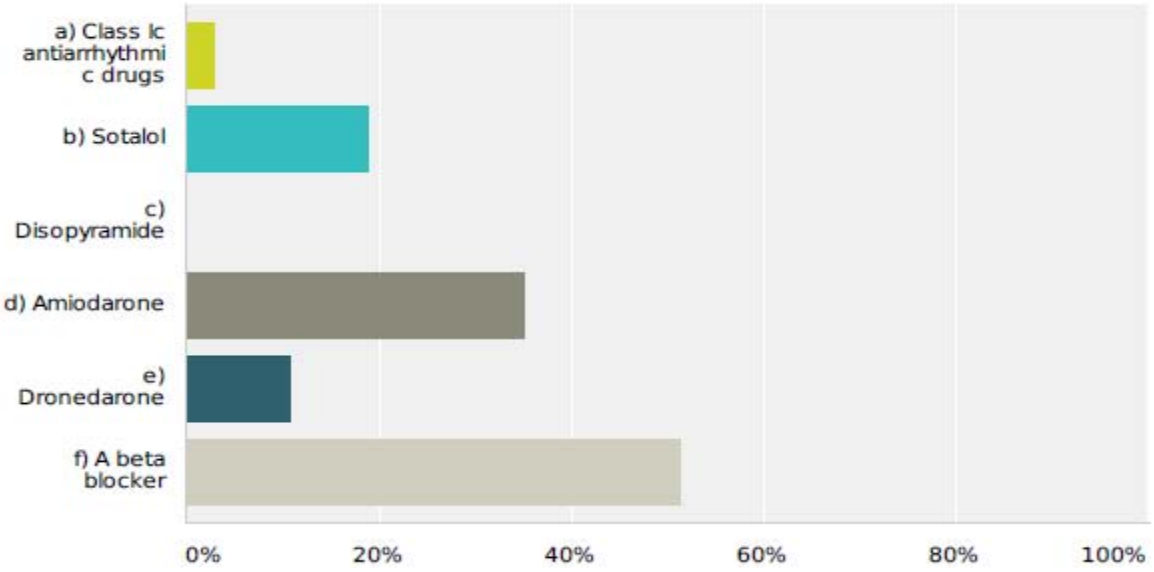
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Class Ic antiarrhythmic drugs	**2.70%**	1
b) Sotalol	**35.14%**	13
c) Disopyramide	**0%**	0
d) Amiodarone	**18.92%**	7
e) Dronedarone	**10.81%**	4
f) A beta blocker	**51.35%**	19
Total Respondents: 37		

Q12 What is your preferred first-line drug for patients with heart failure in stable NYHA I/II class?

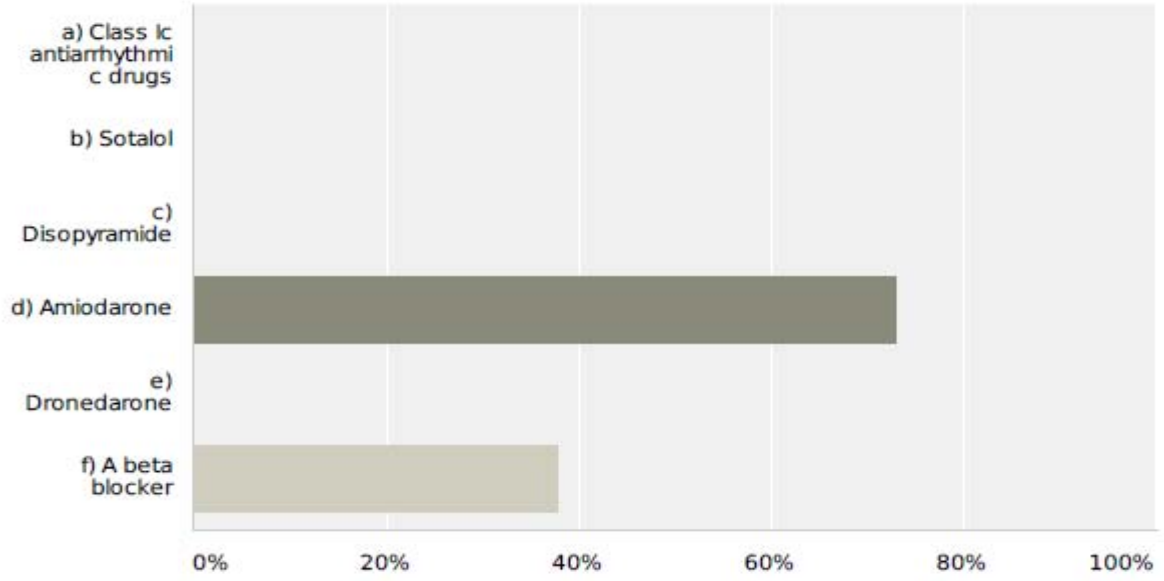
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Class Ic antiarrhythmic drugs	**2.70%**	1
b) Sotalol	**18.92%**	7
c) Disopyramide	**0%**	0
d) Amiodarone	**35.14%**	13
e) Dronedarone	**10.81%**	4
f) A beta blocker	**51.35%**	19
Total Respondents: 37		

Q13 What is your preferred first-line drug for patients with advanced heart failure (NYHA III/IV class)?

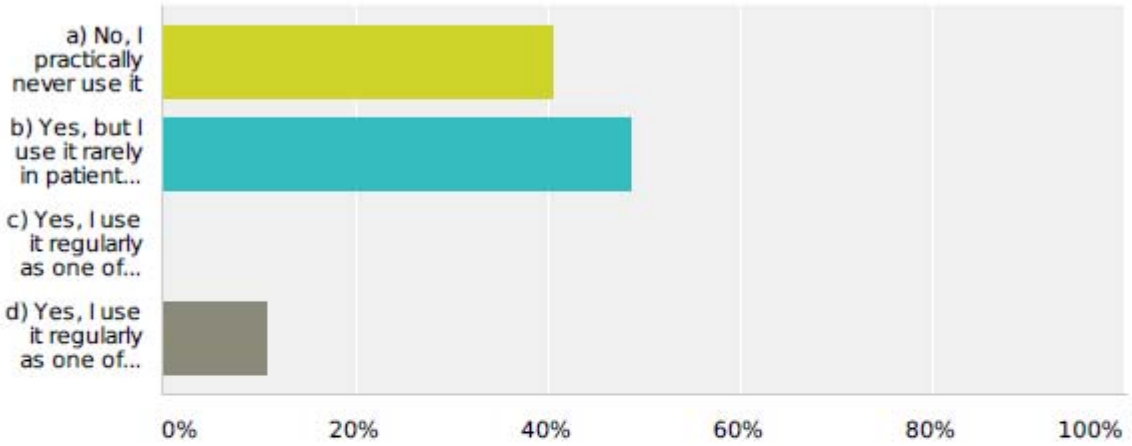
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Class Ic antiarrhythmic drugs	**0%**	0
b) Sotalol	**0%**	0
c) Disopyramide	**0%**	0
d) Amiodarone	**72.97%**	27
e) Dronedarone	**0%**	0
f) A beta blocker	**37.84%**	14
Total Respondents: 37		

Q14 Do you use dronedarone?

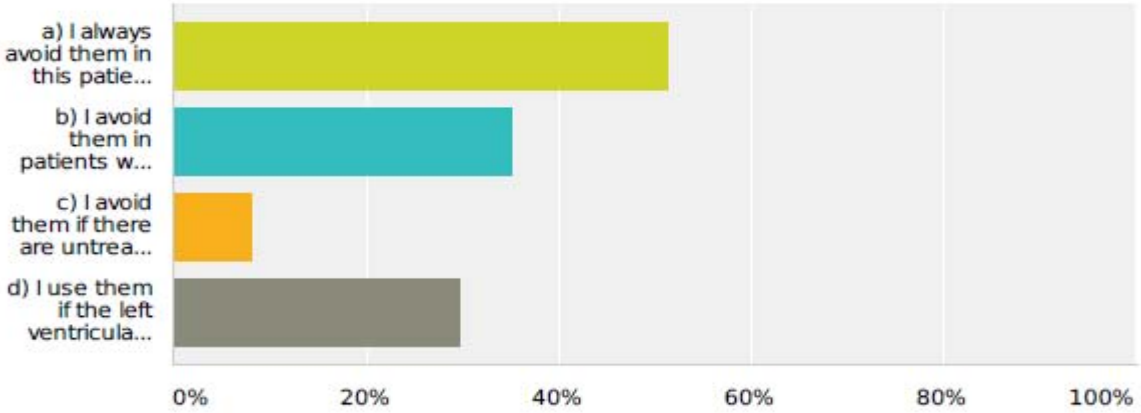
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) No, I practically never use it	**40.54%**	15
b) Yes, but I use it rarely in patients with paroxysmal or persistent AF if other antiarrhythmic drugs have failed	**48.65%**	18
c) Yes, I use it regularly as one of first-choice drugs in patients with paroxysmal or persistent AF but only in the absence of structural heart disease	**0%**	0
d) Yes, I use it regularly as one of first-choice drugs in patients with paroxysmal or persistent AF without or with mild to moderate heart disease (e.g. hypertension with left ventricular hypertrophy, coronary artery disease with preserved left ventricular ejection fraction)	**10.81%**	4
Total		37

Q15 What is your practice with class Ic antiarrhythmic drugs in patients with coronary artery disease? (multiple answers possible)

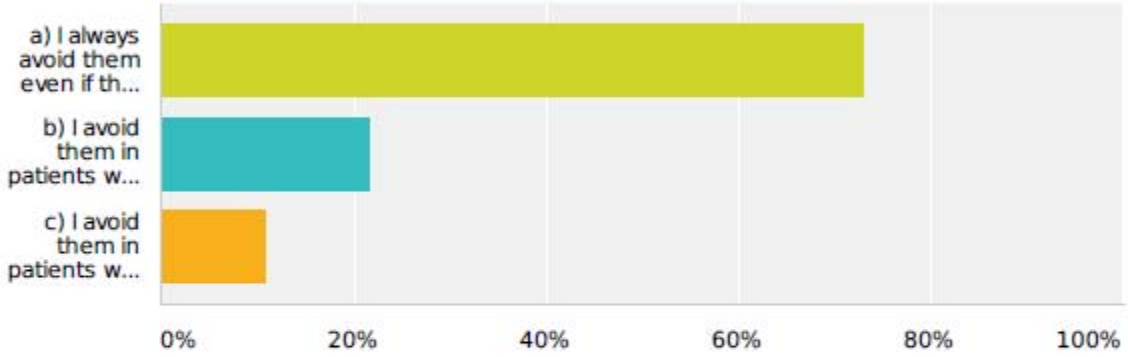
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) I always avoid them in this patient group.	**51.35%**	19
b) I avoid them in patients with reduced left ventricular ejection fraction (e.g. <40%) .	**35.14%**	13
c) I avoid them if there are untreated coronary lesions that could lead to ischemia even if the patient has no symptoms and the left ventricular ejection fraction is normal	**8.11%**	3
d) I use them if the left ventricular ejection fraction is normal unless there is direct evidence of ischemia in a stress test (exercise ECG, stress echocardiography, myocardial scintigraphy)	**29.73%**	11
Total Respondents: 37		

Q16 What is your practice with class Ic antiarrhythmic drugs in patients with dilated cardiomyopathy?

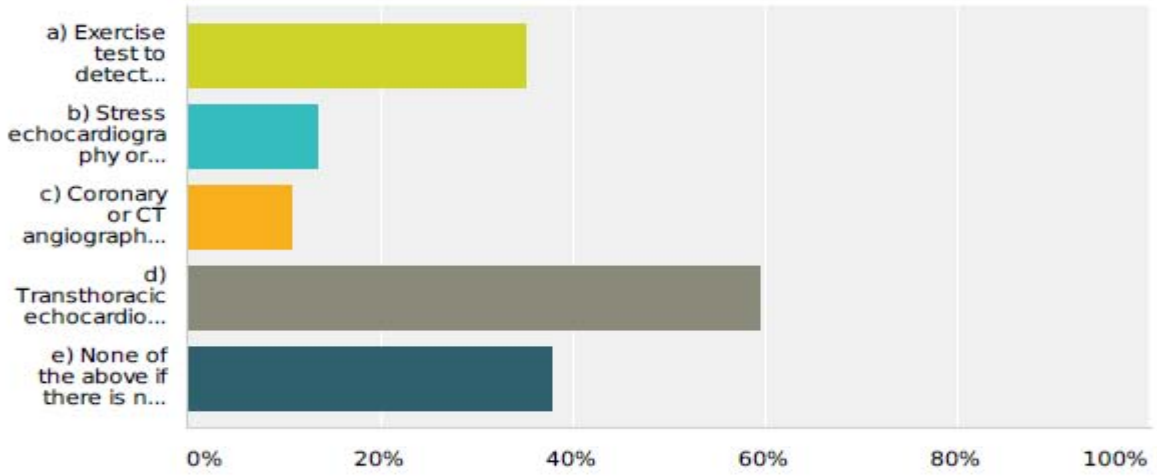
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) I always avoid them even if the left ventricular systolic function is only mildly impaired	**72.97%**	27
b) I avoid them in patients with moderately (<40%) or severely reduced left ventricular ejection fraction	**21.62%**	8
c) I avoid them in patients with severely reduced left ventricular ejection (<30%)	**10.81%**	4
Total Respondents: 37		

Q17 Which of the following examinations do you consider necessary before you initiate class Ic antiarrhythmic drugs (multiple answers possible)?

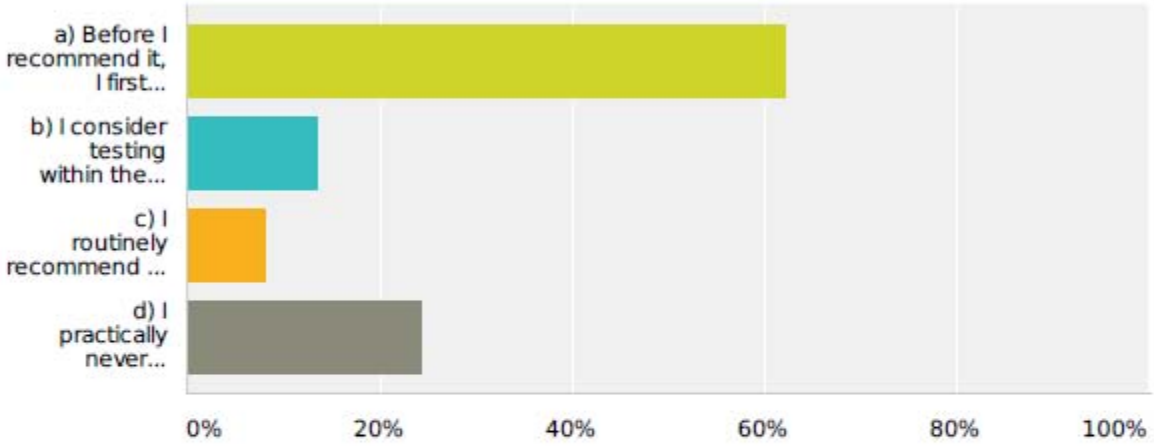
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Exercise test to detect myocardial ischemia	**35.14%**	13
b) Stress echocardiography or myocardial scintigraphy since they are more sensitive than a simple exercise test for detection of ischemia	**13.51%**	5
c) Coronary or CT angiography in order to be sure that there is no coronary artery disease	**10.81%**	4
d) Transthoracic echocardiography	**59.46%**	22
e) None of the above if there is no evidence for structural heart disease from the patient's history, clinical examination, ECG and chest X-ray	**37.84%**	14
Total Respondents: 37		

Q18 What is your approach towards the pill-in-the-pocket therapy (flecainide or propafenone)?

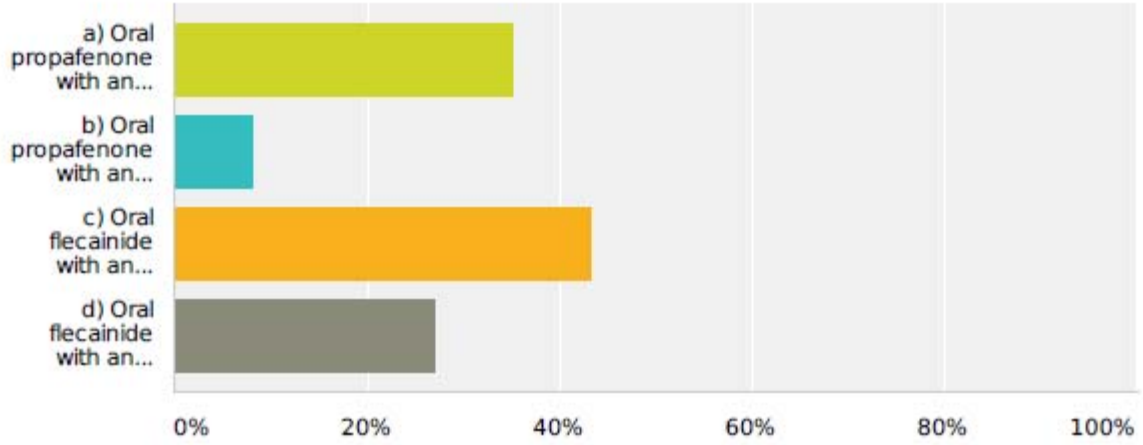
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Before I recommend it, I first routinely test its efficacy and safety within the hospital	**62.16%**	23
b) I consider testing within the hospital as important only for patients with structural heart disease. For patients without structural heart disease, I recommend it without previous testing.	**13.51%**	5
c) I routinely recommend it without previous in-hospital testing	**8.11%**	3
d) I practically never recommend it	**24.32%**	9
Total Respondents: 37		

Q19 Which drugs do you use for pill-in-the-pocket therapy?

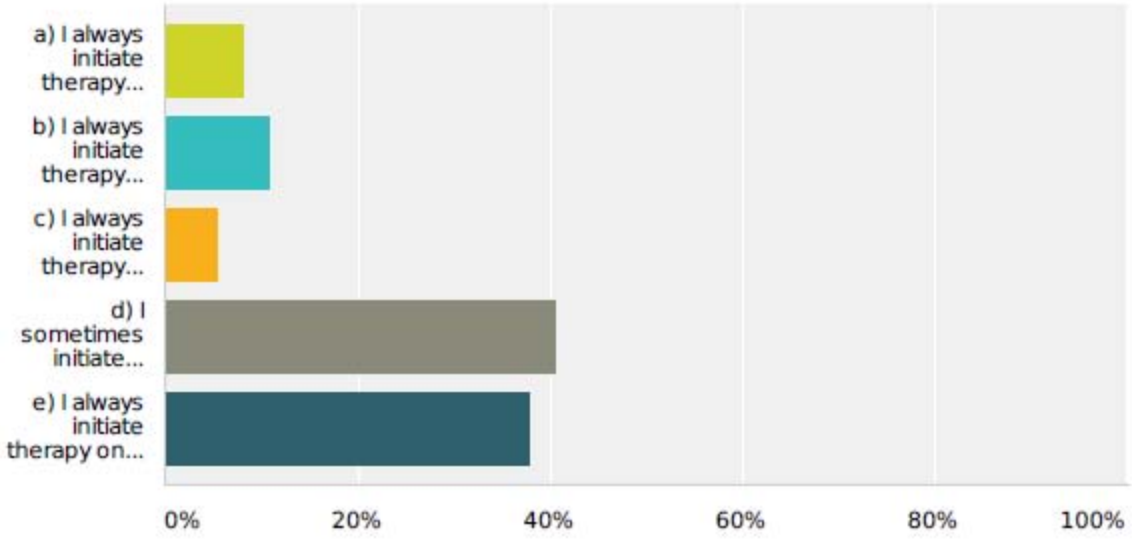
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Oral propafenone with an initial dose of 300 mg and an additional dose of 150-300 mg after 1-2 hours if the first dose was not successful	**35.14%**	13
b) Oral propafenone with an initial dose of 450-600 mg	**8.11%**	3
c) Oral flecainide with an initial dose of 100-200 mg and an additional dose of 100 mg after 1-2 hours if the first dose was not successful	**43.24%**	16
d) Oral flecainide with an initial dose of 200-300 mg	**27.03%**	10
Total Respondents: 37		

Q20 How do you initiate therapy with class Ic antiarrhythmic drugs:

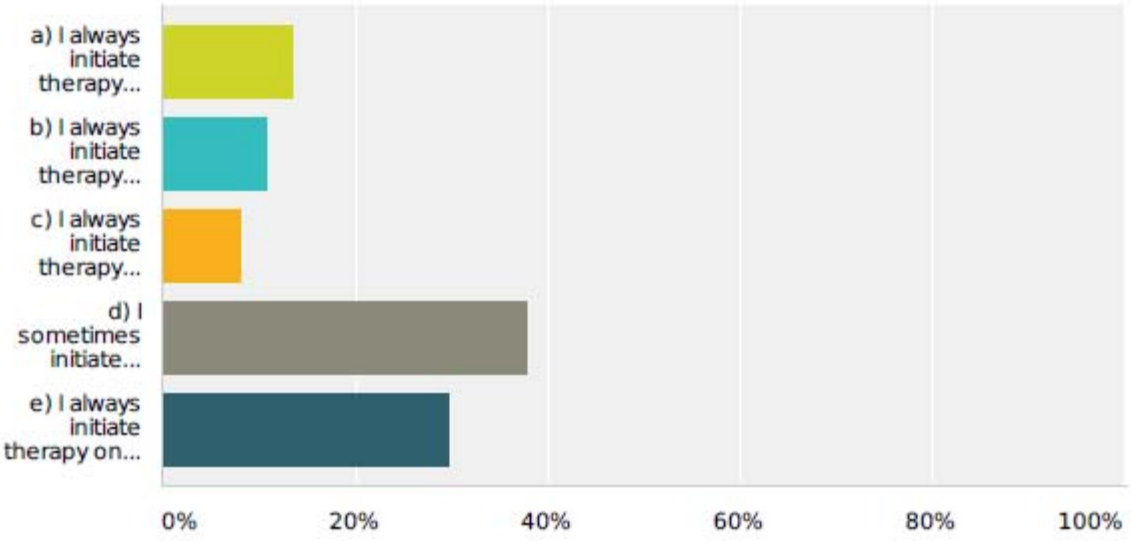
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) I always initiate therapy during hospitalisation with less than 24 hours of ECG telemetric monitoring	**8.11%**	3
b) I always initiate therapy during hospitalisation with ECG telemetry for 24-48 h	**10.81%**	4
c) I always initiate therapy during hospitalisation with ECG telemetry for more than 48 hours	**5.41%**	2
d) I sometimes initiate therapy during hospitalisation	**40.54%**	15
e) I always initiate therapy on an out-patient basis	**37.84%**	14
Total Respondents: 37		

Q21 How do you initiate sotalol therapy?

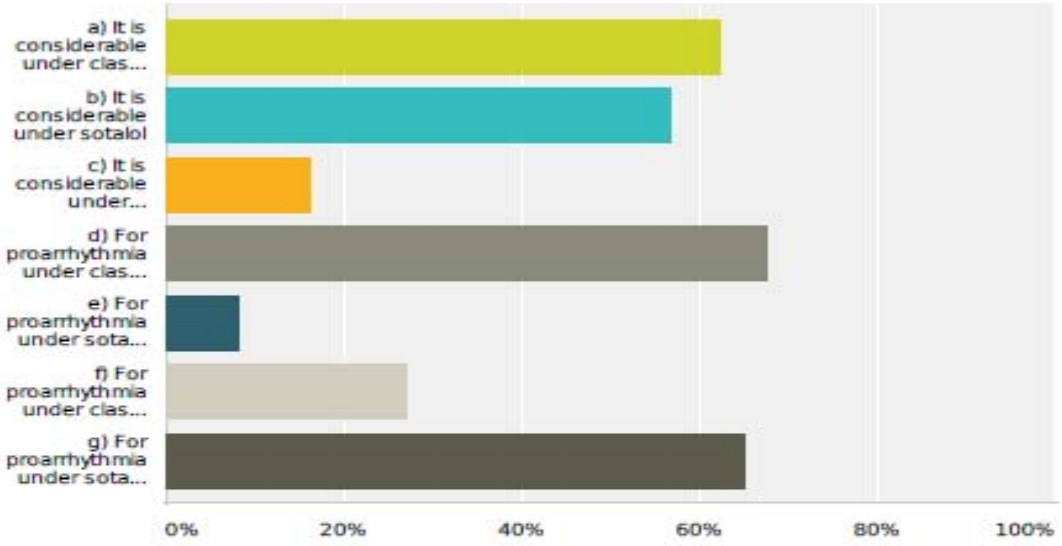
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) I always initiate therapy during hospitalisation with less than 24 hours of ECG telemetric monitoring	**13.51%**	5
b) I always initiate therapy during hospitalisation with ECG telemetry for 24-48 h	**10.81%**	4
c) I always initiate therapy during hospitalisation with ECG telemetry for more than 48 hours	**8.11%**	3
d) I sometimes initiate therapy during hospitalisation	**37.84%**	14
e) I always initiate therapy on an out-patient basis	**29.73%**	11
Total		37

Q22 What do you think about the risk of proarrhythmia under antiarrhythmic treatment (multiple answers possible)?

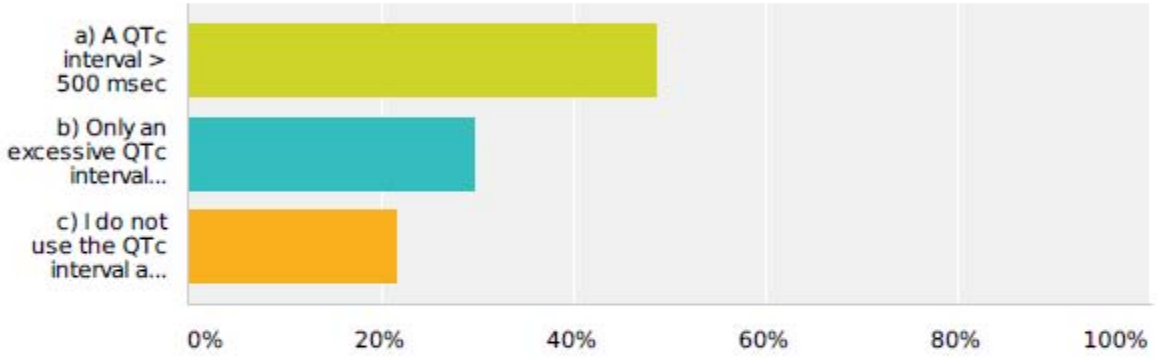
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) It is considerable under class Ic antiarrhythmics	**62.16%**	23
b) It is considerable under sotalol	**56.76%**	21
c) It is considerable under amiodarone	**16.22%**	6
d) For proarrhythmia under class Ic antiarrhythmics, I monitor the QRS duration as a risk marker	**67.57%**	25
e) For proarrhythmia under sotalol and amiodarone, I monitor the QRS duration as a risk marker	**8.11%**	3
f) For proarrhythmia under class Ic antiarrhythmics, I monitor the QT interval as a risk marker	**27.03%**	10
g) For proarrhythmia under sotalol and amiodarone, I monitor the QT interval as a risk marker	**64.86%**	24
Total Respondents: 37		

Q23 During amiodarone therapy, which QT interval would be a reason for discontinuation?

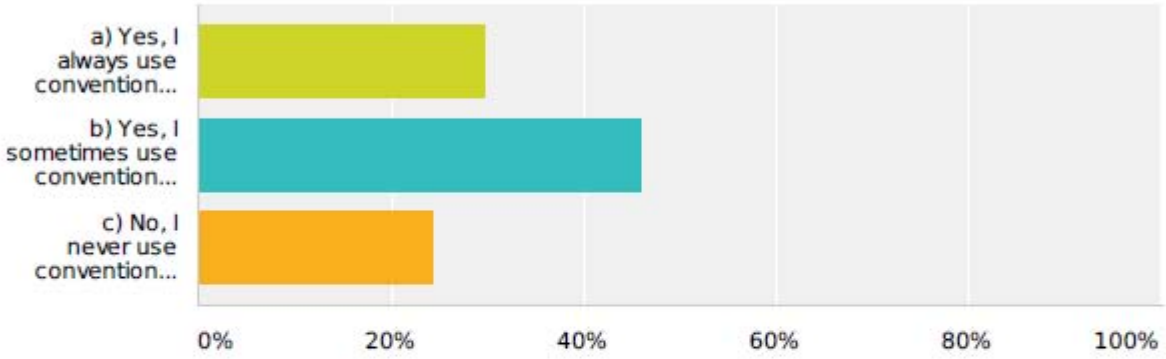
Answered: 37 Skipped: 2



Answer Choices	Responses	
a) A QTc interval > 500 msec	**48.65%**	18
b) Only an excessive QTc interval prolongation (e.g. > 550 msec), since the proarrhythmic risk under amiodarone therapy is low	**29.73%**	11
c) I do not use the QTc interval as a guide for discontinuation of amiodarone therapy	**21.62%**	8
Total		37

Q24 Do you use conventional beta blockers as prophylactic antiarrhythmic therapy for AF?

Answered: 37 Skipped: 2



Answer Choices	Responses	
a) Yes, I always use conventional beta blockers as first-choice drugs due to the low risk associated with this therapy	**29.73%**	11
b) Yes, I sometimes use conventional beta blockers as first-choice drugs	**45.95%**	17
c) No, I never use conventional beta blockers as first-choice drugs due to their low efficacy	**24.32%**	9
Total		37