Cardiac Services BC
Provincial Health Services Authority

BC AFC Dronedarone Initiation and Titration Pathway (For Prescribers)

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

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Clinical Indication:

- Symptomatic AF in the absence of significant heart failure or liver abnormalities

Absolute Contraindications:

- Permanent AF
- Heart failure with recent decompensation requiring hospitalization
- Left ventricular systolic dysfunction (LVEF <40%)
- High degree atrioventricular conduction disorders (unless functioning pacemaker is present)
- Patients with previous lung or liver injury related to prior use of amiodarone
- Pre-existing QTc prolongation (congenital or acquired long QT syndromes)
    - Consider avoiding dronedarone in the presence of a QTc >440 msec (men) or >460 msec (women) in the absence of a pre-existing bundle branch block
- Severe hepatic impairment

Relative Contraindications (caution for use):

- Sinus bradycardia (<50 bpm)
- Hypokalemia or hypomagnesemia (correct imbalances prior to use and throughout therapy)
- Concomitant use of strong CYP3A inhibitors (ketoconazole, itraconazole, voriconazole, cyclosporine, telithromycin, clarithromycin, nefazodone, and ritonavir)

Baseline Investigations:

- Blood pressure
- ECG (within 1 week)
- Echocardiogram (or other assessment of LV function; within 1 year)
- Laboratory investigations (within 1 week) - Serum electrolytes, LFTs, and Serum Creatinine/eGFR

Dosing:

- 400 mg BID

Monitoring:

Parameter	Frequency	Considerations
ECG	Within 7 days of initiation Every 6-12 months if stable	Notify prescriber if any of the following develop: • >25% increase from baseline QTc (>500ms) • Heart rate <50 bpm If prescriber not immediately available then consider reducing dose or temporary discontinuation

Patient response	With initiation 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
		  ○ Notify prescriber to discuss alternative therapies
		• If AF persists and sinus rhythm cannot be restored
		  ○ Discontinue dronedarone

Medication Tolerance	With initiation and at each patient follow-up appointment	• Syncope
		  ○ Discontinue dronedarone, report to ER
		• Exacerbation/New onset of HF symptoms
		  ○ Strongly consider holding propafenone pending the outcome of clinical review
		• Dizziness/lightheadedness
		  ○ Notify MD/NP if acute onset, severe, or persistently problematic for the patient
		• Nausea, diarrhea
		  ○ Supportive measures (up to 1 month)
		  ○ Notify prescriber if symptoms persists and are problematic
		• Symptoms of liver injury (as outlined below)
		  ○ Obtain LFTs and notify prescriber

24 hour Holter Monitor	Once patient stable	• Arrange for Holter and follow-up visit (in-clinic or telehealth) in 3-6 months (or as previously scheduled)
Labs (Liver Panel and bilirubin)	Every 3 months for the first year then every 6 months	

Patient counseling to include:

- Report immediately any symptoms suggestive of:
  - Pulmonary toxicity (Dyspnea or non-productive cough)
  - Hepatic injury (anorexia, nausea, vomiting, fever, malaise, fatigue, RUQ pain, jaundice, dark urine, itching)

Tapering / Discontinuation Schedule

- Not applicable

Wash-out period prior to initiating alternate antiarrhythmic

- 3 days