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Case Report

A Case of Persistent Atrial Fibrillation for Laparoscopic Cholecystectomy

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ABSTRACT

Introduction: Atrial fibrillation can be disturbing to the patient, may present as palpitations, syncope. When persistent and causing Haemodynamic disturbances to be treated, either pharmacologically when stable or with Cardioversion under sedation.

Case Report: Our patient aged 50 years male presented with pain abdomen, diagnosed as cholelithiasis. He also presented with palpitations, with an irregular heart rate, giddiness; when ECG was taken it showed a Heart rate of 130 to 150 and had no p waves and irregularly irregular. (Figure 1) (to add).

ECG Showed Atrial Fibrillation and Left Ventricular hypertrophy, Chest X-ray showed increased bronchovascular markings; 2D ECHO showed Mild Concentric LVH, Trivial MR and AR, Mild TR; EF:50%,HbA1c of 9.3%. Other Investigations within normal limits.

Patient was started on Tab. Metoprolol 50mg Twice daily and Tab Rivaxa 20mg once daily for one week and heart rate came down to 70bpm.Tab Rivaxa was stopped 12 hrs before surgery.

Premedicated with Inj.Fentanyl 100mcg, Inj.Loxicard 100mg, Induced with Inj. Propofol 100mg and Intubated with Inj Suxamethonium 100mg. Maintained with O_2, N_2O and Isoflurane and Inj Vecuronium. Monitored with HR, NIBP, SPO_2, Temperature. IV fluids RL&NS were given. Analgesia with Fentanyl, IV Paracetamol. Was uneventful. Reversed with Inj Neostigmine & Inj Glycopyrrolate and extubated. Post-operative period was uneventful.

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Conclusion: We successfully managed a patient with symptomatic Atrial Fibrillation with B blockers and without cardioversion.

KEYWORDS

• Atrial Fibrillation • Lap cholecystectomy

INTRODUCTION

Atrial fibrillation can be disturbing to the patient , may present as palpitations, syncope. When persistent and causing Haemodynamic disturbances to be treated, either pharmacologically when stable or with Cardioversion under sedation.

DISCUSSION

Atrial fibrillation is a very common type of arrythmia which may present with a Mitral valve pathology, could be stable or unstable. Unstable cases require cardioversion under mild sedation or Anaesthesia.[1]

In one case report by Sethi etal, patient was posted for laparotomy, they have used Inj Amiodarone and they could control the heart rate and revert back to sinus rhythm.[2]

Though Atrial fibrillation is common, haemodynamic disturbances can occur and necessitate intervention with anti-Arrythmias or cardioversion to correct and stabiles the patient.

New onset AF or pre-existing AF may be precipitated by several factors like sepsis, electrolyte and acid-base abnormalities, pulmonary complications, hypoxia, hypovolemia, myocardial ischemia.[3]

A report by Roger *et al* says that overall incidence of supraventricular tachycardia was estimated to be less than 1%, the incidence of AF and atrial flutter was 30% and 12%.[4]

The efficacy of esmolol and verapamil in the management of AF was reported by Platia *et al* concluded that the reduction in ventricular rate and the incidence of hypotension were similar.[5]

In a review article they have discussed strategies to minimize perioperative risk, treating patient and surgery-related factors that might precipitate AF.[6]

CONCLUSION

We successfully managed a patient with symptomatic Atrial Fibrillation with B blockers and without cardioversion.

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