THE AFIB REPORT
www.afibbers.org • Editor: Hans R. Larsen, MScChE

My Way Back to NSR

By Erling Waller

I am a 74-year-old male enjoying excellent health, free of the afib that used to be my frequent and unwelcome companion. My afib career began about 10 years ago. I was doing some light carpentry at home mid-day, feeling fine, when all of a sudden my heart started racing. Not irregular at all, but a steady rhythm at 155 bpm. When my chest began to hurt I drove to my doctor's office and, in the ER, learned that I had something called atrial flutter. The episode lasted about 3 hours.

In hindsight I now realize that I had experienced PACs (premature atrial complexes) perhaps 3 or 4 years earlier and that starting in 1991 or 1992 I probably had experienced brief runs of atrial fibrillation now and then. The PACs had been dismissed as being of no concern by my cardiologist and I did not pay much attention to them until the autumn of 1995 when I had my first full-blown afib episode at the age of 67 years.

The second episode came about 3 months later, but from this time on they became more frequent, time between episodes varying from a month to a day, with more than 20 per year. The shortest ever was just a few minutes long (not including many very brief runs of a second or two), the longest about 44 hours. I always converted spontaneously. Episodes that would last more than a few minutes were almost always highly symptomatic, making me incapable of anything except lying down with feet up, or sometimes heading off to the ER for intravenous calcium channel blocker, ECG, and companionship. Once I went prepared with an article by an ER doctor who had used intravenous magnesium sulphate to successfully convert a patient. My ER doctor was interested and ordered it, but with no result. We agreed that it probably meant that I was not magnesium deficient to begin with. Later on I converted on my own, as always.

My episodes would almost always begin during the day, only occasionally at night while asleep. I did not discover any triggers as such although I suspect that at least some of my episodes involved a light reactive hypoglycemia following a meal or subsequent to enjoying a beer or two after work. Needless to say, I no longer drink beer. I believe it could precipitate a hypoglycemic reaction or that some substance in the "chemical brew" called beer might have been part of the complicated afib equation, but a direct cause-and-effect relationship was never clear to me.

I, of course, made the usual rounds of GPs and cardiologists and did learn that my heart was sound. At one time a "silent ischemia" was suspected because of a slight S-T segment depression during a stress test; however, this was disproved with a follow-up thallium stress test. Maximal heart rate exercise (treadmill testing) never provoked arrhythmia or angina. I tried the beta-blocker atenolol (Tenormin) for several weeks. It made me feel very tired and I suspect precipitated a very lengthy afib episode so I stopped using it. Eventually I was prescribed amiodarone (Cordarone), but decided against taking it.

At this point I finally realized that if I were to overcome my afib I would have to find the solution myself. So I began by asking 3 questions:

1. What changed within me to cause afib to arrive in my life at age 67?
2. What would change within me to initiate an episode?
3. What would change within me to terminate an episode?

Having learned that I had no underlying heart disease, I could assume that the chromosomal and mitrochondrial DNA codes for the substances and energies required for healing and maintenance of my cells were still intact. Obviously they used to be intact because I was healthy and without full-blown afib up until age 67. If the codes were indeed intact then the answers to my questions could be:

1. Chemical excesses or deficiencies, or both, had compromised the ability of the DNA codes to be actualized thereby making the cardiac tissues vulnerable to fibrillation.
2. Shifts in the amounts or types of internal chemicals would somehow initiate an afib episode.
3. Further chemical shifts would somehow terminate an episode.

After much study about cardiac cells, and the significance of cell membrane integrity and cellular energy in maintaining NSR, I finally focused in on the nutritional requirements of cells and the all important issues of omega-6 to omega-3 ratio, EPA and DHA fish oils, coenzyme Q10, l-carnitine, and magnesium.

Omega-3 (w3) and omega-6 (w6) are families of the essential polyunsaturated fats. They are essential in the diet because they are required and the body can't produce them. Probably everyone consumes too much w6 fats relative to the w3s since they are abundant in our food supply. The task for me was to know the sources and reduce their intake. The principal sources of w6s and w3s in our foods are the vegetable oils such as soybean, safflower, sunflower, canola, etc. If the food label lists polyunsaturated fats it's w6 and w3. The ratio of w6 to w3 in these food oils is too high to be conducive to health, and the methods used in extracting the oils make them unsuitable for consumption. "Virgin" applied to olive oil implies that gentle, low heat, non-destructive methods were used in extracting the oil, I've never seen that word used for other oils in our food. By reducing food oils and other common sources of polyunsaturates, and by adding supplemental w3s in the form of EPA/DHA fish oils I was able to improve my ratio. I have never aimed for a certain daily amount of w6, and would have a hard time doing so – I just watch my step. I figure that if I just stay low on most foods with oils I will still be getting plenty of w6, a required nutrient. But by doing so my intake of w3 is reduced. The most important w3s, EPA/DHA, are not in these oils anyway. They are either made in the body from other w3s in food (which for many is problematic), or they need to be supplemented. I usually take daily 4 capsules of fish oil providing 720 mg EPA and 500 mg DHA, but some days only 2 or 3 capsules. For a long time I was taking more than I am now. I absolutely stay away from hydrogenated oils which seem to be everywhere in processed foods. Hydrogenation produces "trans" fats with a molecular shape that screws up cell membranes. The book "Fats that Heal, Fats that Kill" by Udo Erasmus is powerful knowledge. Some days I only take 2 capsules, some days none, but I'm out of the woods now (in a maintenance mode) and am enjoying being less fussy about these things.

I also learned that I could likely improve my situation by ensuring that I had an adequate intake of two nutrients vital to proper cell functioning, l-carnitine and coenzyme Q10. For a long time I took about 2000 mg per day of l-carnitine, but now that I am just maintaining I'm down to about 1000. My doctor kindly wrote a prescription for Carnitor, the only prescription form in the US. Carnitine over-the-counter is a bit expensive, so with insurance I have only a moderate expense. Acetyl-l-carnitine is, by many accounts, superior for reasons having to do with entry into the cells, but the body converts l-carnitine to the acetyl form anyway. So I was never certain that the extra cost was justified. If I was starting over and knew what I know now I am sure I would go all out and buy the acetyl form.

I now take 100 mg per day of coenzyme Q10 in the form of an oil-based capsule, but for a long time it was 180 to 200 mg. There has been some discussion about taking CoQ10 while being on warfarin. For a period of time some years ago I was on warfarin and about 180 mg of CoQ10 daily, and there was never a problem with my INR nor was a question ever raised about the combination by my cardiologist or my other doctor. There is nothing in any of the voluminous scientific literature today that proscribes the combination. It's true that, because of its molecular similarity to vitamin K, CoQ10 does have a similar effect on clotting, but I was never told to limit my intake of spinach or other high vitamin K foods. A young person will perhaps not benefit from CoQ10 supplementation because the body normally produces sufficient quantities. Later in life (during the 30s) CoQ10 production falls off markedly. I was in my 60s when afib began and anyone with afib is probably not "normal" as regards to cellular energy and antioxidant protection, another important CoQ10 function.

I endeavoured to learn everything that I could about the minerals magnesium and potassium, because I learned that they are intimately linked to normal heart rhythm, and deficiencies can lead to arrhythmias. I read that magnesium is required in over 300 enzymatic reactions, including ones involved in the production of cellular energy. I also learned that magnesium is called "nature's physiologic calcium blocker". Since it is known that some 80% of people in our culture are magnesium deficient, I take 400 mg or so per day as a supplement. For some time I was using magnesium aspartate, but avoid it now because it seemed that it actually increased the frequency of a-fib events, probably due to the known "excitatory" effect of aspartic acid (aspartate). There are many other excellent supplement forms available. I don't supplement with potassium since there is a huge amount in common foods.

My other supplements include a mixed vitamin E supplement and about 1 to 2 grams per day of vitamin C. I also try to keep my calcium/magnesium ratio at about 2:1 versus the recommended 4:1. I believe this and eliminating most dairy products have also contributed to my healing.

Am I healed? I certainly believe so. I have been in normal sinus rhythm since January 2002, after experiencing a great reduction in frequency and intensity of afib events during the fall of 2001. I am experiencing the health and vitality of 30 years ago. I take no medications, my PACs have essentially ceased, and the fear of experiencing another afib episode has completely disappeared. Looking back, I now believe that the most important steps that I took to achieve this were to begin taking fish oils (EPA and DHA), reducing my intake of omega-6 fats, completely eliminating my intake of hydrogenated oils, and supplementing with CoQ10, l-carnitine, and magnesium. Another very important contribution was to stop putting into my body suspicious chemical ingredients and additives in processed foods. Besides avoiding like the plague MSG and aspartame in all of their guises, my general rule is, if I cannot pronounce it I probably should not eat it. I believe that dietary indiscretions resulting from an ignorance of sound nutritional principles had caused a gradual decline in my health over a period of many years, finally resulting in afib, a blessing in disguise. I deplore that having been given a good body, I let it deteriorate out of ignorance and blind obedience to false cultural dietary norms. I wish everyone with the nasty afib affliction could be as fortunate as I have been in finding a way out.

Colorado - October 2002

The AFIB Report is published 10 times a year by Hans R. Larsen MSc ChE
1320 Point Street, Victoria, BC, Canada V8S 1A5
Phone: (250) 384-2524
E-mail: editor@afibbers.org
URL: http://www.afibbers.org
ISSN 1203-1933.....Copyright © 2001-2010 by Hans R. Larsen

The AFIB Report do not provide medical advice.
Do not attempt self- diagnosis or self-medication based on our reports.
Please consult your health-care provider if you wish to follow up on the information presented.