

Living with atrial fibrillation



**Ascension
Saint Thomas Heart**

FPO

For Placement Only

Inside Front Cover



Important information

Cardiac electrophysiologist: _____

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Cardiologist: _____

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Primary care doctor: _____

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Care transition nurse: _____

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Pharmacy: _____

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Resources

Ascension Saint Thomas Heart

ascension.org

American Heart Association

heart.org

Heart Rhythm Society

hrsonline.org

Stop Afib

stopafib.org



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What is atrial fibrillation?

Atrial fibrillation, often referred to as Afib or AF, is the most common irregular heart rhythm. There are an estimated 2.7-6.1 million Americans with Afib currently. As many as 1 in 4 adults will experience Afib in their lifetime.

In a normal rhythm, a single electrical impulse begins in the top chambers of the heart (atria), travels across the top, and causes the atria to push the blood into the lower chambers (ventricles). That same impulse then travels through the lower chambers. This causes the ventricles to pump the blood out to the body. This happens continuously, and these impulses are fired at a normal rate of 60-100 times per minute.

In Afib, instead of one electrical impulse, there are many, from all over the atria. This causes the atria to quiver instead of squeeze normally. Some impulses travel to the ventricles, but some do not. Instead, they circle rapidly around the atria. Because only some of the impulses are getting through to the ventricles, this makes the rhythm irregular. What you feel as your pulse (or rhythm) is the pumping of the ventricles. You cannot feel the rhythm of the atria.

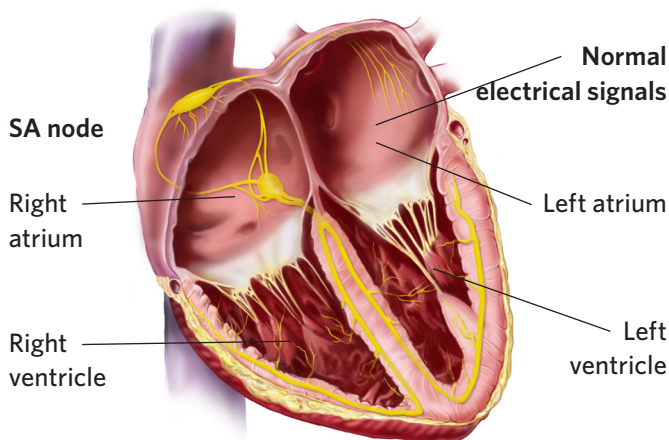
Some patients purchase home monitors which measure blood pressure and heart rate. When the heart is in Afib, the monitor is not able to give an accurate count for the heart rate, because not all of the beats are sensed by the monitor. The monitor may show a lower number than the actual heart rate.

Symptoms

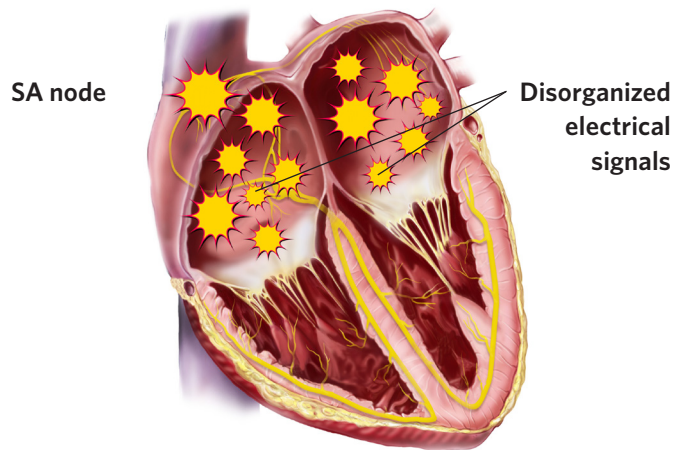
When the atria and ventricles are not pumping in rhythm, the heart's effectiveness as a pump may decrease 20-30 percent. Patients in Afib may experience any or all of the following symptoms:

- Heart palpitations (pounding, fluttering, racing)
- Fatigue, weakness, lack of energy, decreased physical endurance
- Shortness of breath
- Chest discomfort or pain
- Faintness, light-headedness, dizziness

Normal electrical conduction



Atrial fibrillation



Types of Afib

Atrial fibrillation is classified according to how frequently the episodes occur and how quickly they stop. Some patients may stay in Afib while others go in and out of Afib many times throughout the day.

Paroxysmal Afib

This refers to Afib that occurs suddenly and then returns to a normal rhythm without treatment. The Afib may last for seconds, minutes, hours, or up to seven days before the heart returns to its normal rhythm. As the heart goes in and out of Afib, the pulse rate may change from slow to fast and back again in short periods of time.

Persistent Afib

Persistent Afib occurs when the Afib does not stop by itself. Medicines and/or cardioversion (an externally delivered electrical shock, administered by a healthcare provider) may be used to help the heart return to its normal rhythm. If no treatment is given, the heart will stay out of rhythm.

Permanent Afib

This refers to Afib that cannot be corrected. Medicines or cardioversion cannot help the heart return to a normal rhythm. The heart is always in Afib and the condition is considered permanent. The main goal with permanent Afib is to control the heart rate and protect the patient from the risk of stroke by using blood thinners.

Treatment goals

- Relieve Afib symptoms and improve a patient's quality of life
- Prevent blood clots, to decrease the risk of stroke, by using blood thinners (anticoagulants)
- Control the heart rate with rate-slowing medicines to allow the ventricles enough time to fill with blood
- Reset the heart rhythm with medicine and/or procedures to allow the atria and ventricles to work together more effectively as a pump

When to call your doctor

- Worsened and sustained rapid heart rate
- Light-headedness, dizziness, confusion
- Bleeding that cannot be stopped (if taking a blood thinner)
- Fainting/near-fainting episode
- Side effect from medicine

Controlling risk factors for Afib

There are many steps you can take to control your risk factors. Taking these steps will help to lessen symptoms and occurrences, and may help restore and keep a normal heart rhythm.

Risk factors that you can change

Obesity: There is an important link between the severity of obesity and the risk of developing Afib. Obesity increases the risk of developing Afib by 49 percent and as BMI increases, the risk for Afib increases even further.

Recommendations:

- If you have a normal weight, maintain it.
- If you are overweight, enroll in a weight management program. If one is not available where you live, consult with your doctor.

Obstructive sleep apnea (OSA): Approximately half of the patients with Afib also have sleep apnea. During an OSA episode, the airway becomes blocked, the patient gasps for air, and is often awakened by a loud snore. A prolonged OSA episode causes a negative pressure in the chest and an increase in blood pressure. This affects the electrical signals in the top of the heart, and increases the risk for Afib to develop.

Recommendations:

- If you snore, or are told that you do, ask your doctor about a referral to a sleep specialist.

High blood pressure (hypertension or HTN): High blood pressure is a well-established risk factor for Afib and stroke. Even after having an ablation, patients with high blood pressure are at an increased risk for the return of Afib. Strict management of high blood pressure is necessary to decrease the risk of Afib and stroke.

Recommendations:

- Eat a well-balanced, low-sodium diet and see your doctor regularly to help control blood pressure.

Diabetes: Diabetes is a risk factor for the development of Afib.

Recommendations:

- See your doctor regularly to help keep blood sugar under control and maintain a healthy weight.

Alcohol: Drinking too much alcohol is harmful to the heart muscle. It can increase Afib episodes and may also increase the risk of stroke, clots, or deep vein thrombosis (DVT). Drinking alcohol may trigger the return of Afib after ablation. There is a lower success rate of Afib ablations in moderate and heavy drinkers.

Recommendations:

- Limit alcohol intake to three drinks or less per week.

Stimulants: Many drugs, drinks and foods contain substances which can affect the heart by triggering fast, regular or irregular rhythms. Caffeine is found in coffee, tea, sodas, energy drinks, and chocolate. Nicotine, in tobacco (whether chewed or smoked), is a stimulant. Diet pills and many over-the-counter drugs (example, decongestants) contain substances which may trigger fast, irregular rhythms. Taking illegal drugs or abusing legal drugs can cause dangerous heart rhythms.

Recommendations:

- Talk to your doctor about how the use of specific stimulants may affect your heart rhythm.

Cigarette smoking: Smoking cigarettes (and inhaling smoke from other people) is not only a leading factor for heart disease, it is also a known cause of abnormal heart rhythms. This is due to the combined effects of the nicotine from the tobacco and the carbon monoxide from the smoke. Smokers are twice as likely to develop Afib as non-smokers, and people who have stopped smoking are at a much lower risk than those who continue to smoke.

Recommendations:

- If you smoke, ask your doctor about a referral to a smoking cessation program.

Exercise: Either too little or too much exercise can increase the risk of Afib. The greatest benefit to your health comes with moderate exercise. People at the lowest end of physical fitness have a five times greater risk of experiencing Afib. On the other hand, athletes who exercise at the highest levels of activity over long periods of time also have a five times greater risk of developing Afib. However, this was noted in middle-aged adults, rather than young athletes. This is believed to be related to the changes which take place with the aging heart. Endurance training produces the athlete's heart with chamber enlargement and thicker muscle walls. These changes may lead to the development of Afib and other abnormal heart rhythms.

Recommendations:

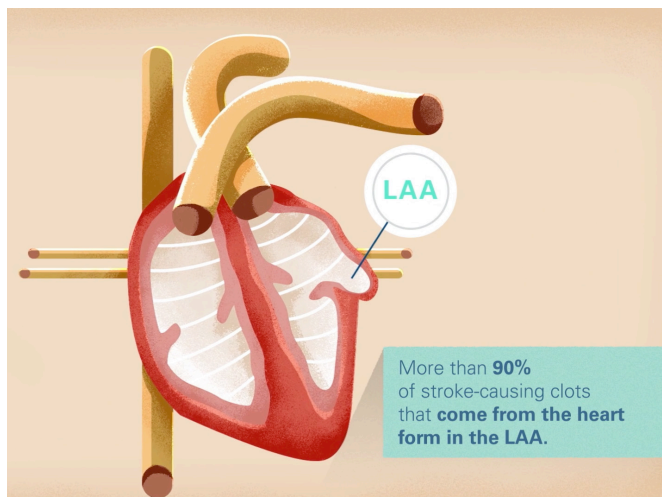
- For physically inactive patients with Afib, a regular exercise program will help with weight management. This will help to increase heart muscle strength and tone, which may reduce the risk and amount of Afib.
- For the endurance athlete, decreasing physical activity levels can reverse the changes caused by the vigorous exercise and reduce the incidence of Afib.
- Consult with your doctor for recommendations for an appropriate level of exercise.



Stroke risk

Stroke — The greatest risk of having atrial fibrillation

Patients in Afib are five times as likely to suffer a stroke as someone not in Afib. When the heart is in Afib, it lacks the normal push of blood from the atria to the ventricles. The blood is allowed to pool in the atria and may form a clot. When the heart goes back into a normal rhythm, this clot may move into the ventricles and then be pumped out to the body. If the clot travels through the blood vessels to the head, it blocks the flow of blood to the brain and causes a stroke.



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- The blood clot lodges itself in the blood vessels of the brain, restricting blood flow and causing a stroke.
- The blood clot dislodges from the atria and travels through the arterial system.
- The standing blood becomes an ideal environment for a blood clot to form.
- Atrial fibrillation causes blood to pool in the left atrial appendage (LAA).

Signs and symptoms of a stroke

Because some patients do not experience symptoms with Afib, it is important to be aware of the symptoms of a stroke. Use the letters in **B.E.F.A.S.T.** to spot a stroke.

Other signs may include:

- Sudden numbness, especially on one side
- Sudden severe headache with no known cause
- Sudden confusion

If you are experiencing any of these symptoms, you should call 911!



Balance

Sudden difficulty walking or standing?



Eyes: Sudden blurred vision, double vision or loss of vision?



Facial drooping: Sudden facial drooping. Ask patient to smile. Does one side of the face droop?



Arm weakness: Sudden arm weakness. Ask the patient to raise both arms. Weakness or drift present?



Speech difficulties: Sudden changes in speech. Ask the patient to repeat a simple phrase. Is their speech slurred or strange?



Time: When did you last remember being without these symptoms?

Understanding my atrial fibrillation medications

Important information about medicines

- It is very important to follow your doctor's instructions exactly as prescribed.
 - No matter how you feel, **do not** change your medicine dose or stop taking it without the instruction of your doctor.
 - If you are having trouble paying for your medicine, talk to your doctor or pharmacist. There may be another medicine that can be used.
 - Don't run out of your medicines. Be aware of how many refills you have left.
 - Get all your medicine from the same pharmacy. This will help make sure they are safe to use together.
 - Store in original manufacturer's bottle.
 - Keep an updated list of medicines (prescriptions, over-the-counter, and herbal products) with you so that all of your doctors know what you are taking. Bring this list to any appointments or if admitted to the hospital.
 - Take your medicines at the same time **every day**. Have a way to help you remember to take your medicines (pillbox, medicine calendar, phone app, etc.)
 - If you miss a dose, and it is within 1-2 hours of the scheduled time, take the missed dose. Otherwise, call your doctor's office or pharmacist for further instructions.
 - Because some of these medicines decrease your blood pressure, you may get dizzy when you stand up. After lying down, it is helpful to sit first, wiggle your feet, and then stand slowly.
 - If you are going out of the house, and there is a chance you will not be home for your next dose of medicine, make sure to take your medicines with you.
- Let your doctor know if you feel that your medicines are not working or that your symptoms are not improving. You are a team and are working together to find the best treatment plan for you.
 - Before taking any new medicines, other than what has been prescribed for you, always check with your doctor to make sure the drug will not interfere with your current medicines or your condition.



Anticoagulants

Anticoagulants, also called blood thinners, are given to patients with Afib to protect them from the risk of a stroke. Anticoagulants prevent blood clots from forming. There are different types of anticoagulants. You and your doctor will decide which anticoagulant is best for you.

Types of blood thinners (anticoagulants)

Vitamin K antagonist

Warfarin (Coumadin®)

- Given once daily in the evening
- Requires regular blood checks (PT/INR), to make sure that the blood is not too thick or not too thin
- Talk to your doctor about your PT/INR goals.
- Warfarin interacts with some foods and some drugs.

Direct Thrombin inhibitor

Dabigatran (Pradaxa®)

- Given twice daily
- No blood checks required
- Dabigatran does not interact with food, but does interact with some drugs.

In case of emergent bleeding with any of these drugs, your doctor will determine the most appropriate drug/course of action to control the bleeding.

Factor Xa inhibitors

Apixaban (Eliquis®)

- Given twice daily
- No blood checks required
- Apixaban does not interact with food, but does interact with some drugs.

Rivaroxaban (Xarelto®)

- Given once daily with evening meal
- No blood checks required
- Rivaroxaban does not interact with food, but does interact with some drugs.

Edoxaban (Savaysa®)

- Given once daily
- No blood checks required
- Edoxaban does not interact with food, but does interact with some drugs.

Which blood thinner am I taking?

The following is a review of the most common medications used for atrial fibrillation. Your doctor will determine which of these medications you will take.

Medicines to control heart rhythm

Antiarrhythmics		
Name	How do they help?	Potential side effects
Amiodarone (Pacerone®) Dofetilide (Tikosyn®) Dronedarone (Multaq®) Flecainide (Tambocor®) Procainamide (Pronestyl® Procan-SR®) Propafenone (Rhythmol®) Sotalol (Betapace®)	They control abnormal heart rhythms by slowing the electrical impulses as they travel through the heart tissue or by blocking these impulses.	<ul style="list-style-type: none"> • Nausea • Vomiting • Tremors • Diarrhea • Loss of appetite • Dizziness • Tiredness • Headache • Sleep problems
Special instructions		
<p>Antiarrhythmics interact with many other medicines. Be sure you tell your doctor about:</p> <ul style="list-style-type: none"> • Any medicines you are presently taking • Any medicine or food allergies • Any history of heart failure, kidney, liver, lung disease, or thyroid problems • If you miss a dose, and it is within 1-2 hours of the scheduled time, take the missed dose. Otherwise, call your doctor's office or pharmacist for further instructions. 	<p>Special notes for patients taking Amiodarone:</p> <ul style="list-style-type: none"> • If you take the cholesterol drug Simvastatin (Zocor®), it is recommended that Simvastatin be switched to Atorvastatin (Lipitor®) or Rosuvastatin (Crestor®) • If you take warfarin or Digoxin, you may need a lower dose, as Amiodarone affects the blood levels of these medications • As long as you take Amiodarone, your doctor will check your blood work for thyroid and liver function regularly, and may also check a periodic chest X-ray. 	

Call your doctor with any of the following symptoms:

- Chest pain
- Severe dizziness
- Feeling like you might pass out
- Fast or pounding heartbeats
- Confusion
- Slow heart rate
- Difficulty breathing
- A heart rate or rhythm that worries you

Which medication(s) am I taking?

Medicines to control heart rate

Beta blockers		
Name	How do they help?	Potential side effects
Metoprolol (Toprol XL®) Atenolol (Tenormin®) Carvedilol (Coreg®) Nebivolol (Bystolic®) Bisoprolol (Zebeta®)	They decrease the work of the heart by lowering the heart rate and blood pressure.	<ul style="list-style-type: none">• Feeling tired• Dizziness• Slow heart rate
Special instructions		
<ul style="list-style-type: none">• Beta blockers may worsen breathing problems. Let your doctor know if you have asthma or other breathing conditions.• Initially, symptoms may appear worse as your heart responds to the medicine. Between 2-3 weeks, you should feel improvement in your symptoms.• Carvedilol should be taken with a meal.• If you have diabetes, these medicines can prevent your body from having its usual symptoms of low blood sugar (such as shaking and headache). Sweating could be the only symptom you will notice.		

Which medication(s) am I taking?

Medicines to control heart rate

Calcium channel blockers		
Name	How do they help?	Potential side effects
Diltiazem (Cardizem®) Verapamil	These drugs slow the rate of the electrical impulses through the heart.	<ul style="list-style-type: none">• Headache• Swelling in legs• Slow heart rate• Constipation• Dizziness, weakness, tiredness• Nausea• Flushing
Special instructions		
<p>Make sure you tell your doctor about:</p> <ul style="list-style-type: none">• Trouble breathing• Slow heartbeats• Dizziness, fainting, or fast/pounding heartbeat• A red/purple, itchy, burning skin rash (especially face or upper body), which could be a skin reaction to the sun caused by calcium channel blockers		

Which medication(s) am I taking?

Medicines to control heart rate

Cardiac glycosides		
Name	How do they help?	Potential side effects
Digoxin (Lanoxin®)	Digoxin can make the heartbeat stronger and more regular.	<ul style="list-style-type: none">• Nausea• Feeling tired• Vision changes
Special instructions		
<p>Your doctor may do blood tests to check your level of this medicine. Special caution is taken when this drug is used in elderly patients or those with decreased kidney function.</p> <p>Make sure you tell your doctor about:</p> <ul style="list-style-type: none">• Vision changes (blurred or yellow vision)• Nausea• Decreased appetite• Vomiting/diarrhea		

Which medication(s) am I taking?

Procedures

There are several procedures which can be performed to restore a patient's normal heart rhythm, **or** if a normal rhythm cannot be restored, may help to control the patient's rate and symptoms.

Chemical or electrical cardioversion

The word "cardioversion" means to restore the normal rhythm of the heart.

Chemical cardioversion: A chemical cardioversion is when medicines alone are effective in restoring a normal heart rhythm.

Electrical cardioversion: An electrical cardioversion is a procedure which is performed in the hospital. This is done while the patient is asleep and monitored. A shock is delivered to the heart using paddles placed on the patient's chest and back. The purpose of the cardioversion is to reset the abnormal heart rhythm. This is successful about 90 percent of the time, but cannot guarantee that the Afib will not return later. Because of the danger of clot formation in Afib, cardioversion is always combined with a blood thinner and sometimes combined with antiarrhythmic medicines. If the patient has been in Afib for 48 hours or more, a blood thinner will be required for 3-4 weeks before the procedure can be done safely.

In some cases, your doctor may decide that you need the cardioversion sooner than 3-4 weeks. If that happens, you will need a TEE (transesophageal echocardiogram) before the cardioversion. In a TEE, a special tube is placed in the esophagus (throat) and guided down behind the heart to see if there are blood clots in the atrium. If no clots are present, the cardioversion can be done. If blood clots are present, the procedure must be delayed due to risk of the clot moving out of the heart.



Heart rhythm in atrial fibrillation

Cardioversion shock

Normal heart rhythm

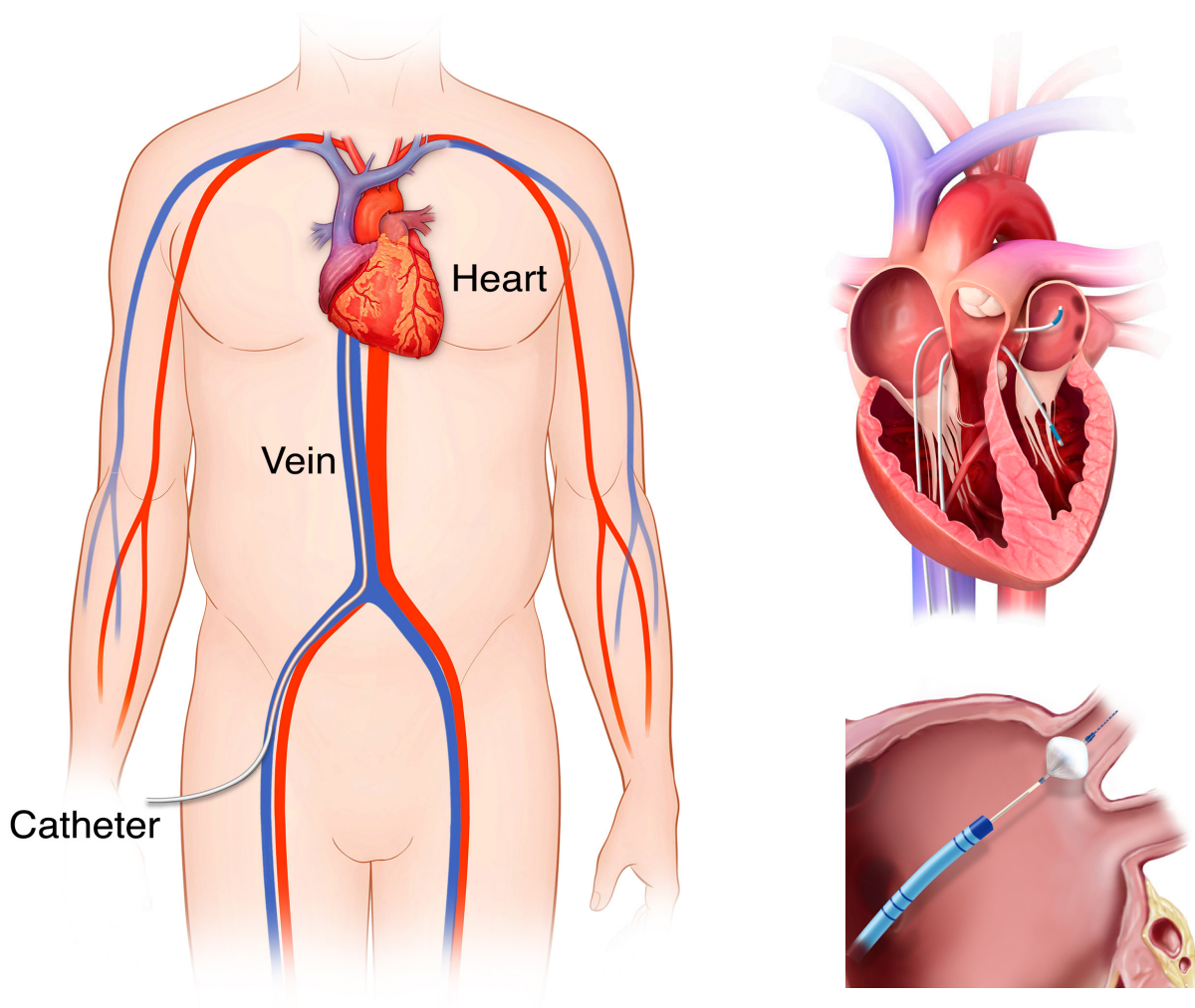
Electrophysiological (EP study) and catheter ablation

In the EP study, a map of the heart's electrical activity is created using a combination of advanced computer mapping technologies and imaging techniques. This map is used to pinpoint the areas of the atrium where the abnormal electrical signals are starting, and to confirm, after the ablation procedure, that the signals are no longer present.

Research has shown that Afib usually begins in the pulmonary veins where they attach to the left atrium. The pulmonary veins are large blood vessels that carry blood from the lungs to the left atrium. There are four major pulmonary veins and one or all may be involved in triggering Afib. The goal of catheter ablation is to prevent unwanted electrical currents from traveling out of the pulmonary veins into the left atrium.

During the ablation procedure, long flexible tubes (catheters) are inserted into blood vessels in the groin and guided into the atrium. Using the electrical map as a guide, energy (heating or freezing) is delivered through the tip of the catheter to the tissue which has been targeted for ablation. Catheter ablation destroys the unwanted electrical signals or blocks them from reaching the left atrium. As the tissue heals, it creates areas and lines of scar, through which the abnormal electrical signals are not able to pass. This is known as Pulmonary Vein Isolation (PVI).

Many patients, especially those with persistent Afib, have additional sources of Afib outside the pulmonary vein. These sources will be identified and ablated as well with either cryoenergy (intense cold) or radiofrequency (radio wave) energy.



After your ablation

Discharge information and instructions

- To avoid bleeding from the catheter puncture sites, we ask that you avoid strenuous physical exertion for up to seven days after your procedure.
- You are encouraged to walk and perform light activity. Do not do any pushing, pulling or lifting more than 10 pounds for up to seven days after the procedure.
- As soon as your doctor allows, you can return to work a few days after the procedure, if you aren't experiencing any problems.
- You may take a shower when you get home and remove the bandages. You may reapply Band-Aids® as needed. It is important to keep the puncture sites dry.

It is common to feel or have:

- General soreness and aching muscles in arms, legs or back from lying still in the same position during the procedure
- Fatigue and being quite tired for several days
- Chest discomfort during the first several days, especially during deep breaths
- Sore throat from the tubes used to check for blood clot (TEE) or to support your breathing during anesthesia. Some people have a hoarse voice for a few days.
- A dry cough is common.
- Bruising in the area(s) where the catheters were inserted. These bruises should resolve in a few weeks. It is common to have a lump under the skin at the catheter insertion site; this may take several months to resolve.
- Abnormal or irregular heartbeats for weeks or even months (may last for up to 90 days) after the procedure.

You may develop recurrent episodes of atrial

fibrillation. This experience is common and gradually lessens with time. It is related to the irritation of the heart tissue from the procedure itself. This does not mean that the procedure was not successful, but it does suggest that you may take weeks or months before you get maximum benefit from the procedure.

You will need to take your anticoagulant (blood thinning medication) for at least 2-3 months after the procedure to prevent blood clots and reduce the risk of stroke. You may need to continue this medication for longer than three months, depending on your individual risk for stroke. Your doctor will tell you when it is safe for you to stop. **It is essential that you do not stop your anticoagulant without contacting your doctor.**

You may also need to take an antiarrhythmic medication to control abnormal heartbeats for a time after your procedure.

You will be seen in the clinic about 1-3 months following your procedure to check your heart rhythm and review your medications. Some medications may be stopped after that visit.

When to call your surgeon

- A fever over 100 degrees
- Shortness of breath or more severe chest pain
- Difficult or painful swallowing
- Afib lasting longer than 24 hours
- Increased bleeding, bruising, swelling or pain near the catheter insertion site

Pacemakers and defibrillators

Although not used as a stand-alone treatment, these devices may be used together with medicine or catheter ablation. Some pacemakers and defibrillators have features that detect Afib early and help control episodes. In patients with long-standing Afib who have not responded to treatment and whose fast rate has caused severe symptoms and weakened the heart muscle, an AV node ablation may be needed. The AV node is the door through which the electrical signals travel from the top part (atria) of the heart to the bottom (ventricles). This type of ablation closes that door. Because no signals are coming from the top part of the heart after the ablation, a pacemaker is now necessary for a normal, stable rate. The Afib remains, but the rapid atrial rate can no longer increase the heart rate.

Surgical options for Afib ablation

One option for the ablation of Afib is the MAZE procedure. This involves creating lines of scar tissue on the outside of the heart. Typically this is an open-chest procedure and is done in patients with Afib who are already undergoing open-heart surgery for other reasons.

Some patients, who have long-standing Afib, or who have significant atrial enlargement, may benefit from a different version of the MAZE, which is called the Convergent MAZE. This is typically done in two procedures. The first procedure is performed by a heart surgeon. It involves going under the ribs, into the sac around the heart, and ablating the back wall by creating lines of scar in the heart tissue. In the second procedure, on a different day, the EP cardiologist performs a traditional Afib ablation from inside the heart to connect the surgical lines of scar. The EP cardiologist then maps the area to confirm that the abnormal electrical impulses have been destroyed.

Left atrial appendage closure (LAAC)

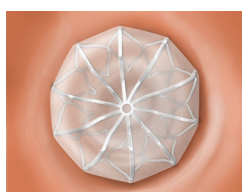
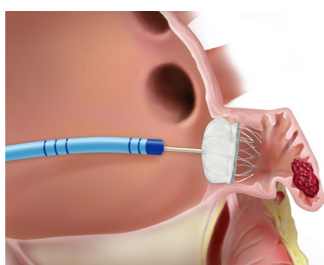
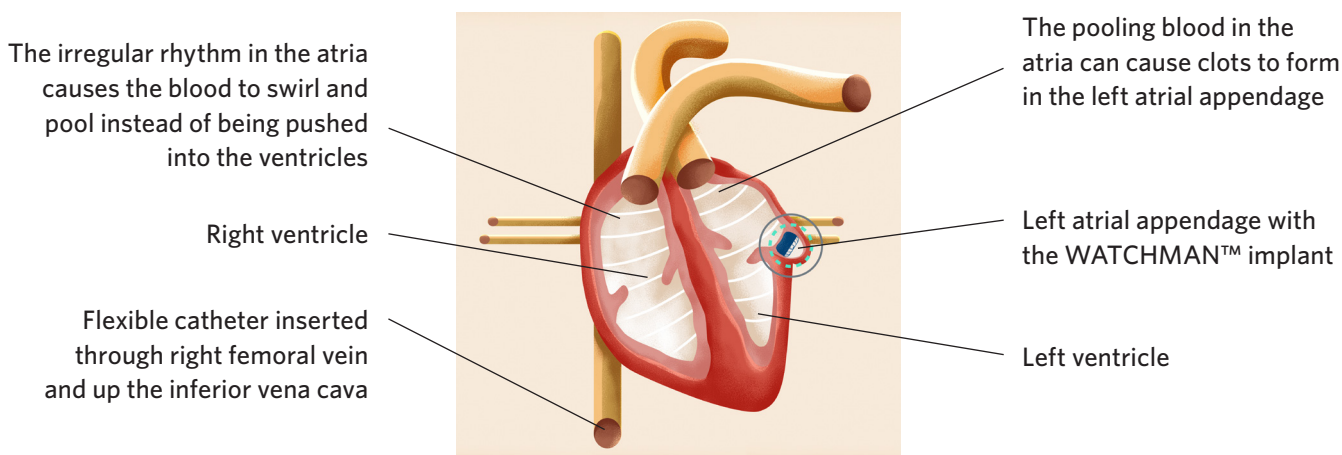
The first line of treatment for the prevention of clots (and risk of stroke) in patients with Afib is usually a blood thinner. However, there are some patients who have conditions in which long-term use of a blood thinner is not advised. These would include conditions such as:

- History of major bleeding while on blood thinners
- Taking other medications that are not compatible with anticoagulation
- If on warfarin, patient is not able to keep INR (the blood test which measures blood thinness) at a stable level, **or**
- If the patient on warfarin is not able to monitor INR regularly and has no access to an available approved alternate blood thinner
- A medical condition, occupation or lifestyle which places the patient at high risk for major bleeding from a traumatic injury (such as falls, work injuries, etc.)

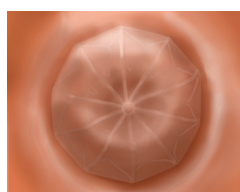
For patients with these conditions, an implantable left atrial appendage closure (LAAC) device may be an option.

The left atrial appendage (LAA) is a small pouch, which is attached to the left atrium and lies next to the outside wall of the left ventricle. Its function is thought to relieve pressure from the left atrium when the left ventricle is squeezing. Because of its shape and location, it has also been found to be a likely area where blood may pool when a patient is in Afib, increasing the risk of a clot causing a stroke.

When implanted, the device acts as a plug over the LAA, preventing blood from entering the LAA and forming clots.



WATCHMAN™
Device at the left atrial
appendage shortly
after implant



Heart tissue grows
over the device,
typically within a
few weeks.

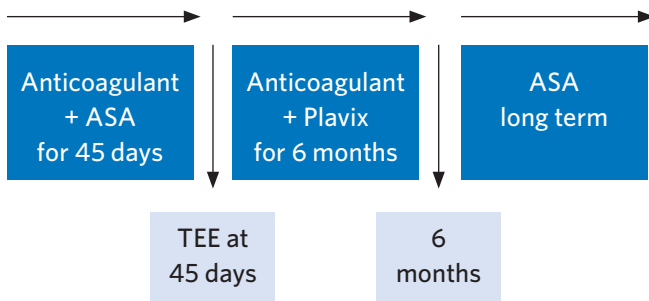


The LAA, the most
common source of strokes
in Afib patients, will be
sealed off permanently.

Requirements for consideration of the LAAC:

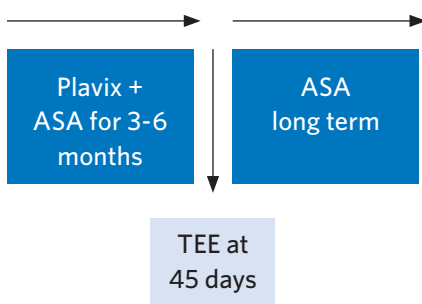
- Must be at increased risk for stroke, caused by a clot.
- Must be able to take an anticoagulant for 45 days, or aspirin and Plavix for 3-6 months.
- Must have a medical condition, occupation or lifestyle which places the patient at high risk for major bleeding from a traumatic injury (such as falls, work injuries, etc.), or any issue that prevents the use of long-term blood thinners.
- If your doctor determines, with you, that the LAAC is an appropriate alternative to blood thinners, the following tests will be ordered, in preparation for the procedure:
 - CT scan of the heart — To obtain accurate measurements of the heart, blood vessels, LAA size, and shape
 - Transesophageal echocardiogram (TEE) — A TEE is an echocardiogram (ultrasound study of the heart) in which a special probe is guided down the esophagus, while the patient is sleeping, which allows a clear picture of the heart and blood vessels from inside the chest. The primary purpose of the TEE is to make sure that there are no clots in the heart prior to the LAAC procedure.
- Ability to follow the recommended post-implant guidelines

Implant



OR

Implant



It is important to note that the LAAC will not correct the Afib. It prevents clots from forming in the LAA, which may cause a stroke. However, strokes may be caused by other factors, such as high blood pressure; narrowing of the blood vessels that carry blood to the brain; or bleeding into the brain, as from an injury. The LAAC cannot prevent a stroke which may be caused by these other factors.

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Ascension Saint Thomas Heart

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