Cardiac Services BC
Provincial Health Services Authority

BC AFC Propafenone Initiation and Titration Pathway (For Prescribers)

Document Purpose: Standardized recommendations for initiation of Propafenone and ongoing monitoring/patient management

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Clinical Indications:

- Symptomatic AF in the absence of ischemic/structural heart disease or decompensated heart failure

Absolute Contraindications:

- Pre-existing advanced AV block (second- or third-degree AV block) or conduction system disorders (left bundle branch block, or right bundle branch block when associated with left hemiblock) unless functioning pacemaker is present.
- Ischemic heart disease (active ischemia or history of myocardial infarction)
- Decompensated heart failure or LVEF <40%
- Brugada Syndrome
- Severe hepatic impairment
- Myasthenia gravis

Relative Contraindications (caution for use):

- Sinus bradycardia (<50 bpm) or sick sinus syndrome
- Significant left ventricular hypertrophy
    - LVH with repolarization abnormalities (ST and T wave changes) on ECG
    - LVH >1.4 cm on echocardiogram
- Bronchospastic disease or severe obstructive lung disease
- Hypokalemia or hypomagnesemia (correct imbalances prior to use and throughout therapy)
- Severe renal impairment (CrCl <30 mL/min)

Baseline Investigations:

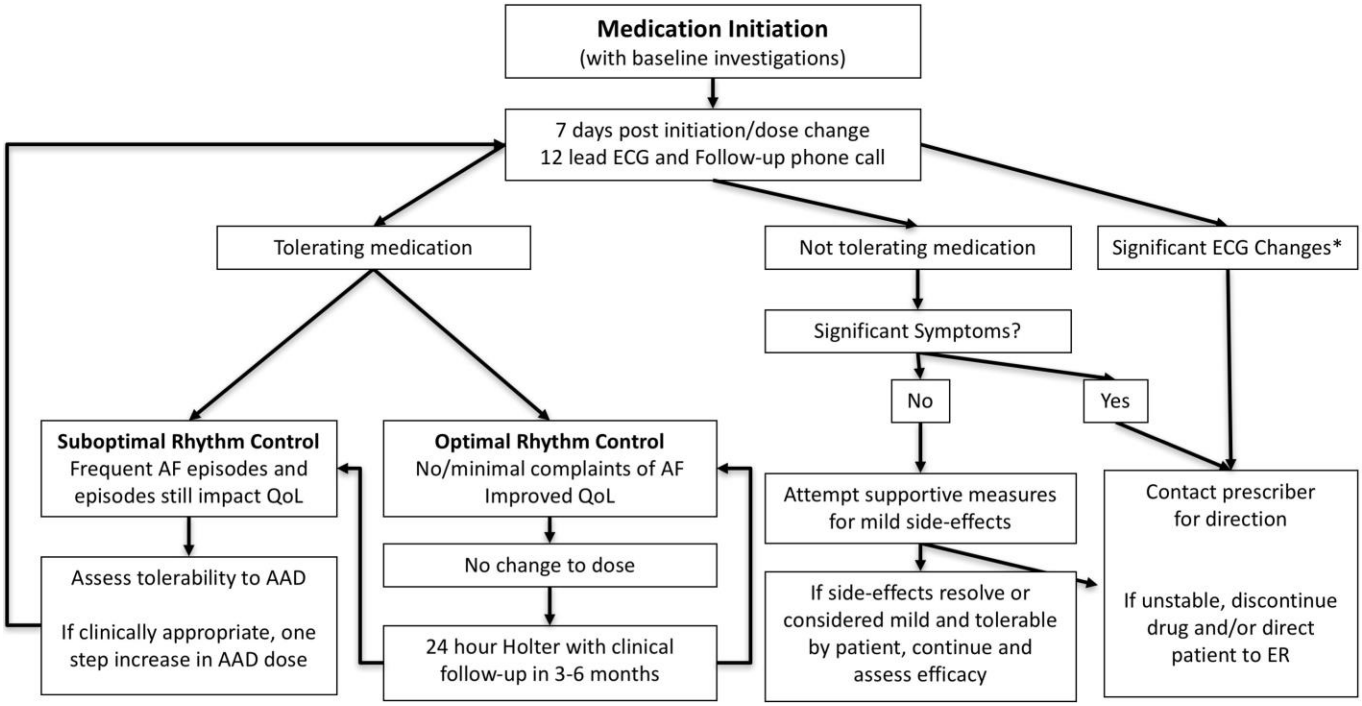
- Blood pressure
- ECG (within 1 week)
- Echocardiogram (or other assessment of LV function; within 1 year)
- Stress Test (if not done within past year)
- Laboratory investigations (within 1 month) - Serum electrolytes, and Serum Creatinine/eGFR

Dosing:

- Starting Dose
    - 150 BID (optional) or 150 TID (usual starting dose) combined with an AV nodal blocker (ie. beta blocker or ditalizem/verapamil)
- Titration: See table below

Current Dose	Increase Dose to	Decrease Dose to
150 mg BID	150 mg TID	-----
150 mg TID	225 mg TID or 300 mg BID	150 mg BID
225 mg TID/300 mg BID	300 mg TID	150 mg TID

If the patient's dosing does not fall into one of the intervals, contact the EP/ cardiologist or consult clinical pharmacist for closest equivalent dosing.



Monitoring:

Parameter	Frequency	Considerations
ECG	Within 7 days of a dose change Every 6-12 months if stable	Notify prescriber if any of the following develop: • PR Interval >200 msec • >25% increase from baseline QRS Duration or >150ms • Heart rate <50 bpm If prescriber not immediately available then consider reducing dose or temporary discontinuation

Patient response	With each dose change and at each patient follow-up appointment	• If symptoms improved and/or decreased frequency of episodes:
		  ○ Maintain at current dose and arrange follow-up (including Holter) as per algorithm.
		• If no/minimal improvement in AF symptoms and patient tolerating propafenone at current dose
		  ○ Titrate propafenone per protocol and send patient for a repeat ECG within 7 days

Medication Tolerance	With each dose change, and at each patient follow-up appointment	• Exacerbation/New onset of HF symptoms
		  ○ Strongly consider holding propafenone pending the outcome of clinical review
		• Exacerbation of reactive airway disease
		  ○ Consider holding pending the outcome of clinical review
		• Syncope
		  ○ Discontinue propafenone, report to ER
		• Dizziness/lightheadedness
		  ○ If acute onset, severe, or persistently problematic send for clinical review
		  ○ Consider holding propafenone pending clinical review
		• Headache, sleep disturbance, unusual taste, GI upset or constipation
		  ○ Supportive measures (up to 1 month)
		  ○ Notify prescriber if symptoms persists and are problematic

24 hour Holter Monitor	Once patient maintained on stable dose	• Arrange for Holter and follow-up visit (in-clinic or telehealth) in 3-6 months following last dose adjustment (or as previously scheduled)
Ischemia assessment	Yearly	• Assess patients for symptoms of CAD annually, and consider stress testing IF significant symptoms present.
Labs (serum electrolytes and renal function)	Annually for stable patients Every 6 months (CrCl 30-60 ml/min)	• Rarely, propafenone may cause blood dyscrasias or hepatic dysfunction. • Consider bloodwork to assess if clinical suspicion

Patient counseling to include:

- Contact primary care physician or AFC with situations that might provoke electrolyte disturbances or renal dysfunction, such as diarrhea/vomiting/dehydration or diuretic therapy
- Contact primary care physician with unexplained fever, sore throat or chills, oral ulcerations with or without fever (especially within the first 3 months of initiation)
- Stop propafenone and report to ER if the patient experiences a syncopal episode

Tapering / Discontinuation Schedule

- Not applicable

Wash-out period prior to initiating alternate antiarrhythmic

- 3 days