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Atrial fibrillation

Drug treatment of psychiatric symptoms in the context of other conditions CHAPTER 10 Atrial fibrillation Atrial fibrillation (AF) is the most common cardiac arrhythmia. It particularly affects older people but may occur in an important proportion of people aged less than 40 years. Risk factors include anxiety, obesity, diabetes, hypertension, long-standing aerobic exercise and high alcohol consumption.1–3 AF itself is not usually life-threatening but stasis of blood in the atria during fibrillation predisposes to clot formation and substantially increases the risk of stroke.4 The use of warfarin or direct-acting oral anticoagulants is therefore essential.3 AF can be defined as ‘lone’ or paroxysmal (occurring infrequently, and spontaneously reverting to sinus rhythm), persistent (repeated and prolonged [>1 week] episodes usually, if temporarily, responsive to treatment) or permanent (unresponsive). Risk of stroke is increased in all three conditions.3 Treatment may involve DC conversion, rhythm control (usually flecainide, propafenone or amiodarone) or rate control (with diltiazem, verapamil or sotalol). With rhythm control the aim is to maintain sinus rhythm, although this is not always achieved. With rate control, AF is allowed to continue but ventricular response is controlled and the ventricles are filled passively. Many people with paroxysmal or persistent AF can be effectively cured of the condition by catheter or cryoablation of aberrant electrical pathways,5,6 now a routine and effective procedure.7 AF is commonly encountered in psychiatry not least because of the high rates of obesity, diabetes and alcohol misuse seen in mental health patients. The onset of AF also provokes prescription of antidepressants, anxiolytics and hypnotics.8 When considering the use of psychotropics several factors need to be taken into account: ■ ■Interactions between psychotropics and anticoagulant therapy. ■ ■Arrhythmogenicity of psychotropics prescribed. AF usually results from cardiovascular disease, and drugs affecting cardiac ion channels may increase mortality in these patients, especially those with ischaemic disease.9,10 Drugs that prolong the QT interval may also increase the risk of incident AF11 although their effect on established AF is not known. ■ ■Effect on ventricular rate: some drugs induce reflex tachycardia via postural hypotension, others (clozapine, quetiapine) directly increase heart rate. ■ ■Reported association between individual psychotropics and AF (Table 10.15). ■ ■Risk of interaction with co-prescribed antiarrhythmics or rate-controlling drugs. ■ ■Whether AF is paroxysmal (aim to avoid precipitating AF), persistent (aim to avoid prolonging AF) or permanent (aim to avoid increasing ventricular rate).

846 The Maudsley® Prescribing Guidelines in Psychiatry Table 10.15 Recommendations for using psychotropics in atrial fibrillation (AF). CHAPTER 10 Condition Suggested drugs Drugs to avoid Schizophrenia/ schizoaffective disorder The condition itself may be associated with an increased risk of AF12 In paroxysmal or persistent AF, cariprazine, brexpiprazole or lurasidone may be appropriate choices. In permanent AF with rate control, drug choice is less crucial but probably best

to avoid drugs with potent effects on the ECG (ziprasidone, pimozide, etc.) and those that increase heart rate. One case–control study suggested antipsychotics increase risk of AF by 17%13 All antipsychotics appear to increase the risk of bleeding when combined with DOACs in AF.14 Bipolar disorder Valproate Lithium Carbamazepine Depression Untreated depression predicts recurrence of AF27 SSRIs but beware interaction with warfarin and other anticoagulants29 as severe bleeding risk is increased.30 Presence of AF increases risk of depression and anxiety28 Animal studies suggest an antiarrhythmic effect for SSRIs.31,32 Paroxetine improved paroxysmal AF in a series of non-depressed patients.33 Venlafaxine does not directly affect atrial conduction34 and may cardiovert paroxysmal AF.35 One study suggested no increased risk of bleeding when combined with DOACs,36 another suggested a particular risk of bleeding when SNRIs are combined with apixaban.37 Mirtazapine and trazodone may increase bleeding risk when combined with DOACs in AF.37 AF incidence falls after starting antidepressant treatment.38,39 No evidence that agomelatine affects cardiac conduction or clotting. AF reported with clozapine,15,16 olanzapine,17,18 aripiprazole19,20 and paliperidone.21 Causation not clearly established but avoid use in lone, paroxysmal or persistent AF. Avoid QT-prolonging drugs in ischaemic heart disease (see section on QT prolongation in Chapter 1). Association of antipsychotics with AF13 may be linked to metabolic disturbance22 although some studies suggest no link between antipsychotics and AF.23 Mood stabilisers appear not to affect risk of AF. Valproate may cause AV conduction block.24 One case of AF following lithium overdose25 and one in chronic toxicity.26 Avoid tricyclics in coronary disease.40 Tricyclics may provoke AF41,42 but do not increase risk of haemorrhage when combined with warfarin29 or DOACs.37 One database study suggested antidepressants in general do not increase risk of AF43 although another suggested both depression and antidepressant use are linked to incident AF.44

Revision #1
Created 2026-01-04 20:17:53 UTC by Omar Ayman
Updated 2026-01-04 20:17:53 UTC by Omar Ayman