

# Dysrhythmias

## Dysrhythmias

In patients with atrial fibrillation (AF),  $\beta$ -blockers, digoxin or calcium channel blockers should be continued in order to control rate. New AF or atrial flutter should be investigated and treated. These patients should be considered for cardioversion as restoring sinus rhythm can improve cardiac output by 15% ( Figure 21.5 ). Patients with an abnormal rhythm on ECG, for example tachycardia/bradycardia or heart block, should also be discussed with a cardiologist ( Figure 21.6 ). Symptomatic heart blocks and asymptomatic second- (Mobitz II) and third-degree heart blocks, if discovered at the preoperative assessment clinic, will need cardiology consultation and potentially temporary or permanent pacemaker insertion. Warfarin in patients with AF should be stopped 5 days preoperatively to achieve an international normalised ratio (INR) of 1.5 or less, which is safe for most surgery . The newer anticoagulants such as dabigatran (direct thrombin inhibitor) or rivaroxaban, apixaban and edoxaban (direct factor Xa inhibitors) do not have antagonists and must be stopped preoperatively , generally for 2–3 days in patients with normal renal function and longer when renal function is impaired. Alternative anticoagulation is not required in the perioperative

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V1 II V5 Figure 21.5 Atrial /f\_l utter

period unless the risk of stroke is high (assessed using the CHA<sub>2</sub>DS<sub>-2</sub>-VASc [congestive heart failure, hypertension, age  $\geq 75$  years, diabetes mellitus, stroke or transient ischemic attack, vascular disease, age 65–74 years, sex category] score). Decisions on bridging therapy should balance the risks of stroke and bleeding.

V1 II V5 Figure 21.6 Routine preoperative electrocardiogram in an 83-year-old patient with no symptoms other than lethargy for the last 3 months. This shows complete heart block with dissociated P waves and QRS complexes, requiring preoperative pacing.

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