

How long should I take a particular medication for before trying another, if it is not controlling my symptoms or if it is producing side effects?

There are two major objectives in managing patients with atrial fibrillation. The priority is to minimise the risk of AF-related stroke with the second objective being improvement of quality of life. The determinants of duration of drug therapy differ dependent on the specific objective.

Regarding drugs for AF-related stroke risk these are likely to be advised in perpetuity. The exception would be if blood-thinning agents were started simply to cover a particular episode or intervention e.g. ablation or electrical cardioversion. The individual drug advised might change if a side effect is experienced or medical practice changes. There are recent examples of changing practice most strikingly the move back against aspirin in those with AF unless there is another e.g. vascular indication.

In general terms anti-thrombotic medication is well tolerated. There will of course be occasional idiosyncratic responses and even warfarin that was always considered a relatively well-tolerated drug may cause issues with non-specific lethargy/tiredness or more specific hair loss that may prompt re-consideration. Usually, however, antithrombotic medication would be commenced after proper discussion on best available advice and continued for life.

With drugs for symptoms the considerations are different. The objective is to identify a drug that suppresses symptoms without intrusive side effects and improves net quality of life. The general tactic therefore is to start the drug and assess the individual response so the question is how long should the period of observation be? With drugs like flecainide efficacy or tolerability may be obvious immediately. Alternatively, beta-blockers cause untoward usually non-specific effects at the outset that may then in some ameliorate over time. Amiodarone may take a while to work so a longer period of observation is required before deciding on a change. On occasion it's possible to alter the scheme of drug administration to improve for example, changing the time of day that the drug is taken, or even a particular scheme in terms of, say, twice a day or three times a day to maximise efficacy whilst minimising side effects. Such manoeuvres would again take time.

The key issue is that the impact of AF and the drugs used to treat it is highly individual. The doctors may be unable to define precisely which drug will suit a particular patient at the outset. Accordingly, some form of individual *experimentation* is to be expected, and this requires patience on both sides. The key thing is to make steps strategically and give sufficient time to assess responses making careful decisive moves at each step. To gain most benefit the doctors must communicate clearly the rationale, the anticipated outcomes and the timelines of any particular intervention they suggest.