



**Canadian Cardiovascular Society**  
*Leadership. Knowledge. Community.*

# YOUR COMPLETE GUIDE TO **ATRIAL FIBRILLATION**

LIVING WELL WITH ATRIAL FIBRILLATION  
(MODULE 3)

# CONTENTS

- iii **Overview of managing AF**
- 01 **What to expect from your AF management plan**
- 04 **Following a healthy lifestyle**
- 11 **Understanding common responses and finding support**
- 17 **Patient stories**



IN MODULE 1 YOU LEARNED ABOUT AF AND ATRIAL FLUTTER. IN MODULE 2 YOU LEARNED HOW IT CAN BE MANAGED WITH MEDICINE OR PROCEDURES.

Module 3 will help you learn to live your best life when you have AF, what you can expect, how to live a healthy lifestyle, some common responses people have when told they have a chronic condition, and where to find support.

## OVERVIEW OF MANAGING AF

<b>MODULE 1</b>	AF Diagnosed What is it? Is it harmful?		Find and Treat Common Causes	
<b>MODULE 2</b>	Manage Arrhythmia Symptoms		Assess Stroke Risk (CHADS2)	
	Rate Control • Medicine • Procedures	Rhythm Control • Medicine • Procedures	Blood Thinner, Aspirin, or Nothing	
<b>MODULE 3</b>	Living Well with AF			
	What to Expect from Your AF Management Plan	Following a Healthy Lifestyle	Understanding Common Responses and Finding Support	Patient Stories

# WHAT TO EXPECT FROM YOUR **AF MANAGEMENT PLAN**

AF can't be predicted, happens more than once, and in time, will happen more often and last longer. This doesn't mean that you'll feel worse. Some people may go into AF permanently. It's a chronic condition and can't be cured. However, you can learn to live well with AF.

There are many important reasons to manage AF. First of all, managing your AF reduces symptoms. With a good management plan, you will be able to keep doing all or most of the activities you enjoy. Your management plan will change overtime. Managing AF is also important because, even though AF in itself isn't life-threatening, it can put you at risk for having a stroke. In some people, it can cause the heart to become weaker over time if the fast heart rate isn't managed.

Your symptoms may or may not be related to having AF. They may be related to therapies used to manage AF. That's why it's important to tell your doctor or healthcare provider if what was recommended before isn't working now.

Knowing you have a heart condition can be scary at first. You may have some emotional ups and downs. Learning how to recognize and respond to episodes of AF can help you cope. Also, the more you know about your condition, the less anxious or afraid you'll be. This helps you maintain a good quality of life.

While the goal of managing AF is to decrease the symptoms and their effects to improve your quality of life, there's no "one size fits all" treatment. Everyone's experience—symptoms, causes, triggers, risk factors, and how they respond to managing AF—is different. Your management plan will be what works best for you.

Most people need medicine to control their heart rate, restore regular (sinus) rhythm, or both. Non-drug treatments or procedures (like [ablation](#) or [cardioversion](#)) may also be used to restore and/or maintain regular rhythm. Other medicine is needed to prevent stroke. Read [Module 2: Managing AF](#), to learn more.

You may need to try several different kinds of medicine to control your heart rate or restore sinus rhythm. Also, if you have side effects from a medicine, if your health changes, or if the arrhythmia isn't controlled, your drug management plan may change over time.



Many side effects get better or go away as your body gets used to the medicine. One example is when you take a beta blocker—you may feel very tired for a few weeks. You may need to decide which is easier to tolerate: your AF symptoms or the minor side effects of the medicine. You and your doctor can talk about what's best for you.

It's important to keep doing your usual activities, including exercising every day. Sometimes you may have to move more slowly or not exercise for as long, but always try to stay active. Talk to your healthcare provider about the type of exercise that's best for you.

The rest of this module is about making helpful lifestyle changes, understanding common emotional and physical responses, and knowing how and when to find more information or ask for help.

At the end of this module, you can read about other people's experience with AF. Reading these stories and their tips may help you.



# FOLLOWING A **HEALTHY LIFESTYLE**

## RECOGNIZING RISK FACTORS

There are other risk factors for AF that can be changed (modified). Some of these risk factors include:

### **SLEEP APNEA**

This is a breathing problem that interrupts your sleep.

Symptoms include:

- snoring and have pauses in your breathing while sleeping
- feeling sleepy during the day, but you don't know why
- feeling tired
- not able to concentrate

If you have any of these symptoms, your doctor may order a sleep test to learn if you have sleep apnea. Treating sleep apnea is important as it reduces the number of AF episodes. The sleep doctor will talk with you about your different treatment choices.

### **DRINKING TOO MUCH ALCOHOL**

Drinking too much alcohol causes more episodes of AF.

The best way to know how much alcohol you can drink is to know the [low-risk drinking guidelines](#):

- Women: no more than 2 drinks a day and 10 drinks a week.
- Men: no more than 3 drinks a day and 15 drinks a week.

Read more about common causes of AF in [Module 1: Understanding Atrial Fibrillation](#)

## **RECOGNIZING TRIGGERS**

We don't always know what causes AF. For some people, episodes come on unexpectedly and unpredictably. Others may find that certain events or behaviours may cause episodes. These are called triggers. These triggers **aren't** a direct cause of AF. For some people, avoiding triggers can help decrease episodes of AF.

Read more about recognizing triggers of [AF in Module 1: Understanding Atrial Fibrillation](#).

## **LIFESTYLE CHANGES**

Healthy lifestyle choices and habits help people manage their AF and feel better overall.

High blood pressure can make a person prone to AF and other heart-related problems.



## CHECK YOUR BLOOD PRESSURE REGULARLY

Blood pressure is the force put on the walls of arteries by circulating blood. It's expressed with two numbers. The top number is the pressure created when the heart contracts and pumps out blood (systolic pressure). The bottom number is the blood pressure created when the heart relaxes and refills with blood (diastolic pressure). The higher the blood pressure and the longer it has been high, the more likely it is that the heart and blood vessels have been damaged.

Normal blood pressure is between 120/80 mm Hg and 129/84 mm Hg. Blood pressure that is always more than 140/90 mm Hg when measured in the doctor's office or 135/85 mmHg when measured at home is considered high. People with diabetes should have blood pressure lower than 130/80 mmHg.

More than 60% of people with AF have high blood pressure (hypertension). High blood pressure also increases the risk of AF by making the heart work harder. So keeping your blood pressure under control is an important step to better control of your AF. Reducing blood pressure also lowers your risk for other heart diseases. High blood pressure is controlled with diet, exercise, and medicine.

Your healthcare provider will check your blood pressure at every visit. You may also be asked to monitor your blood pressure at home. If you have a home monitor, make sure you take it to your healthcare provider once a year as it needs to be calibrated (adjusted) to make sure it is still accurate.

Hypertension Canada ([hypertension.ca](http://hypertension.ca)) has lots of information about causes and treatment of high blood pressure.



## **STOP SMOKING**

Smoking increases the risk of AF, as well as the risk for heart disease and stroke. Nicotine in cigarettes causes plaque to build up in arteries, making it harder for the heart to pump blood. Nicotine also lowers oxygen levels in the blood.

If you are thinking about quitting, your healthcare provider can suggest ways to help you stop smoking, safely, and successfully.

These resources may also be helpful:

- The Canadian Cancer Society's Smokers' Helpline website ([smokerhelpline.ca](http://smokerhelpline.ca)) and toll-free at 1-877-513-5333
- Health Canada's toll-free quit line at 1-866-366-3667 and [website](#) with more provincial or territory information, or read the [On the Road to Quitting](#) guide.
- Heart and Stroke Foundation's [Smoking](#) information



## EAT WELL

A balanced and healthy diet helps improve your general well-being and helps you stay at a healthy body weight. To reduce your risk of heart disease and help manage AF, your diet should be low in saturated fat, trans fat, cholesterol, and salt. It should include a variety of whole grains, fruits, and vegetables.

**Losing weight if you're overweight helps manage AF.** If you need help to eat well, you can ask your healthcare provider to refer you to a dietitian.

These resources may also be helpful:

[Eating Well with Canada's Food Guide](#)

[Heart and Stroke Foundation: Healthy Eating](#)

[Health Canada: Food and Nutrition](#)

[EatRightOntario](#)

## BE ACTIVE

Sometimes people feel they can't exercise during AF because they don't feel well, are afraid, or feel frustrated because they can't reach their target heart rate. As long as you are feeling well, you can still exercise. Remember that if you are on heart slowing medicines, you won't be able to reach your target heart rate. If you are worried about exercising because you have AF, speak with your healthcare provider.

Regular exercise helps you stay at a healthy weight, reduces your risk for AF and other conditions (like heart disease and diabetes), and sleep apnea. Regular exercise can also make you feel better because it gives you more energy, makes you feel better about yourself, and reduces stress.

A regular exercise routine is as important as medicine when you have AF. For most health benefits, try to get at least 2½ hours (150 minutes) of moderate physical activity every week (like walking or walking fast). If you're in a wheelchair or can't walk for other reasons, other types of exercise can be suggested. Ask your healthcare provider what activities are best for you.

Here are some guidelines that can help you get started:

- **Set a goal** (for example, to exercise 2½ hours spread over a week).
- **Make a plan** (for example, to walk for 30 minutes, 5 days a week).
- **Pick a time and place** (for example, morning, or evening, around the neighbourhood or at a track).

### **Remember—every step counts!**

Health Canada and the Canadian Physical Activity Guidelines offer other tips to help you get and stay active:

- **Choose a variety of physical activities you enjoy.** Try different activities until you find the ones that feel right for you. Take up a sport you used to enjoy, or try a new activity such as urban trekking or nature hikes.
- **Get into a routine.** Go to the pool, join a dance class, set a regular walk or run (mall walking is popular in winter months). Make it social by having someone join you. Try training for a walk or run for charity. Offer to walk a neighbour's dog if you don't have a dog. Rake your lawn and offer to do the same for a friend.

- **Join a team.** Take part in group sports and recreation activities.
- **Spend less time watching TV or sitting in front of a computer.**
- **Just get moving.** Whenever you can, walk, run, or bicycle instead of taking the car. Use a pedometer and do 10,000 steps every day.
- **Spread your activity throughout the week.** Do at least 10 minutes of moderate physical activity at a time.

You may find these resources helpful:

[Canadian physical activity guidelines](#)

[Health Canada: Physical Activity](#)

[YMCA Canada exercise programs](#)

[YWCA Canada](#)

## **TAKE YOUR MEDICINE AS PRESCRIBED**

Taking the medicine that your healthcare provider prescribes is an important part of living well with AF and managing your overall health. Herbal or complementary medicines may interfere with some of the medicine that you take because of your AF. It's important to tell your healthcare team about all the products you take, such as vitamins, herbal remedies, and supplements.

Don't start or stop taking any medicine without speaking to your healthcare provider or pharmacist first.

The new blood thinner pills (anticoagulants) have a shorter half-life than warfarin. This means that the medicine is out of your body 24 hours after you take it. This is why it's important to take your blood thinner on a schedule. One way to do this is to make sure to order your refill before you run out.

Whether you take a rate-control or rhythm-control medicine, it's important to remember that you may still have episodes of AF. The goal of managing your AF is to reduce symptoms as much as possible so that you can do your everyday activities, including exercise.

All medicine can cause side effects. If your medicine is causing problems that bother you or you don't think are managing your symptoms, speak with your healthcare provider or pharmacist.



# UNDERSTANDING COMMON RESPONSES AND **FINDING SUPPORT**

AF and other health problems are disruptive and annoying because they may cause physical symptoms and limit your everyday activities. Even managing an illness can sometimes cause problems. For example, you may need regular tests or treatments, take medicine according to a schedule, change your diet, or have to make other adjustments.

As you learn to live with AF, you may go through many feelings and emotions. By working closely with your AF healthcare team and learning how to manage your AF, you can reduce the effect of AF on your life and improve your overall health. For example, know your triggers, have a plan to manage your symptoms, and know that it's okay to feel emotions like fear or a low mood.

## **COMMON RESPONSES**

It's normal to have questions about why you have AF, or ask "Why me?" Other questions someone living with AF may have include:

- "Aren't I too young to have a heart problem?"
- "Is this genetic? Will I give this to my kids?"
- "What should I do if I have an episode while I'm on vacation/at work/looking after my grandchildren/alone?"
- "Won't exercise put too much strain on my heart?"

It can be frustrating to feel that your questions aren't being answered. Always feel free to speak with your healthcare team if you have questions or concerns. Keep asking until you understand.

## ADDRESS THE STRESS

Everyone has some stress from life's challenges. But too much stress can make you feel poorly—it may even trigger AF. Stress can also make it harder to manage your AF (for example, if it causes you to miss a medical appointment or not exercise).

If you feel overwhelmed, anxious, or stressed, speak with your doctor or other healthcare provider. Some people may find they feel better after speaking with a psychologist, social worker, or psychiatrist.

Some signs of stress include:

- feeling low or depressed
- feeling worried or anxious
- feeling frustrated, irritable, or angry
- feeling like something bad is going to happen
- wanting to be alone
- heart palpitations
- headaches
- stomachache/heartburn
- shaking



You might find the web resource [Positive coping with health conditions](#) helpful.

## **STRESS AND ANXIETY**

While it's not surprising that someone with AF might become worried or tense, some people spend a lot of time worrying about "what ifs" or expect that the worst is going to happen.

Worry and tension might be a problem if:

- you worry much of the time—even when you're trying to do things you enjoy
- you often feel nervous or even panicky
- you always feel like something bad is going to happen
- you feel tense, restless, have a headache, or feel sick to your stomach (nausea) and it's not being caused by your health condition or medicine you take (it can be hard to figure this out—talk with your healthcare provider)

Even though it may feel as though always thinking about your AF or other health issue is a way to work through them, always worrying about them isn't the way to solve problems. There are three reasons why:

1. Worry usually just goes in circles and doesn't get you closer to a solution.
2. Worry often happens when you're trying to do something else, like watch a movie with family or friends. It stops you from enjoying the moment.
3. If you feel very tense, you won't be thinking clearly. It's hard to concentrate when you're tense.



## HAVE A PLAN TO MANAGE YOUR WORRIES

Understand the reasons you have stress and/or anxiety and have a plan for managing them. Looking at your stress and problems in an organized way can help you reduce and manage them. That is why learning to manage stress symptoms is an important part of managing your AF.

The most useful skills for dealing with worry and tension are:

- relaxation (learning how to let go of tension, for example by breathing slowly and regularly)
- managing worry (know what makes you anxious and think realistically)
- solving problems (coming up with an action plan that deals with the “what-ifs”)

Below are other self-care strategies that can help you deal with your anxiety about AF:

- **Accept** that you have a new health challenge and that you will need new strategies to deal with it.
- **Remember** that AF is not life-threatening and that it can be well managed. Your healthcare provider has already talked to you about some of your options and/or has prescribed medicine that is best for you.

- **Be aware of how other people affect you.** Other people’s emotions and reactions can influence your own. Recognize those who help you stay calm and those who may make you more anxious.
- **Give yourself a “worry period”.** Give yourself a short period of time each day—say, 15 or 20 minutes—to focus on your concerns and develop solid ways to address them. Once the time is up, it’s time to stop worrying and focus on a new task or activity. During the worry period:
  - If you are worried about something, ask yourself if the problem can be solved. Is there anything you can do about it right now? If not, leave it until you can do something about it.
  - Accept uncertainty. It can be challenging to accept that you may not be able to control your AF. Acknowledging this can help you deal with anxiety.
  - Challenge your anxious thoughts to help you take control.

## RECOGNIZE DEPRESSION

Like stress, symptoms of low mood or depression can be common in people living with AF. Low mood and depression can lower your quality of life.

Some common signs are the same as stress. They include:

- changes in your sleep: you sleep more or less than is normal for you
- being less active: you don't feel like doing things that you normally enjoy
- a change in your appetite: you eat more or less than normal so that you either gain weight or lose it
- trouble concentrating: it becomes hard to focus on a task
- changes in your behaviour: you may get angry quickly or be irritable
- feeling guilty
- having less energy
- feeling more tense or anxious

Talk to your healthcare provider if you feel any of these signs for longer than 2 weeks. Depression can and should be treated.

(If you ever have thoughts of harming yourself or thoughts of suicide, talk to your healthcare provider or go to the nearest emergency room.)



## WHEN AND WHERE TO FIND SUPPORT OR MEDICAL HELP

It can be a challenge to know when you need medical help or other support. If any part of your treatment for AF worries you, or if anxiety or other feelings about your health become too much or affect your life, get help. Often, a close family member will be the first one to recognize a change in your moods, emotions, or reactions.

You can get medical help in different ways. Start with your family doctor or healthcare provider. If you think you need help, ask if there is an anxiety or low mood clinic you can be referred to.

The important thing to remember is there are many people you can ask for help and places you can go to help you learn as much as you need to about AF and your health. This can help you feel confident and secure about your AF and managing it.

As you have learned reading these modules, some important things to remember are:

- knowing what to do when you have an episode of AF
- when you should go to a hospital emergency room
- how to recognize symptoms of stress, anxiety, and depression

Read more about what to do and when to go to a hospital emergency room in [Module 2: Managing AF](#).



# PATIENT **STORIES**

You can also watch video stories of people (not actors) living with AF and other heart diseases at [heartandstroke.ca/videostories](http://heartandstroke.ca/videostories).



## **MARY**

Mary is 78 years old. In the past, she noticed “skipped” heartbeats, but they never bothered her enough for her to go see her doctor. About 6 months ago, while she was cleaning up after a dinner party, she felt a strong fluttering in her chest. She sat down to rest but the feeling got worse. She started to feel like her heart was pounding hard, as if there were horses galloping in her chest. She took some deep, slow breaths but the strong pounding didn’t go away. Mary decided to ignore the pounding and finish tidying up. But as soon as she stood up, she started to feel light-headed and unwell. She had to lie down. Then, as quickly as it started, the pounding in her chest stopped. It happened again a week later while Mary was at the grocery store. Because she couldn’t lie down, was feeling short of breath, and a bit panicked, Mary asked a store clerk to call an ambulance. The doctor in the emergency

department ordered tests, including an electrocardiogram, chest x-rays, and blood tests.

A nurse told her that her heart was beating at about 150 beats per minute, far above her normal heart rate. The emergency department doctor gave her medicine through an IV to slow her heart to a normal rate. Mary was shocked to learn she had heart disease. She had never heard of AF, which was what was causing her to feel like her heart was pounding.

Mary went on to learn a lot about AF and her health. She had always been pretty healthy and rarely saw a doctor. In hospital, she learned that she had high blood pressure. At first, she thought it meant that she was “hyper” and “tense”, but a nurse explained that it actually meant that there was high tension or pressure in her arteries.

The nurse said that although maybe feeling tired after her party or the stress she had felt getting food ready, played a role in triggering the episode, the cause of her AF was likely caused by many years of having high blood pressure.

Mary started taking medicine to lower her blood pressure, slow her heart rate, and ease the symptoms of AF. Her doctor also prescribed a blood thinner to reduce her risk of stroke. She explained to Mary that when people have AF, blood can pool in the left atrium and form small clots. These small clots can break away and travel to the brain. Mary was not happy taking the blood thinner—it seemed to her that it took a lot of time to get it to the right level.

She had to go for a lot of blood tests and her dose kept changing as her doctor worked to get the right level of the blood thinner in her body. She was also warned to be careful not to get bumps or bruises because the blood thinner would cause her to bleed easily. But after talking to her daughter and her pharmacist and weighing the risks and benefits, Mary decided to follow her doctor's advice and keep taking the blood thinner. She didn't want to take the chance of having a stroke if she could help prevent one.

Although she takes medicine for AF, there are still times when Mary feels her heart skip a beat. Now that she knows the cause and takes the right medicine, she finds that not only doesn't it bother her; it doesn't stop her from doing her favourite activities.

Understanding that she has AF and high blood pressure, learning the signs of a stroke, taking new medicine, and making lifestyle changes to lower her blood pressure have all been big changes for Mary. In fact, it's been a bumpy road. But things are settling. Now, she has a new routine, sees her family doctor regularly, and is determined to avoid another trip to the hospital.



## JAMES

James remembers that his heart palpitations started 10 years ago, when he was just 43. His heart would pound very fast for a few beats or a few minutes, and then would just stop on its own. “I could feel my pulse racing, especially when I was lying on my left side,” describes James. “I started having more episodes and they were lasting longer. They also started to wake me up at night.”

At first, he decided not to worry about it. But as time went on, the pounding and fast heartbeat became stronger and lasted longer—from a few hours to sometimes a day or two. He was also feeling more tired, short of breath, and sometimes dizzy when he got up too fast after sitting. He decided to see his family doctor. After he had an electrocardiogram (ECG), James wore a test device called a Holter monitor which recorded his heart rhythm for 24 hours. His doctor referred him to a cardiologist.

James was diagnosed with AF. He started taking medicine to reduce his symptoms and his risk of stroke. He tried three different types of medicine to keep his heart rhythm normal, but none of them seemed to work. James was

still having episodes a couple of times a week. As time went on, he became more bothered and frustrated by the pounding in his chest and shortness of breath. He was often tired, and no longer had the energy to play golf or go for a walk in the woods, things he loved to do. He felt “down” because he knew that staying active would help his heart. At times, when the pounding came on, he also felt anxious and scared. His family was concerned about his worsening health and his low mood.

James met with his heart doctor (cardiologist). She suggested it was time to think about a more invasive strategy to manage his AF. She recommended a pulmonary vein catheter ablation. The cardiologist warned James that unfortunately, as is the case with medicine, ablation might not stop the AF altogether. But ideally, he would have fewer episodes. After talking about risks and the benefits, James decided to have an ablation.

On the day of the procedure, James was admitted to an outpatient cardiology area of the hospital. The Electrophysiology Lab looked a bit like an operating room. It had lots of equipment. There was also a large camera that

would be positioned over his chest during the procedure. The nurses and doctors wore hats and masks. He was asleep during most of the procedure so didn't remember it when he woke up. He told his wife that he didn't feel different or sore. He was able to eat and walk around that very same evening. He stayed overnight in the hospital.

At a follow-up visit, James reported that he was no longer waking up at night with symptoms of AF. His energy was coming back and he had started golfing and walking with his wife again. Although he knew his AF wasn't cured, he knew he had made the right choice.

James will take a blood thinner, likely for the rest of his life, because his AF could come back. His cardiologist told him that if this happens, he may not feel it or he may have more subtle symptoms than he did before his ablation. She also said that he may eventually have to start taking AF medicine again. In the meantime, he is learning to live well with AF. He is getting back to an active lifestyle, eating well, limiting caffeine and alcohol, and trying to manage stress better.



## **TONY**

At age 59, Tony was an avid cyclist and fitness buff. Unfortunately, a biking accident changed everything for him. He fell over his bike's handlebars and landed hard on the pavement. In the hospital emergency department, Tony had a CT scan to make sure there was no bleeding or swelling in his head. He found out some shocking news. The CT showed that the bike accident had not caused any injury but it did show that he had once had a stroke on the left side of his brain.

Tony didn't understand. When and how could it have happened without his knowing? Although the neurologist wanted to keep Tony in the hospital to do more tests, Tony felt overwhelmed and wanted to go home. The neurologist agreed to arrange for the tests to be done over the next few days so that Tony could see him in his office the following week. Based on the results of blood tests already done in the hospital, Tony was advised to start taking aspirin and a medicine to lower his cholesterol.

Tony had never seen so many doctors or spent any time in hospital before his bike accident. First, he had a carotid Doppler, a test that looks at the blood flow in the arteries

supplying his brain. He also had another CT scan of his head. On another day, he was fitted with a Holter monitor that he had to wear for 24 hours.

When he visited the neurologist, there was yet another surprise. The heart monitor showed 3 hours of an irregular and disorganized heart rhythm. The neurologist suspected that his earlier stroke was caused by this AF. He explained that during AF, the blood in the atrium or top chamber of the heart isn't pumped out as well and can thicken and form a clot. If the clot loosens and travels to the brain, it can get stuck and block blood flow to the brain.

Since it was clear that Tony had already had one stroke, his risk for having another stroke was high. To reduce the risk, the doctor recommended that Tony take another blood-thinning medicine with the aspirin. Tony was frustrated and confused. He had had no symptoms of illness, just an accident, and was now being told he needed to take several types of medicine.

The neurologist explained that the aspirin would probably not be enough to reduce Tony's risk for stroke. He talked about the risks and benefits of each therapy he could use. Tony felt that because he was prone to nosebleeds, he

didn't want to take anything that could make this problem worse, and decided to take only aspirin.

Over the next year, Tony stayed healthy and continued his cycling. One morning, while he was getting ready for a ride, he noticed that his right hand felt numb and he couldn't button his shirt or pick up his toothbrush. He also found it hard to put his pants on because his right leg was weak. Tony was scared and called 911.

Tests showed that Tony had had another stroke. After a week in hospital, Tony was transferred to a rehabilitation unit to work on getting back the strength in his right side.

Working hard every day to regain his strength and physical abilities, Tony is back at work, and is exercising again. He is doing his best to lower his risk of another stroke (by taking blood thinners) and controlling his AF.

### **FACT SHEET: TIPS: DURING YOUR CLINIC OR DOCTOR VISIT**

### **FACT SHEET: IMPORTANT POINTS TO REMEMBER: HOW TO LIVE WELL WITH AF**

## DISCLAIMER (CCS)

This educational material was developed by Canadian atrial fibrillation experts through consideration of medical literature and clinical experience. These modules provide reasonable and practical information for patients and their families and can be subject to change as medical knowledge and as practice patterns evolve. They are not intended to be a substitute for clinical care or consultation with a physician.

## DISCLAIMER (HSF)

This publication **Your Complete Guide to Atrial Fibrillation** is for informational purposes only and is not intended to be considered or relied upon as medical advice or a substitute for medical advice, a medical diagnosis or treatment from a physician or qualified healthcare professional. You are responsible for obtaining appropriate medical advice from a physician or other qualified healthcare professional prior to acting upon any information available through this publication.

## REFERENCES - MODULE 3

Atrial Fibrillation: A Patient Handbook #607577 (2010/02) Alberta Health Services

St. Michael's Hospital (2010). A Patient's Guide to Living with Atrial Fibrillation. Form # 70448.

American Heart Association (2011). Prevention strategies for AF. Retrieved on October 10, 2011 from: [www.heart.org/HEARTORG/Conditions/Arrhythmia/AboutArrhythmia/Prevention-Strategies-for-AF\\_UCM\\_423784\\_Article.jsp](http://www.heart.org/HEARTORG/Conditions/Arrhythmia/AboutArrhythmia/Prevention-Strategies-for-AF_UCM_423784_Article.jsp)

Heart and Stroke Foundation (2011a). High blood pressure. Retrieved on October 10, 2011 from: [www.heartandstroke.com/site/c.iklQLcMWJtE/b.3484023/k.2174/Heart\\_disease\\_High\\_blood\\_pressure.htm](http://www.heartandstroke.com/site/c.iklQLcMWJtE/b.3484023/k.2174/Heart_disease_High_blood_pressure.htm)

Heart and Stroke Foundation (2011b). Smoking, heart disease, and stroke. Retrieved on October 10, 2011 from: [www.heartandstroke.com/site/?c=iklQLcMWJtE&b=3484037&src=home](http://www.heartandstroke.com/site/?c=iklQLcMWJtE&b=3484037&src=home)

Heart and Stroke Foundation (2011c). Basic principles of physical activity. Retrieved on October 10, 2011 from: [www.heartandstroke.com/site/c.iklQLcMWJtE/b.3484253/k.4FE0/Healthy\\_living\\_Physical\\_Activity.htm](http://www.heartandstroke.com/site/c.iklQLcMWJtE/b.3484253/k.4FE0/Healthy_living_Physical_Activity.htm)

Hypertension Canada (2011). *What is hypertension?* Retrieved on November 12, 2011 from: [www.hypertension.ca/en/what-is-hypertension](http://www.hypertension.ca/en/what-is-hypertension)

Bilsker D, Samra J, Goldner E. (2009). *Positive coping with health conditions*. Retrieved on October 11, 2011 from: [www.comh.ca/selfcare](http://www.comh.ca/selfcare)

National Heart Lung and Blood Institute. (2011). *Living with Atrial Fibrillation*. Retrieved on October 10, 2011 from: [www.nhlbi.nih.gov/health/healthtopics/topics/af/livingwith.html](http://www.nhlbi.nih.gov/health/healthtopics/topics/af/livingwith.html)

# GLOSSARY

**Ablation** – A procedure in which a small portion of heart tissue is destroyed using heat ([radiofrequency ablation](#)) or freezing ([cryoablation](#)) to control abnormal heart rhythms.

**Anesthesia** – Medicine given through an [intravenous](#) (IV). It may be given to make a person feel sleepy or to sleep during a procedure or surgery (for example: during electrical cardioversion).

**Anti-arrhythmic medicine** – Drugs used to keep the heart beat in a normal sinus rhythm.

**Anti-coagulant medicine** – Drugs used to make the blood less likely to clot. Also called blood thinners.

**Anti-platelet medicine** – Drugs used to thin the blood. These aren't as strong as anti-coagulants (blood thinners).

**Arrhythmia** – An abnormal heart rhythm or irregular heart beat.

**Asymptomatic** – Having no symptoms or signs of an illness or disease.

**Atria** – The two upper chambers of the heart (right atrium and left atrium) that receive and collect blood before filling the lower chambers (ventricles).

**Atrial fibrillation** – An arrhythmia caused by very fast, chaotic/disorganized electrical activity in the atria.

**Atrial flutter** – An arrhythmia caused by very fast, organized electrical activity in the atria.

**Atrial remodelling** – Structural changes in the atria caused by disease or aging.

**Atrioventricular (AV) node** – Part of the heart's electrical conduction system; it co-ordinates electrical signals between the atria and ventricles.

**Atypical atrial flutter** – Atrial flutter in which an organized electrical impulse circulates around parts of the atria other than the circuit of typical atrial flutter. The circuit of atypical flutter is usually in the left atrium.

**Blanking period** – The period after ablation, usually 3 months, when a person may have an episode of AF. This may be due to the procedure itself rather than meaning that the procedure didn't work. If AF happens after the blanking period, then the procedure may have to be done again.

**Blister pack** – An organizing system designed to help someone to remember to take their medicine. Ask your pharmacist about blister packs.

**Cardiac electrophysiologist** – A doctor who treats problems with the heart's electrical system.

**Cardiac tamponade** – Bleeding into the sac that surrounds the heart (pericardium). The bleeding compresses/squeezes the heart, which can cause a sudden drop in blood pressure. It is treated by draining fluid.

**Cardiomyopathy** – Condition where the heart muscle enlarges and/or becomes weaker.

**Cardioversion** – A way to make the heart switch from an abnormal to a normal rhythm, either by using medicine (chemical cardioversion) or [electrical cardioversion](#).

**Cardiovascular system** – Also called the circulatory system. It includes the heart and blood vessels of the body. It carries blood, oxygen, and nutrients to the organs and tissues of the body. It also carries the waste and carbon dioxide from these tissues for the body to remove.

**Carotid doppler** – An ultrasound to view the carotid arteries in the neck.

**Catheter** – A flexible wire with electrodes used to measure electrical impulses in the heart. Some catheters also deliver therapy, as in ablation.

**Computerized tomography (CT) scan** – Also called a CAT scan. It's a very detailed type of x-ray.

**Congestive heart failure (CHF)** – A condition in which the heart can't supply the body with the blood it needs because the ventricles are either too large or weak. It causes fluid to build up in the lungs and/or other tissues.

**Contraction** – Squeezing action of the atria or ventricles.

**CHADS<sub>2</sub>** – A scoring tool used to learn a person's risk of having a stroke.

**Circulation** – The normal flow of blood through the body's blood vessels and organs.

**Conscious sedation** – Medicine given by IV; the person is not fully "asleep" but may not remember everything about the procedure.

**CT angiogram** – A CT image of parts of the circulatory system.

**Cryoablation** – A procedure in which a small portion of heart tissue is destroyed using freezing.

**Dosette** – Like a blister pack but the pills are placed in a window that can be opened for each day of the week, rather than "punched" out. Ask your pharmacist about dosettes.

**Electrical cardioversion** – A way to make the heart switch from an abnormal to a normal rhythm using a machine called a defibrillator.

**Electrical conduction system** – The electrical "wiring" or pathways through which impulses or signals travel through the heart.

**Electrical impulses** – The electrical energy created by specialized pacemaker cells within the heart that follows a pathway from the atria to the ventricles.

**Electrocardiogram (ECG or EKG)** – The recording of the electrical activity of the heart.

**Electrodes** – Sticky discs that are placed on the chest. They pick up the heart's electrical signals during an ECG, Holter monitor, or Event recorder. The metal contacts on the catheters placed in the heart during an electrophysiology study and ablation are also called electrodes.

**Electrophysiology lab** – A hospital room or area set up to do ablations and other procedures related to the heart's electrical system.

**Electrophysiology studies** – A procedure where one or more wires (catheters) are passed through the blood vessels and into the heart to record the electrical signals. The studies can help the doctor learn the cause of abnormal heart rhythms. It is one of the tests that can decide if an ablation is needed.

**Esophagus** (food pipe) – The tube food travels down after it is swallowed. It is directly behind the heart.

**General anesthesia** – Medicine that causes a person to sleep. It can be given into a vein or can be breathed into the lungs.

**HAS-BLED** – A scoring system to estimate a person's risk of bleeding (for example: if they are to take a blood thinner).

**Heart failure** – A condition in which the heart can't supply the body with the blood it needs because the ventricles are either too large or weak.

**Heart rate** – The speed the heart beats. It is measured in beats per minute (bpm).

**Holter monitor** – A portable device that records the heart's electrical activity. The test is usually done at home over 24 to 48 hours. Electrodes are placed on the chest and connected to a recorder worn on a belt. The person will carry on with their usual daily activities.

**Hypertension** – High blood pressure.

**International Normalized Ratio (INR)** – A blood test to check how well the blood clots when taking some types of blood thinners (like warfarin).

**Intravenous** – Into the vein.

**Local anesthesia** – Medicine given to freeze (numb) a specific area of the body.

**Lone or Primary atrial fibrillation** – AF without underlying heart disease or for which the cause is unknown. It's more common in younger people.

**Magnetic resonance imaging (MRI)** – A machine that creates detailed images of the body's tissues using magnetic impulses rather than x-rays.

**Natural pacemaker** – The SA node, found in the top right atrium (see sinoatrial node).

**Oral anti-coagulant** – A medicine taken by mouth that prevents clots from forming in the blood.

**Palpitations** – The awareness or sensation that the heart is beating irregularly and/or too fast.

**Pericarditis** – Inflammation of the sac surrounding the heart. It causes chest pain.

**Permanent pacemaker (artificial)** – A small device that is implanted under the skin of the chest. Up to 3 wires are placed in different chambers of the heart to prevent pauses and/or control abnormal heart rhythms. This device uses electrical pulses to stimulate the heart to beat at a normal rate.

**Phrenic nerve** – The nerve that controls the muscle for breathing (diaphragm).

**Pill-in-the pocket** – A rhythm control treatment plan that can be used for people that don't have many AF episodes. It includes medicine to control the heart rate and rhythm.

**Pulmonary veins** – Vessels that carry oxygenated blood from the lungs to the left atrium. It is also the site where AF often starts.

**Pulmonary vein stenosis** – A narrowing or blockage in one of the veins that drains blood from the lungs into the heart. It can cause shortness of breath.

**Radiofrequency ablation** – A procedure in which a small portion of heart tissue is destroyed using heat

**Remodeling** – Changes in structure or electrical properties of the chambers of the heart

**Rhythm** – The pattern of the heart beat.

**Sinoatrial (SA) node** – The body's natural pacemaker. Found where the superior vena cava and right atrium meet. It creates the first of the electrical signals that make the heart beat.

**Sinus rhythm** – A normal, steady heart beat, usually between 60 and 90 beats per minute.

**Sleep apnea** – When the throat muscles relax and block the airway during sleep (obstructive sleep apnea). It sometimes can happen because of a "glitch" in the nervous system that regulates sleep (central sleep apnea). It leads to pauses in breathing and low blood oxygen levels during sleep.

**Stroke** – Sometimes called a "brain attack". Ischemic stroke is caused by a blood clot blocking a blood vessel to the brain. Hemorrhagic stroke is caused by bleeding into the brain tissue

**Subcutaneous** – Under the skin.

**Symptoms** – Usually unpleasant feelings caused by an illness, disease, or a condition.

**Tachycardia-induced cardiomyopathy** – A type of weakening of the heart muscle caused by long periods of a fast heart rate (usually weeks or months).

**Transeptal puncture** – A procedure where a long, thin hollow tube is passed from the right atrium into the left atrium. The needle is used to make a hole in the thin wall (septum) separating these chambers. This allows access to the left atrium if an ablation is being done there.

**Transient ischemic attack (TIA)** – Sometimes called a mini-stroke or stroke warning. It's a short interruption of blood flow to the brain, causing temporary, stroke-like symptoms that don't last longer than 24 hours.

**Typical atrial flutter** – An arrhythmia in which an organized electrical impulse circulates in the right atrium, around the tricuspid valve.

**Valves** – Structures in the heart that separate the atria from the ventricles. They open and close, allowing blood to flow through in one direction. The four valves of the heart are the tricuspid, mitral, pulmonary, and aortic valves.

**Ventricles** – The two (right and left side) lower chambers of the heart. They pump blood to the lungs and around the body.

**Ventricular rate** – The speed at which the bottom chambers of the heart contract.

# SUMMARY OF CONTRIBUTORS:

Nationwide AF Patient Education Initiative January 2011 – Present

## MODULE 1 – UNDERSTANDING ATRIAL FIBRILLATION

Lead: Jennifer Cruz (Nurse Practitioner, AF Clinic - St. Michael's Hospital, Toronto, ON)

### CONTENT CONTRIBUTORS

Pamela Colley, Vancouver General Hospital, Vancouver, BC, Nurse Practitioner  
Nancy Marco, University Health Network - TGH, Toronto, ON, Nurse Practitioner  
Kandice Schroeder, Foothills Medical Centre, Calgary, AB, Nurse Clinician  
Suzette Turner, Sunnybrook Hospital, Toronto, ON, Nurse Practitioner

### REVIEWERS

Kristen Redman, St. Paul's Hospital, Vancouver, BC, Patient Educator  
Marcie Smigorowsky, Mazankowski Alberta Heart Institute, Edmonton, AB, Nurse Practitioner  
Shadab Rana, Heart and Stroke Foundation, Toronto, ON, Senior Specialist, MD, MPH

## MODULE 2 – MANAGING ATRIAL FIBRILLATION

Lead: Laurie Burland (Nurse Clinician, AF Clinic - Foothills Medical Centre, Calgary, AB)

### CONTENT CONTRIBUTORS

Maria Anwar, Foothills Medical Centre, Calgary, AB, Pharmacist  
Cathy Bentley, London Health Sciences, London, ON, Clinical Research Coordinator  
Andrea Cole-Haskayne, Foothills Medical Centre, Calgary, AB, Nurse Clinician  
Heather Kertland, St. Michael's Hospital, Toronto, ON, Pharmacist  
Serena Kutcher, St. Paul's Hospital, Vancouver, BC, Patient Educator  
Jenny MacGillivray, Vancouver General Hospital, Vancouver, BC, Pharmacist  
Andrew Mardell, Foothills Medical Centre, Calgary, AB, Electrophysiology lab & AF Clinic Supervisor  
Nancy Newcommon, Foothills Medical Centre, Calgary, AB, Nurse Practitioner  
Tricia Reid, Mazankowski Alberta Hospital, Edmonton, AB, Registered Nurse  
Lindsey Ward, Royal Jubilee Hospital, Victoria, BC, Registered Nurse

### REVIEWERS

Harold Braun, Foothills Medical Centre, Calgary, AB, Nurse Clinician  
Tammy Bungard, University of Alberta Hospital, Edmonton, AB, Director, Anticoagulation Management Services  
Petra Dorrestijn, Foothills Medical Centre, Calgary, AB, Nurse Clinician  
Sharlene Hammond, Kingston General Hospital, Kingston, ON, Research Coordinator & Manager  
Leanne Kwan, Royal Columbian Hospital, New Westminster, BC, Pharmacist  
Margaret Sidsworth, Vancouver General Hospital, Vancouver, BC, Pharmacist  
Christine Le Grand, Heart and Stroke Foundation, Ottawa, ON, Senior Knowledge Translation Specialist

## MODULE 3 - LIVING WELL WITH AF

Lead: Sandra Lauck (Clinical Nurse Specialist - St. Paul's Hospital, Vancouver, BC)

### CONTENT CONTRIBUTORS

Nancy Cameron, Royal Jubilee Hospital, Victoria, BC, Patient Educator  
Jenny Pak, University Health Network - TGH, Toronto, ON, Nurse Practitioner  
Aaron Price, Royal Jubilee Hospital, Victoria, BC, Nurse Clinician  
Erin Tang, Vancouver General Hospital, Vancouver, BC, Nurse Educator

### REVIEWERS

Cathy Bentley, London Health Sciences, London, ON, Clinical Research Coordinator  
Pamela Colley, Vancouver General Hospital, Vancouver, BC, Nurse Practitioner  
Belinda Ann Furlan, St. Paul's Hospital, Vancouver, BC, Nurse Practitioner  
Carol Laberge, Kelowna General Hospital, Kelowna, BC, Director, Cardiac Services  
Shadab Rana, Heart and Stroke Foundation, Toronto, ON, Senior Specialist, MD, MPH

## **PROVINCIAL REVIEW COORDINATORS**

Laurie Burland, Foothills Medical Centre, Calgary, AB, Nurse Clinician  
Dina Cutting, Royal Alexandra, Edmonton, AB, Registered Nurse  
Jennifer Cruz, St. Michael's Hospital, Toronto, ON, Nurse Practitioner  
Ann Fearon, Queen Elizabeth Health Services, Halifax, NS, Research Nurse  
Belinda Ann Furlan, St. Paul's Hospital, Vancouver, BC, Nurse Practitioner  
Sharlene Hammond, Kingston General Hospital, Kingston, ON, Research Coordinator & Manager  
Jenny Pak, University Health Network - TGH, Toronto, ON, Nurse Practitioner  
Kristen Redman, St. Paul's Hospital, Vancouver, BC, Patient Educator  
Johanne Veillette, Montreal Heart Institute, Montreal, QC, Clinical Programme Lead, AF  
Gillian Yates, QE II Health Sciences Centre, Halifax, NS, Nurse Practitioner

## **GRAPHIC CONSULTANTS**

Maria Anwar, Foothills Medical Centre, Calgary, AB, Pharmacist  
Margaret MacNaughton, Hamilton General Hospital, Hamilton, ON, Nurse Clinician

## **EARLY REVIEW PANEL**

Beverly Arnborg, Foothills Medical Centre, Calgary, AB, Nurse Clinician  
Laurie Burland, Foothills Medical Centre, Calgary, AB, Nurse Clinician  
Jennifer Cruz, St. Michael's Hospital, Toronto, ON, Nurse Practitioner  
Carol Galte, Fraser Health Authority, Vancouver, BC, Nurse Practitioner  
Nicole Gorman, Halifax Infirmary, Halifax, NS, Nurse Practitioner  
Heather Kertland, St. Michael's Hospital, Toronto, ON, Pharmacist  
Sandra Lauck, St. Paul's Hospital, Vancouver, BC, Clinical Nurse Specialist  
Marie- José Martin, Canadian Cardiovascular Society, Ottawa, ON, Project Manager  
Debbie Oldford, QE II Health Sciences Centre, Halifax, NS, Nurse Practitioner

## **Physician Lead**

Dr. Anne Gillis, MD, FRCPC (Dept of Cardiac Sciences, University of Calgary, Libin Cardiovascular Institute of Alberta- Foothills Medical Centre - Calgary, AB)

## **Nursing Lead**

Sandra Lauck, PhD, RN (St. Paul's Hospital – Vancouver, BC)

## **Core Team Leaders**

Laurie Burland, RN (Foothills Medical Centre – Calgary, AB)  
Jennifer Cruz, MN, NP-Adult, CCN(C) (St. Michael's Hospital – Toronto, ON)  
Dr. Paul Dorian, MD, MSc. FRCPC (Division of Cardiology, University of Toronto, St. Michael's Hospital – Toronto, ON)  
Dr. Anne Gillis, MD, FRCPC (Dept of Cardiac Sciences, University of Calgary, Libin Cardiovascular Institute of Alberta- Foothills Medical Centre - Calgary, AB)  
Dr. Charles Kerr, MD, FRCPC (St. Paul's Hospital Heart Centre, University of British Columbia – Vancouver, BC)  
Sandra Lauck, PhD, RN, (St. Paul's Hospital– Vancouver, BC)  
Dr. Allan Skanes, MD, FRCPC (Division of Cardiology, University of Western Ontario, London Health Sciences – London, ON)

## **Project Lead**

Jennifer Cruz, MN, NP-Adult, CCN(C) (St. Michael's Hospital – Toronto, ON)

## **Health Literacy and Patient Education Specialist**

Debby Crane, RN, BC (Technical Writing) Health Content Resources- Alberta Health Services

## **Content Contributors**

Dr. F. Russell Quinn, BA, MB, BCh, MRCP, PhD (Dept of Cardiac Sciences, University of Calgary, Libin Cardiovascular Institute of Alberta- Foothills Medical Centre - Calgary, AB)  
Dr. D. George Wyse, MD, PhD, FRCPC (Dept of Cardiac Sciences, University of Calgary, Libin Cardiovascular Institute of Alberta- Foothills Medical Centre - Calgary, AB)

# FACTSHEET

To learn more, see [Module 3: Living Well with Atrial Fibrillation](#)

## TIPS : DURING YOUR CLINIC OR DOCTOR VISIT

Your doctor or healthcare provider may ask you some questions to learn more about your AF. Below are some of the questions your doctor may ask. Think about the answers before your visit:

What symptoms are bothering you?

---

---

---

When did these symptoms start?

---

How often do you have episodes of AF?

---

How long do they usually last?

---

When do you notice the symptoms – at rest or during activity?

---

How do you feel when you are having the symptoms? (for example: I barely notice them, or I notice them but can keep doing what I'm doing, or I have to sit or lie down because I feel so bad)

What makes these symptoms worse?

---

What makes these symptoms better?

---

Have you had any recent illness?

---

When was your AF first diagnosed or documented by ECG or a Holter monitor test?

---

How was your AF treated? Did the treatment help improve your symptoms?

---

It's also okay to ask for a second opinion about managing your AF.

**REMEMBER TO BRING ALL THE MEDICINES YOU TAKE TO EVERY CLINIC VISIT.**

# FACTSHEET

To learn more, see [Module 3: Living Well with Atrial Fibrillation](#)

## IMPORTANT POINTS TO REMEMBER: HOW TO LIVE WELL WITH ATRIAL FIBRILLATION (AF)

While the goal of managing AF is to decrease the symptoms and their effects to improve your quality of life, there is no “one size fits all” treatment.

Most people need medicine to control their heart rate, restore regular (sinus) rhythm, or both. Non-drug treatments or procedures (like [ablation](#) or [cardioversion](#)) may also be used to restore and/or maintain regular rhythm. Other medicine is needed to prevent stroke. Read [Module 2: Managing AF](#), to learn more.

It's important to continue with your usual activities, including exercising every day. Sometimes you may have to move more slowly or not exercise for as long, but always try to stay active. Talk to your healthcare provider about the type of exercise that's best for you.

### **Try to follow a healthy lifestyle:**

- For some people, avoiding triggers can help decrease episodes of AF. Read more about recognizing triggers of AF in [Module 1: Understanding Atrial Fibrillation](#).

- Lifestyle changes - Healthy lifestyle choices and habits help people manage their AF and feel better overall.
  - Check your blood pressure regularly - Normal blood pressure is between 120/80 mm Hg and 129/84 mm Hg.
  - Stop smoking - Smoking increases the risk of AF, as well as the risk for heart disease and stroke.
  - Eat well - A balanced and healthy diet helps improve your general well-being and helps you stay at a healthy body weight.
  - Losing weight if you're overweight helps manage AF.
  - Be active.
  - Take your medicine as prescribed.

# FACTSHEET

To learn more, see [Module 3: Living Well with Atrial Fibrillation](#)

## Understanding common responses and finding support

- By working closely with your AF healthcare team and learning how to manage your AF, you can reduce the effect of AF on your life and improve your overall health.
  - It can be frustrating to feel that your questions aren't being answered. Always feel free to speak with your healthcare team if you have questions or concerns. Keep asking until you understand.
  - Know and address signs of stress, anxiety, and depression.

## When and where to find support or medical help.

- Learn when you should go to a [hospital emergency room](#).
- You can get medical help in different ways. Speak with your family doctor or healthcare provider.
- If you think you need help, ask if there is an anxiety or low mood clinic you can be referred to.