

THE AFIB COMPASS

A Cardiologist's Plain Guide to Living Well with Atrial Fibrillation

Companion Pages for Listeners

2027 Edition · Raye Bellinger, MD · Sure Thing Press

These pages go with the audiobook of The AFib Compass. They hold the tables, the dose reference, the episode log, My AFib Plan, the questions to ask your doctor and the glossary, which are easier to read than to hear. Print them, fill them in and bring them to your visits.

Inside

1. The CHA2DS2-VASc stroke risk score (Chapter Six)
2. Blood thinner doses in plain words (Chapter Seven)
3. Medication table (Appendix C)
4. Episode log and My AFib Plan (Appendix D)
5. Questions to ask your doctor (Appendix B)
6. Glossary (Appendix A)

Please read first

This book is intended for general informational and educational purposes only. It is not medical advice, and it is not a substitute for care from a clinician who knows you. Do not start, stop, or change any medicine because of something you read here without talking with your own doctor. If you think you are having a medical emergency, call 911 or your local emergency number. The author and publisher disclaim any liability arising directly or indirectly from the use of this book.

The patients in this book are composites built from real cases. Names are left out, and ages, places, occupations, and other details have been changed so that no one can be identified.

Medicines are named by their generic names. Brand names appear only in Appendix E of the print and ebook editions, so that you can match them to the medicines on your own labels, and are not endorsements.

Evidence reviewed through October 2026.

Call 911 right away if you have:

- Chest pain or pressure
- Fainting or nearly fainting
- Severe shortness of breath, especially if you cannot lie flat
- Sudden weakness or numbness of the face, arm or leg, facial droop, trouble speaking or understanding, confusion, loss of vision or a sudden severe headache
- A head injury while taking a blood thinner, or bleeding that will not stop

1. The CHA2DS2-VASc Stroke Risk Score

From Chapter Six, Your Stroke Risk, in Plain Numbers

The score most widely used in the United States is called CHA2DS2-VASc, usually pronounced "chads-vasc." Each letter stands for a risk factor, and you add up the points.

Risk factor	Points
Congestive heart failure, or a weakened heart muscle	1
Hypertension (high blood pressure, even if treated)	1
Age 75 or older	2
Diabetes	1
Stroke, mini-stroke (TIA) or a clot elsewhere in the body in the past	2
Vascular disease, such as a prior heart attack, blockages in the leg arteries or plaque in the aorta	1
Age 65 to 74	1
Sex category: female	1

Age counts only once: 1 point from 65 to 74, or 2 points at 75 or older. The highest possible score is 9. The higher the score, the higher the yearly risk of stroke.

The 2023 American approach

The 2023 American guideline ties the score to yearly stroke risk.

- Recommended. When the estimated risk is 2 percent a year or more, which corresponds to a score of 2 or more in men and 3 or more in women, a blood thinner is recommended.
- Reasonable. When the risk is between 1 percent and just under 2 percent a year, which is a score of 1 in men and 2 in women, a blood thinner is reasonable, and the decision depends on your values and other factors.
- Not needed for AFib alone. At a score of 0 in men or 1 in women. For a woman, a score of 1 is the point for being female and nothing else, and it does not call for a blood thinner.

The 2024 European approach: CHA2DS2-VA

In 2024, the European guideline dropped the point for female sex and now uses CHA2DS2-VA, with no "Sc" at the end. Being a woman raises stroke risk mainly when other risk factors are present, so the extra point tended to overstate risk in otherwise healthy women, and it forced separate thresholds for men and women. The European score uses one set of thresholds for everyone.

- A score of 2 or more: a blood thinner is recommended.
- A score of 1: a blood thinner should be considered.
- A score of 0: a blood thinner is not needed for AFib alone.

Conditions that call for a blood thinner whatever the score

- Moderate or severe mitral stenosis, a narrowing of the valve between the left atrium and left ventricle, usually from old rheumatic fever.
- A mechanical heart valve.
- Hypertrophic cardiomyopathy, an inherited thickening of the heart muscle.

- Cardiac amyloidosis, in which abnormal protein deposits stiffen the heart.

Only the first two require warfarin. In hypertrophic cardiomyopathy and amyloidosis, the newer pills work well. Chapter Seven explains the warfarin rules.

My score

Date	CHA2DS2-VASc score	CHA2DS2-VA score	Checked with my doctor?

2. Blood Thinner Doses in Plain Words

From Chapter Seven, Choosing a Blood Thinner

DOACs are not one-size-fits-all. For each of them, the dose depends on kidney function, and for apixaban also on age and weight, according to rules on the drug's label. Getting the dose right matters in both directions. Too high raises bleeding risk. Too low leaves the brain underprotected. Lowering the dose "to be safe" when the rules do not call for it is a common error.

This table shows the usual US doses for AFib in plain words. It is for understanding your prescription, not for adjusting it. Your doctor and pharmacist set the dose, and they may take other medicines and conditions into account. Creatinine clearance is an estimate of kidney function in milliliters per minute, calculated from a blood test, your age and your weight.

Medicine	Usual dose	Lower dose, and when
Apixaban	5 mg twice a day	2.5 mg twice a day, only if at least two of these three apply: age 80 or older, weight 60 kg (about 132 pounds) or less, serum creatinine 1.5 mg/dL or higher
Rivaroxaban	20 mg once a day with the evening meal	15 mg once a day with the evening meal when creatinine clearance is 50 or lower
Edoxaban	60 mg once a day	30 mg once a day when creatinine clearance is 15 to 50. Not used when creatinine clearance is above 95, because it works less well in people with very strong kidney function
Dabigatran	150 mg twice a day	75 mg twice a day in the US when creatinine clearance is 15 to 30

Apixaban needs two of the three, not one. Someone who is 82 but weighs 70 kg with normal kidney tests should be on the full dose.

If you take a DOAC, know three things.

- Your kidney function, and how often it will be checked. For most people this is at least once a year, and more often in older people or those with kidney disease.

- Whether you are on the full dose or a reduced dose, and why.
- How and when to take it. Apixaban and dabigatran are always taken twice a day. Rivaroxaban is taken once a day with the evening meal, because it is not fully absorbed on an empty stomach. Edoxaban is once a day, with or without food.

Never change or stop a blood thinner on your own. Your doctor and pharmacist set the dose.

3. Medication Table

Appendix C

This table lists the medicines most often used in AFib care, by generic name. It is a summary, not a complete guide. Your pharmacist and your doctor can tell you about doses, side effects and interactions for your own situation.

Medicine	Group	What it does	Points to know
Anticoagulants			
Apixaban	DOAC (blocks factor Xa)	Lowers stroke risk	Always twice daily. The dose is lowered only if two of three apply: age 80 or older, weight 60 kg or less, creatinine 1.5 or higher
Rivaroxaban	DOAC (blocks factor Xa)	Lowers stroke risk	Once daily for AFib, taken with food, preferably the evening meal; lower dose when kidney function is reduced
Edoxaban	DOAC (blocks factor Xa)	Lowers stroke risk	Once daily; lower dose when kidney function is reduced; not used when kidney function is very high (creatinine clearance above 95)
Dabigatran	DOAC (blocks thrombin)	Lowers stroke risk	Twice daily; the DOAC most dependent on the kidneys, so kidney function sets the dose
Warfarin	Vitamin K antagonist	Lowers stroke risk	Regular INR checks; steady vitamin K intake; many interactions. Required for mechanical valves, moderate to severe mitral stenosis and antiphospholipid syndrome
Rate control			
Metoprolol, bisoprolol, carvedilol	Beta-blockers	Slow the heart rate	Can cause tiredness, cold hands and low blood pressure
Diltiazem, verapamil	Calcium channel blockers	Slow the heart rate	Not used when the ejection fraction is under 40 percent; can cause ankle swelling and constipation
Digoxin	Cardiac glycoside	Slows the heart rate	Blood levels and kidney function checked; levels can rise when kidney function falls
Rhythm control			
Flecainide, propafenone	Antiarrhythmics	Help keep normal rhythm	Paired with a rate-slowing medicine, because they can turn AFib into a flutter that is conducted very fast. Not used with coronary disease or a weak heart
Dofetilide	Antiarrhythmic	Helps keep normal rhythm	Always started in the hospital with about three days of ECG monitoring; dose set by kidney function; can lengthen the QT interval
Sotalol	Antiarrhythmic and beta-blocker	Helps keep normal rhythm	Started with ECG monitoring, usually in the hospital; dose adjusted for kidney function; can lengthen the QT interval
Dronedarone	Antiarrhythmic	Helps keep normal rhythm	Not for permanent AFib, or for severe or recently worsened heart failure
Amiodarone	Antiarrhythmic	Helps keep normal rhythm	The most effective, with the most side effects; thyroid, lung and liver tests before and during treatment, plus eye checks; raises the INR on warfarin, so the warfarin dose is usually lowered
Weight-loss medicines			
Semaglutide, liraglutide	GLP-1 receptor agonists	Lower weight and	Nausea is common; heart rate may rise a

		blood sugar	little; tell your team before sedation or a procedure
Tirzepatide	Dual agonist	Lowers weight and blood sugar	Similar cautions to the GLP-1 medicines

4. Episode Log and My AFib Plan

Appendix D

Write down each episode here and bring these pages to every visit. Patterns, such as episodes after alcohol, poor sleep or illness, can help guide your treatment.

Call 911 right away if you have:

- Chest pain or pressure
- Fainting or nearly fainting
- Severe shortness of breath, especially if you cannot lie flat
- Sudden weakness or numbness of the face, arm or leg, facial droop, trouble speaking or understanding, confusion, loss of vision or a sudden severe headache
- A head injury while taking a blood thinner, or bleeding that will not stop

My information

Item	My details
Type of AFib	
Stroke risk score and date	
Blood thinner and dose	
Rate or rhythm medicines	
Cardiologist and phone	
Electrophysiologist and phone	
Primary care doctor and phone	
Pharmacy and phone	
Emergency contact	

Episodes

The first row shows an example.

Date and start time	How long	What I felt	Pulse and blood pressure	Possible trigger	What I did
Mar 3, 9:40 pm	about 2 hours	fluttering, tired	118, 132/80	two glasses of wine	sat down, took my as-needed pill, called the office next morning

My AFib Plan

1. What kind of AFib do I have? Paroxysmal, persistent or permanent, and how often it affects me.

2. What is my stroke risk score, and what am I doing about it? My blood thinner and dose, or why I am not taking one.

3. What is my rate or rhythm strategy? My medicines and my heart rate target.

4. What do I do in an episode? When to wait, when to call and when to go to the emergency department.

5. Which drivers am I working on? Weight, alcohol, sleep apnea, blood pressure, activity, blood sugar, smoking.

6. Who is on my team? Names and phone numbers.

7. When is my next review?

5. Questions to Ask Your Doctor

Appendix B

You do not need to ask every question. Circle the ones that matter to you, add your own and bring the page to your visit.

After a new diagnosis

- What type of AFib do I have: paroxysmal, persistent, long-standing persistent or permanent?
- What is my stroke risk score, and what does it mean in plain numbers?
- What tests do I need, and what will each one tell us?
- What did my echocardiogram show about my pumping strength and my left atrium?
- Could something be driving my AFib, such as sleep apnea, thyroid trouble, alcohol or high blood pressure?
- What should I do if an episode starts?
- Should I use a watch or home monitor, and which readings should I send you?
- Who do I call with questions between visits?

Deciding about a blood thinner

- Do I need a blood thinner? Why or why not?
- What is my bleeding risk, and which of those risks can we fix?
- Which blood thinner fits me best, and why?
- Is my dose right for my age, weight and kidney function?
- What should I do if I miss a dose?
- Which medicines, supplements and pain relievers should I avoid?
- What bleeding should make me call you, and what should send me to the emergency department?
- Do I still need aspirin?

Rate or rhythm

- Is rate control or rhythm control the better fit for me, and why?
- What heart rate are we aiming for?
- What side effects and monitoring come with the medicine you recommend?
- Would a cardioversion help me, and how long might normal rhythm last?
- Is a pill in the pocket an option for me?
- Could my AFib be weakening my heart?
- At what point should I see an electrophysiologist about ablation?

Before an ablation

- What would ablation do for me specifically?
- What are my chances of staying free of AFib, and how will we measure that?
- What are the main risks for someone like me?
- Which energy source does your team use, and why?
- How many of these procedures does your team do each year?
- What are my alternatives, including not having the procedure?
- Should I keep taking my blood thinner and other medicines beforehand, or hold any doses?
- Will I go home the same day, and when can I drive, work and exercise?

After an ablation

- What symptoms should make me call you or go to the emergency department?
- How long will I take each medicine, and who decides when to stop it?
- How long do I need my blood thinner, and what happens after that?
- How and when will my rhythm be checked?
- What if AFib comes back during the blanking period, or after it?
- Who will follow me over the long term, and how will my doctors share information?

Living with AFib over the years

- Has my stroke risk score changed since last year?
- Is my blood thinner still the right one, at the right dose?
- When was my kidney function last checked?
- Do I still need all of my medicines?
- Should my rhythm strategy change?
- How are my blood pressure, weight, sleep and alcohol, and what should I work on next?
- Have my goals changed, and does my plan still fit them?

When your health changes

- I have a new diagnosis. Does it change my stroke score or my medicines?
- My episodes are longer or more frequent. What should we change?
- I am having surgery or a dental procedure. When do I stop and restart my blood thinner?
- I fell or had a bleed. Should my blood thinner change?
- I was started on a new medicine. Does it interact with my blood thinner or rhythm medicine?
- My pacemaker or monitor found AFib. How long did the episodes last, and does it change my plan?

6. Glossary

Appendix A

These are the terms used most often in this book, along with some words you may hear in the clinic. Words in a definition that have their own entry are not marked; look them up in alphabetical order.

Ablation. A procedure that creates small areas of scar in the heart to block abnormal electrical signals. In AFib, it usually means pulmonary vein isolation.

Absolute risk. The chance that something will happen to a person over a period of time, such as 2 percent per year. Compare relative risk.

ACE inhibitor. A family of blood pressure medicines that also protect the heart and kidneys.

Acetaminophen. A pain and fever reliever. It is safer than NSAIDs for people on a blood thinner, but regular use can raise the INR in people taking warfarin.

Adherence. Taking medicines as prescribed, day after day.

AF burden. The share of time a person spends in AFib during a monitoring period, given as a percentage.

AF-CARE. The European guideline's framework for AFib care: treat other conditions and risk factors, avoid stroke and clots, reduce symptoms with rate and rhythm control, and evaluate and reassess over time.

AF stages. The 2023 American guideline's four stages of AFib: at risk (stage 1), pre-AF (stage 2), AFib itself (stage 3) and permanent AFib (stage 4). See Chapter One.

AFib (AF). Short for atrial fibrillation. "AF" on a report means the same thing.

Alcohol abstinence. Not drinking alcohol at all. In a randomized trial, it reduced AFib recurrence in regular drinkers.

Amiodarone. A powerful antiarrhythmic medicine that requires regular monitoring of the thyroid, lungs, liver and eyes.

Anemia. A low red blood cell count, which can cause tiredness and shortness of breath and may signal slow bleeding.

Antiarrhythmic medicine. A medicine that changes the heart's electrical behavior to help keep normal rhythm.

Anticoagulant. A medicine that slows blood clotting to lower the risk of stroke. Often called a blood thinner.

Anticoagulation clinic. A clinic, often run by pharmacists or nurses, that checks the INR and adjusts warfarin doses.

Antiphospholipid syndrome. An immune condition that makes the blood clot too easily. People with it who need a blood thinner should take warfarin, not a DOAC.

Antiplatelet medicine. A medicine, such as aspirin or clopidogrel, that makes platelets less sticky. Not a substitute for an anticoagulant in AFib.

Apixaban. A DOAC that blocks factor Xa, always taken twice a day.

Arrhythmia. Any abnormal heart rhythm.

Atria. The two upper chambers of the heart. Singular: atrium.

Atrial fibrillation. A rhythm in which the upper chambers quiver chaotically instead of squeezing, and the lower chambers beat irregularly.

Atrial flutter. A more organized fast rhythm in the upper chambers, often related to AFib, usually treated in similar ways.

Atrial high-rate episode. A fast upper-chamber rhythm recorded by a pacemaker, defibrillator or loop recorder, often called device-detected or subclinical AFib.

Atrial tachycardia. A fast, regular rhythm starting in one area of the atria, sometimes seen after ablation.

Atrioesophageal fistula. A very rare but serious abnormal connection between the esophagus and the left atrium that can follow heat or cold ablation. An emergency.

Atrioventricular node. The electrical gateway between the upper and lower chambers. Ablating it is part of the pace-and-ablate strategy.

Beta-blocker. A family of medicines, such as metoprolol and bisoprolol, that slow the heart rate and lower blood pressure.

Blanking period. The first three months after ablation, when early episodes are common and not counted as failure.

Bleeding risk score. A tool, such as HAS-BLED, that identifies factors raising the risk of bleeding on an anticoagulant.

Blood thinner. The everyday term for an anticoagulant.

BMI. Body mass index, a measure of weight relative to height.

Bridging. Giving short-acting injections of a blood thinner, such as heparin, while warfarin is paused for a procedure. Usually not needed in AFib alone.

Calcium channel blocker. A family of medicines. Two of them, diltiazem and verapamil, slow the heart rate in AFib.

Cardiac rehabilitation. A supervised exercise and education program for people with heart conditions.

Cardiologist. A doctor who specializes in the heart and blood vessels.

Cardiomyopathy. Disease of the heart muscle. See tachycardia-mediated cardiomyopathy.

Cardioversion. Restoring normal rhythm, either with a brief, timed electrical shock under sedation or with medicine.

Catheter. A thin, flexible tube passed through a blood vessel to the heart.

CHA2DS2-VA. The 2024 European version of the stroke risk score, which leaves out sex.

CHA2DS2-VASc. The traditional score used to estimate stroke risk in AFib, based on age, sex and several conditions. Often said "chads-vasc."

Composite outcome. A trial result that combines several events, such as stroke, heart attack and death.

Continuous monitoring. Recording the heart rhythm all the time, for example with an implanted loop recorder.

CPAP. Continuous positive airway pressure, a breathing machine worn at night to treat sleep apnea.

Creatinine clearance. An estimate of kidney function used to choose the dose of some anticoagulants.

Cryoballoon ablation. Ablation that uses a balloon cooled to below freezing to isolate the pulmonary veins.

CT scan. An X-ray-based scan that produces detailed images, used to check for bleeding in the brain or to map the heart before ablation.

Dabigatran. A DOAC that blocks thrombin, taken twice a day. It depends on the kidneys more than the other DOACs.

Defibrillator. An implanted device that can shock the heart out of a dangerous rhythm in the lower chambers.

Device-detected AFib. AFib found by a pacemaker, defibrillator or implanted monitor, often brief and without symptoms.

Digoxin. An old medicine that slows the heart rate in AFib. Its blood level and kidney function need monitoring.

Diltiazem. A calcium channel blocker used to slow the heart rate. Not used when the ejection fraction is under 40 percent.

DOAC. Direct oral anticoagulant: apixaban, rivaroxaban, edoxaban or dabigatran.

Dofetilide. An antiarrhythmic medicine that is always started in the hospital, with about three days of ECG monitoring.

Dronedarone. An antiarrhythmic medicine related to amiodarone. It is not used in permanent AFib or in severe or recently worsened heart failure.

Dual agonist. A medicine, such as tirzepatide, that acts on two gut-hormone receptors to lower blood sugar and weight.

ECG. Electrocardiogram, a recording of the heart's electrical activity from stickers on the skin. Also called an EKG.

Echocardiogram. An ultrasound picture of the heart that shows its size, pumping strength and valves.

Edoxaban. A DOAC that blocks factor Xa, taken once a day. Not used when kidney function is very high.

eGFR. Estimated glomerular filtration rate, a common measure of kidney function.

Ejection fraction. The percentage of blood the left ventricle pumps out with each beat. Normal is about 50 percent or higher.

Electrophysiologist. A cardiologist with extra training in the heart's electrical system who performs ablations and implants devices.

Embolism. A clot or other material that travels in the blood and blocks a vessel.

Endurance athlete. A person who trains for long-distance events. Very high training volumes are linked to AFib in some.

Event monitor. A monitor worn for weeks that records the rhythm when symptoms occur or when it detects an abnormal rhythm.

Factor Xa. A clotting protein blocked by apixaban, rivaroxaban and edoxaban.

First-line therapy. The first treatment tried for a condition.

Flecainide. An antiarrhythmic medicine for people without coronary disease or a weak heart, usually paired with a rate-slowing medicine. Sometimes used as a pill in the pocket.

Frailty. A state of reduced strength and reserve that makes people more vulnerable to illness, falls and treatment side effects.

GLP-1 receptor agonist. A family of medicines, such as semaglutide, that mimic a gut hormone to lower blood sugar and weight.

Guideline. A formal set of recommendations written by expert panels after reviewing the evidence.

HAS-BLED. A bleeding risk score. Best used as a checklist of risks to fix.

Hazard ratio. A measure comparing the rate of events in two groups. A hazard ratio of 0.80 means events occurred about 20 percent less often.

Health anxiety. Persistent worry about one's health that interferes with daily life. Treatable.

Heart failure. A condition in which the heart cannot pump or fill well enough to meet the body's needs.

Heparin. A short-acting blood thinner given by injection or through a vein, used in the hospital, during ablation and for bridging.

HFpEF. Heart failure with preserved ejection fraction: heart failure in which the pumping strength is normal, about 50 percent or higher, but the heart is stiff and fills poorly.

HFrEF. Heart failure with reduced ejection fraction: heart failure with weak pumping, an ejection fraction of 40 percent or lower.

Holter monitor. A monitor worn for one to several days that records every heartbeat.

Hybrid convergent procedure. A combined surgical and catheter approach for persistent AFib.

Hypertension. High blood pressure.

Implantable loop recorder. A small monitor placed under the skin of the chest that records the rhythm for years.

INR. International normalized ratio, the blood test used to measure warfarin's effect. The usual target in AFib is 2 to 3.

Intracranial hemorrhage. Bleeding inside the skull, the most feared bleeding complication of anticoagulants.

Ischemic stroke. A stroke caused by a blocked artery, often by a clot. The main type AFib causes.

Left atrial appendage. A small pouch off the left atrium where most AFib clots form.

Left atrial appendage closure. Sealing off the appendage with a catheter-delivered device or during surgery to lower stroke risk.

Left atrium. The upper left chamber of the heart, which receives blood from the lungs.

Lenient rate control. Aiming for a resting heart rate under 110 beats per minute in AFib, rather than a stricter target.

Long-standing persistent AFib. Persistent AFib that has lasted without a break for more than twelve months.

Major bleeding. Bleeding that is fatal, that occurs in a critical area such as the brain, or that causes a large drop in blood count or needs a transfusion.

Maze procedure. A surgical procedure that creates a pattern of scar in the atria to block AFib circuits.

Mechanical heart valve. An artificial valve made of durable materials. People with one need warfarin, not a DOAC.

MET. Metabolic equivalent, a unit of exercise capacity.

Meta-analysis. A study that pools results from several trials or studies.

Metoprolol. A commonly used beta-blocker.

Mitral stenosis. Narrowing of the mitral valve, usually from rheumatic fever. Moderate or severe cases require warfarin in AFib.

MRI. Magnetic resonance imaging, a scan that uses magnets to create detailed images.

Noninferior. A trial result showing that a treatment was not worse than the comparison by more than a small margin set in advance.

NSAID. Nonsteroidal anti-inflammatory drug, such as ibuprofen or naproxen. Raises bleeding risk with anticoagulants.

Observational study. A study that follows people who made their own choices. It can show associations but not prove cause.

Obstructive sleep apnea. Repeated collapse of the airway during sleep, common in AFib and treatable.

PAC. Premature atrial contraction, an early beat from the upper chambers. Very common and usually harmless.

Pace-and-ablate. Implanting a pacemaker and then ablating the atrioventricular node to control a fast heart rate permanently.

Pacemaker. An implanted device that keeps the heart from beating too slowly.

Palpitations. An awareness of the heartbeat, such as pounding, fluttering or skipping.

Paroxysmal AFib. AFib that stops within seven days, either on its own or with treatment such as cardioversion.

Patch monitor. An adhesive monitor worn on the chest for up to about two weeks.

Patient-years. A way of counting time in a study. One hundred people followed for one year, or fifty people followed for two years, add up to 100 patient-years.

Permanent AFib. AFib that is present all the time, when the patient and doctor have decided not to pursue normal rhythm.

Persistent AFib. AFib that lasts more than seven days. An episode stopped by cardioversion within seven days is still paroxysmal.

Phrenic nerve. The nerve that controls the diaphragm, which runs near the right pulmonary veins.

Pill in the pocket. Taking a single dose of an antiarrhythmic medicine when an episode starts, after it has been tested safely. See Chapter Ten.

Placebo. An inactive treatment used for comparison in a trial.

Pre-AF. Stage 2 of the AF stages: signs that the atria are under strain, such as an enlarged left atrium or frequent PACs, but no AFib yet.

Propafenone. An antiarrhythmic medicine for people without coronary disease or a weak heart, usually paired with a rate-slowing medicine.

Pulmonary vein isolation. The core ablation procedure, which builds an electrical fence around the pulmonary veins.

Pulmonary veins. The four veins that carry blood from the lungs to the left atrium, where most AFib triggers arise.

Pulsed field ablation. Ablation that uses very short, high-voltage electrical pulses rather than heat or cold.

PVC. Premature ventricular contraction, an early beat from the lower chambers. Common and usually harmless.

QT interval. A measurement on the ECG that some medicines lengthen, which can rarely lead to dangerous rhythms.

Radiofrequency ablation. Ablation that uses heat delivered point by point from a catheter tip.

Randomized trial. A study that assigns people to treatments by chance. The strongest test of cause and effect.

Rate control. A strategy that accepts AFib and slows the heart rate.

Recurrence. The return of AFib after treatment.

Redo procedure. A second ablation to close gaps or treat new triggers.

Relative risk. How much a risk changes compared with a starting point, such as 20 percent lower. Compare absolute risk.

Reversal agent. A treatment that counteracts an anticoagulant in an emergency.

Rhythm control. A strategy that aims to restore and keep normal rhythm.

Rivaroxaban. A DOAC that blocks factor Xa, taken once a day with the evening meal for AFib.

Semaglutide. A GLP-1 receptor agonist used for diabetes and weight loss.

Septum. The wall between the right and left sides of the heart, crossed during ablation.

Shared decision-making. Choosing a treatment together, combining the evidence with the patient's values and preferences.

Sheath. A short, hollow tube placed in a vein, usually at the top of the leg, through which catheters pass during ablation.

Silent brain infarct. A small area of brain injury from a blocked vessel that shows on a scan but caused no noticeable symptoms.

Single-lead ECG. A one-channel tracing of the heart's electrical activity, such as from a smartwatch or handheld device. A 30-second tracing reviewed by a doctor can confirm AFib.

Sinus rhythm. The heart's normal rhythm, started by its natural pacemaker, the sinus node.

Smartwatch alert. A notification from a wearable device suggesting an irregular rhythm. Needs medical confirmation.

Sotalol. An antiarrhythmic medicine that is also a beta-blocker. Started with ECG monitoring, and its dose depends on kidney function.

Stroke. Injury to the brain from a blocked or burst blood vessel.

Subclinical AFib. AFib without symptoms, usually found by a device.

Supraventricular tachycardia (SVT). A general term for fast rhythms starting above the lower chambers. Short runs are common on monitors.

Systemic embolism. A clot that travels to an artery outside the brain, such as in a leg or the intestines.

Tachycardia-mediated cardiomyopathy. Weakening of the heart muscle caused by a fast heart rate over weeks to months. It often improves once the rate or rhythm is controlled.

Tamponade. Fluid around the heart that compresses it and must be drained. A rare complication of ablation.

TEE. Transesophageal echocardiogram, an ultrasound of the heart taken with a thin probe passed down the throat into the esophagus, under sedation. Used to look for clots in the left atrial appendage.

Thrombin. A key clotting protein blocked by dabigatran.

Thyroid. A gland in the neck. An overactive thyroid can trigger AFib.

TIA. Transient ischemic attack, a brief stroke-like episode that resolves. A warning sign.

Tirzepatide. A dual agonist medicine used for diabetes and weight loss.

Trigger. Something that sets off an episode, such as alcohol or poor sleep.

Ventricles. The two lower chambers of the heart, which pump blood to the lungs and body.

Verapamil. A calcium channel blocker used to slow the heart rate. Not used when the ejection fraction is under 40 percent.

Vitamin K. A vitamin needed to make clotting proteins. Warfarin works by blocking it, so intake should be steady.

Warfarin. An older anticoagulant that blocks vitamin K and is monitored with the INR. Required for mechanical valves, moderate or severe mitral stenosis and antiphospholipid syndrome.

WPW. Wolff-Parkinson-White syndrome, an extra electrical pathway between the upper and lower chambers. In the rare person who has it, AFib can be conducted dangerously fast, one reason the first ECG is read carefully.

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