



Fascinating Rhythm: Atrial Fibrillation – The Beat Goes On

By John C. Hagan III, MD

Teaser: *As runners pound out mile after mile, year after year wondering what part of our musculo-skeletal system will self-destruct next, we believe our exercise creates a heart and lungs that are indestructible. Wrong!*

We runners worry a lot about injuries. Run long enough, far enough, fast enough and something is sure to ache, break, swell, tear, twist, bleed, blister or grow arthritic. The usual suspects: feet, ankles, knees, hips, back. On the other hand, there are parts of our bodies we never expect to fail. We pride ourselves in our heart and our lungs. As runners pound out mile after mile, year after year wondering what part of our musculo-skeletal system will self-destruct next, we believe our exercise creates a heart and lungs that are indestructible.

My heart, it seems, had not got the indestructible message. Thus my consternation one evening a year and a half ago to feel my heart racing about 190 beats per minute. I haven't been able to generate that kind of tachycardia with maximal exercise effort for 40 years. Not a good thing. I hadn't exercised in two days. In fact, I had just showered and was preparing to go to bed. I retrieved my stethoscope from our home first aid kit. I'm no longer facile with medical instruments unless they have lenses and lights in them. After a brief re-familiarization, I listened to my heart sounds. Hmmm. Irregularly irregular and astonishingly fast. Hey, runners don't get atrial fibrillation (AF) do they? After 30 minutes, I decided to go to the hospital to find out.

With my by now concerned wife, I drove to North Kansas City Hospital. I noted how much different it looked approaching the emergency room as a patient rather than as attending physician. It was, well, scary and intimidating. My complaint of a cardiac arrhythmia moved me to the front of a very long line of waiting, less emergent emergencies. Once hooked up to an EKG monitor, my AF diagnosis was confirmed. "What's with you runners and atrial fibrillation?" an ER doctor I know came over to ask. "The last four physicians treated here in the ER with AF are all big time runners." I had no answer but I vowed to find out.

I was converted with medications to sinus rhythm and hospitalized for an extensive work-up. These tests confirmed my heart was in good shape and there were no other contributing factors to the AF. This, my cardiologist explained, was "lone" AF—the best kind to have. I was discharged on medication and aspirin; the AF returned. I was placed on beta blockers and the AF vanished. But so did all my energy, my exercise capacity and much of my ability to remain conscious when standing up.

Since I treat glaucoma patients with beta blocker eye drops, I thought I had a good understanding of side effects in this ubiquitous class of medications. To put up with these side effects for weeks on end gives one an entirely new perspective. I was breathless after climbing a flight of stairs, running was reduced to laborious walking. Support hose were necessary to deal with significant orthostatic hypotension. I developed a progressive constant cough and post nasal drainage. I was depressed. I was sick and tired of being sick and tired.

Ultimately I decided I could no longer put up with beta blockers. Off medications, the AF returned and I was hospitalized to try yet another medication. When I inquired why I had to be in the monitored coronary care unit, I was told, albeit gently, that some patients developed potentially fatal “pro-arrhythmias.” For three days I watched my pulse blip regularly on the monitor. Thankfully, I was not pro-arrhythmic.

This story, thus far, has a happy ending. I measured serial home blood pressures and my cardiologists agreed that I had mild hypertension that should be treated. I’m on medications for AF and hypertension that are well tolerated. I run and exercise as easily as I did 5 years ago. I’ve given up caffeine and decongestants with pseudoephedrine. I don’t drink alcohol beverages. I get some extra heartbeats now and again especially if I get upset or angry. I try to not get upset or angry.

Learning Good Things From a Bad Experience

This whole “heartening” experience has been a great teacher to me personally and professionally. It has made me a better husband, father, grandfather and friend. It has made me a more skillful and empathetic physician. In my ophthalmology practice, I have reduced my utilization of beta blockers to the absolute minimum. I inquire about side effects frequently on all patients and beta blocker patients in extreme detail.

As a patient, I experienced the value of a readily and constantly available high quality emergency and trauma center. In the hospital, I was reminded of the tremendous importance of good nurses, our partners in healthcare. We must work with the nursing and hospital systems to insure that patient-to-nurse ratios do not rise to the level that quality of care diminishes. I was reminded of how valuable—whether rendered by a physician, nurse, technician or any hospital or medical practice employee – a smile, a kind word, a gentle touch and a caring and empathetic demeanor are in dispelling fear and anxiety. I saw how the malpractice insurance crisis is affecting patient care. My cardiologists were losing associates and unable to find replacements. They were working unbelievable hours to staff their clinics and hospitals. My office appointments were often at 6:30 AM.

I’ve learned that nothing “guarantees” perfect health. This was re-emphasized by the recent death of our young, athletic, non-smoking contributing editor Alan Clark MD from lung cancer. I’m at peace with my own mortality. I exercise and run to improve the quality of my life not necessarily to extend it.

I have learned the value of living each day as if it were my last. I revel in the high honor of belonging to the distinguished profession of medicine. I am re-dedicated to championing medicine in its frequent socio-economic-legal-legislative battles.

I have discussed “lone” AF with my three running colleagues at North Kansas City Hospital. Each tells a story similar to mine. I wrote an acquaintance cardiologist that I met at Emory who, like me, was a member of the Atlanta track club. He’s now team physician to the Atlanta Braves and the Falcons. He responded that AF was one of the more common problems he deals with in these highly trained athletes. He also informed me that he himself has AF that is often triggered by very cold drinks.

That’s it. My conclusions, anecdote piled on anecdote, is that endurance athletes with physiological bradycardia are at increased risk of “lone” AF. Overall exercise reduces the risk of coronary artery disease, aids in the treatment of hypertension, hyperlipidemia, depression and weight control. In moderation, exercise is one of the most important life habits one can have. As I wrote in 1974, in the long run it’s survival of the fittest¹.

Reference

Hagan III JC. "The Doctor as a Coronary Candidate: Survival of the Fittest", *Resident and Staff Physician*, August 1974

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