

Life Quality and Related Factors in Patients Receiving Atrial Fibrillation Ablation

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Abstract

Objective: The aim of this study was to evaluate the quality of life and its correlating characteristics in patients who underwent Atrial Fibrillation (AF) ablation.

Method: This descriptive study encompassed 72 patients aged 18 years and older who had undergone atrial fibrillation ablation at least three months prior and were subsequently monitored at the Department of Cardiology of a university hospital, either as outpatients attending regular follow-up visits or as inpatients for various reasons. Data were collected using a structured questionnaire designed to assess participants' sociodemographic characteristics and health-related behaviors, as well as the Atrial Fibrillation Effect on Quality of Life Questionnaire (AFEQT). For quantitative variables, data are presented as mean $\pm$ standard deviation and median (range). For categorical variables, they were shown as frequency and %.

Results: The participants' average age was 53.7 ± 10.5 years and the average time after AF diagnosis was 44.3 ± 47.1 months. Of the people who took part, 69.4% went for outpatient follow-up and 51.4% were overweight. Palpitations (93.1%), fatigue (52.8%), exhaustion (45.8%) and dyspnea (38.9%) were the AF-related symptoms that people experienced the most. 51.4% of the people who participated said their overall health was "good." 36.1% said their health had not changed during the previous year and 8.3% said it had become worse. The average scores for the AFEQT subdomains were symptoms 72.6 ± 27.3 , daily activities 58 ± 32.9 , treatment concern 73.1 ± 27.3 and treatment satisfaction 65.7 ± 25 . The total AFEQT score was 66.2 ± 26.2 , which means that the quality of life didn't get worse.

Conclusion: It is advisable to do regular long-term monitoring of individuals having ablation to evaluate their quality of life with validated scales. The findings should inform personalized care and educational planning, the formulation of clinical recommendations and the establishment of effective care procedures.

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Keywords: Atrial Fibrillation; Ablation; Quality of Life; Nursing; Care

Introduction

Atrial Fibrillation (AF) is a kind of arrhythmia that happens when the atria are activated in an uncontrolled and irregular way [1,2]. The rising prevalence and incidence with age in developed nations, the role of cardiovascular and cerebrovascular consequences in mortality and the diminished quality of life resulting from AF-related symptoms render it a critical global public health concern [3]. Catheter ablation is a treatment for AF that tries to stop the heart from conducting electricity in the wrong way and encourage it to do so in the right way [4,5]. Ablation aims to eradicate AF episodes without pharmacological intervention or to diminish their frequency and intensity through medical treatment [6,7,8]. Like other heart problems, AF can

make patients' lives worse by causing symptoms and requiring medication [9].

Nurses are the healthcare professionals who work with patients the most in clinical settings; thus, their role in early diagnosis, preventing complications, keeping up with treatment and care and improving the quality of life for AF patients is very important.

This study aimed to assess the quality of life of people who had AF ablation and what factors affected it.

Methodology

This descriptive study was performed in the Adult Cardiology Department of a Hacettepe University hospital. The research cohort comprised individuals who received atrial fibrillation ablation and were subsequently monitored in this department. The sample consisted of 72 patients who underwent AF ablation between 01/12/2019 and 01/05/2020, attended outpatient clinic visits or were hospitalized for various reasons, fulfilled the inclusion criteria and consented to participate. A power analysis found that the smallest sample size needed was 54 with a 95% confidence level. We employed non-probability convenience sampling.

The criteria for inclusion were being at least 18 years old, having had AF ablation at least three months ago, being willing to participate and not having any visual, auditory or cognitive problems. Exclusion criteria encompassed absence of ablation, ablation conducted less than 3 months prior, sensory or cognitive impairment, age under 18 or refusal to participate.

Researchers used the "Structured Questionnaire" and the "Atrial Fibrillation Effect on Quality of Life Questionnaire (AFEQT)" to gather data. Spertus, et al., produced these. The AFEQT is a disease-specific tool with 20 questions divided into four groups: symptoms (questions 1-4), daily activities (questions 5-12), treatment concern (questions 13-18) and treatment satisfaction (questions 19-20). Güneş (2019) did the Turkish validation and authorization was given to use it [10].

The researcher performed face-to-face interviews lasting roughly 30 minutes, during which they read the questions aloud, recorded replies and received both verbal and written informed consent.

We used IBM SPSS V23 to analyze the data. The Shapiro-Wilk and Kolmogorov-Smirnov tests were used to check for normality. The Mann-Whitney U and Kruskal-Wallis tests were utilized for group comparisons. Spearman's rho correlation was utilized to analyze relationships, while linear regression was employed to evaluate determinants of AFEQT scores. A p-value of less than 0.05 was considered statistically significant.

The university's Non-Interventional Clinical Research Ethics Committee gave their approval for the study. The Department of Cardiology, hospital administration and all participants also gave their permission for the study.

Results

The average age of the people who took part was 53.70 years, with 55.6% being women and 44.4% being men. Everyone had health insurance from the government. Ninety-three percent of them were married, thirty-six percent had finished primary education and thirty-six percent had a high school or university degree.

In terms of clinical characteristics, 69.4% came in for outpatient follow-up, whereas 30.6% were inpatient for other reasons. 51.4% of the people who participated were overweight and 37.5% were of normal weight. There were 84.7% of people with paroxysmal AF and 15.3% of people with chronic AF. Seventy-nine percent of people had more than one chronic illness, with high blood pressure being the most frequent (48.6%). A family history of arrhythmia was noted in 12.5%, with 9.7% indicating maternal arrhythmia (Table 1).

Characteristics	Frequency (n)	Percentage (%)
Reason for Admission		
Outpatient follow-up	50	69.4
Inpatient	22	30.6
Body Mass Index (BMI)*		

Overweight	37	51.4
Normal weight	27	37.5
Obesity Class I	6	8.3
Obesity Class II	2	2.8
Type of AF		
Paroxysmal	61	84.7
Persistent	11	15.3
Chronic Disease		
Yes	57	79.1
No	15	20.08
Type of Disease**		
HT (Hypertension)	35	48.6
DM (Diabetes Mellitus)	8	11.1
HL (Hyperlipidemia)	13	18.1
CAD (Coronary Artery Disease)	12	16.7
MVR (Mitral Valve Replacement)	9	12.5
Hypothyroidism	8	11.1
COPD	5	6.9
Hyperthyroidism	4	5.6
AVR (Aortic Valve Replacement)	4	5.6
RA (Rheumatoid Arthritis)	3	4.2
CHF(Chronic Heart Failure)	2	2.8
HCMP (Hypertrophic Cardiomyopathy)	2	2.8
SVO (Stroke)	2	2.8
MP (Myopathy)	2	2.8
Asthma	4	5.6
Other	13	18.1
Family History of Arrhythmia		
Yes	9	12.5
No	63	87.5
Degree of Relation		
Mother	7	9.7
Father	1	1.4
Siblings	1	1.4
*BMI reference ranges were calculated based on the WHO BMI reference ranges.		
**There are participants with multiple systemic disease responses.		

Table 1: Current health status of participants (N=72).

When it came to health behaviors, 65.3% of them didn't smoke and 93.1% of them didn't drink alcohol. Most of the people who participated (66.7%) said they ate a conventional diet. Of those, 52.8% said they followed a low-cholesterol, low-sodium diet and 12.5% said they followed a diabetic diet. 73.6% of people did not exercise; however, 26.4% said they walked regularly (Table 2).

Characteristics	Frequency (n)	Percentage (%)
Smoking		
Yes	6	8.3
No	47	65.3
Quit	19	26.4

Alcohol Use		
No	67	93.1
Yes	5	6.9
Eating Habits		
Regular	48	66.7
Irregular	24	33.3
Diet		
Low-cholesterol, low-sodium diet	38	52.8
Not dieting	24	33.3
Diabetic diet	9	12.5
Low salt	8	11.1
Low fat	1	1.4
Physical Activity		
Does not exercise	53	73.6
Regular walking	19	26.4

Table 2: Participants' Current Health-Related habits.

Palpitations (93.1%), weariness (52.8%), exhaustion (45.8%) and dyspnea (38.9%) were the most common AF-related symptoms recorded (Table 3).

Characteristics	Frequency (n)	Percentage (%)
AF Symptoms*		
Palpitations	67	93.1
Fatigue	38	52.8
Tiredness	33	45.8
Shortness of breath	28	38.9
Chest discomfort	12	16.7
Dizziness	12	16.7
Fainting	6	8.3
Sweating	3	4.2
Numbness in arms	2	2.8
Other	24	33.3

*There are participants who describe more than one symptom

Table 3: Most frequently reported AF-related symptoms by participants.

The mean age of the patients was 53.7 ± 10.5 , the mean BMI was 25.9 ± 4.1 and the mean duration of AF diagnosis was 44.3 ± 47.1 month, the mean score for the symptoms subscale was 72.6 ± 27.3 , the mean score for the daily impact subscale was 58 ± 32.9 , the mean score for the treatment anxiety subscale was 73.1 ± 27.3 , the mean score for the treatment satisfaction subscale was 65.7 ± 25 and the mean total scale score was 66.2 ± 26.2 (Table 4).

	Mid. $\pm$ S.D.	Mid. (Min. - Maks.)
Age	$53,7 \pm 10,5$	56 (23 - 65)
BMI	$25,9 \pm 4,1$	25,8 (14,2 - 37,6)
AF diagnosis (month)	$44,3 \pm 47,1$	24 (3 - 204)
symptoms subscale	$72,6 \pm 27,3$	79,2 (8,3 - 100)
daily impact subscale	$58 \pm 32,9$	54,2 (0 - 100)
treatment anxiety subscale	$73,1 \pm 27,3$	80,6 (11,1 - 100)

treatment satisfaction subscale	65,7 ± 25	66,7 (0 - 100)
Total scale score	66,2 ± 26,2	66,7 (13,3 - 100)

Table 4: Descriptive statistics for quantitative variables.

20.8% of participants reported being extremely satisfied with their current treatment in controlling AF, 20.8% reported being extremely satisfied with the treatment in alleviating the symptoms of AF and 29.1% reported being quite satisfied (Table 5).

AFEQT							
scale - treatment satisfaction subscale					Between Being Satisfied and Not Being Satisfied-		
	Extremely Satisfied (%)			I am n (%)			Extremely Dissatisfied
		Very Satisfied (%)	Very Satisfied (%)		I am quite dissatisfied (%)	Very dissatisfied (%)	(%)
How well is your current treatment controlling your AF?	15(2 0,8)	8(11,4)	22(3 0,5)	20(27, 7)	3(4,1)	0(0)	4(5,5)

Table 5: Item response rates/percentage distributions for the AFEQT scale questions-treatment satisfaction subscale.

30.5% of participants said they felt tired, weak or exhausted while doing a physical activity; 33.3% said they felt short of breath while exercising; 33.3% said they felt short of breath while walking briskly and 27.7% said they felt short of breath while walking uphill quickly or carrying things like "bags-packets" without stopping and without resting while climbing a flight of stairs. 33.3% of participants said they did not have any trouble with strenuous sports activities like lifting or moving furniture, running, tennis or basketball; 23.6% said they had a lot of trouble lifting or moving furniture (Table 6).

AFEQT							
Daily Activities Sub Category							
	Never	Almost	Very little I had some	Partially I had difficulty n(%)	I	Very Difficult n(%)	I Was Extremely Stressed n(%)
	I didn't have any trouble	I didn't have any trouble at all	difficulty		had a hard time n(%)		
	n(%)	n(%)	n(%)				
While engaging in an activity due to fatigue, exhaustion or loss of strength	22(30,5)	5(6,9)	8(11,1)	13(18,5)	13(18,5)	7(9,7)	4(5,5)
When engaging in physical activity due to shortness of breath	24(33,3)	4(5,5)	5(6,9)	12(16,6)	14(19,4)	7(9,7)	6(8,3)
While exercising	24(33,3)	2(2,7)	4(5,5)	11(15,2)	11(15,2)	6(8,3)	14(19,4)
While brisk walking	21(29,1)	3(4,1)	6(8,3)	9(12,5)	10(13,8)	6(8,3)	17(23,6)
While walking quickly uphill or carrying things like "bags and packages" without stopping and climbing a flight	20(27,7)	5(6,9)	4(5,5)	4(5,5)	14(19,4)	9(12,5)	16(22,2)

of stairs without resting							
When engaging in strenuous physical activities such as moving or rearranging furniture, running, tennis or basketball	24(33,3)	5(6,9)	4(5,5)	3(4,1)	8(11,1)	11(15,2)	17(23,6)

Table 6: Item response rates/percentage distributions for AFEQT scale questions-daily activities subscale; physical activities.

43.05% of participants were worried or anxious that AF could start at any time, 50% were worried that AF could make other health problems worse over time, 40.2% were worried about the side effects of medication, 47.2% were worried about the side effects or possible problems that could come up during procedures like catheterization, surgery or pacemaker implantation and 51.3% were worried about the adverse effects of blood thinners, like nosebleeds, bleeding gums when brushing teeth, excessive bleeding from cuts or bruises. 48.6% said they weren't worried that treatment would disrupt their daily lives. 20.8% of participants said they were very happy with the present treatment for controlling AF, 20.8% said they were very happy with the treatment for relieving AF symptoms and 29.1% said they were happy (Table 7).

The Treatment Anxiety Subscale of the AFEQT Scale	I Have Never Felt Uncomfortable n (%)	I Was Hardly Ever Uncomfortable n (%)	I Was Only Slightly Annoyed n (%)	I Was Somewhat Uncomfortable n (%)	I Was Quite Upset n (%)	I Was Very Uncomfortable n (%)	I Was Extremely Annoyed n (%)
The feeling of anxiety or worry that the AF could start at any moment	31(43,05)	8(11,1)	9(12,5)	6(8,3)	7(3,4)	5(6,9)	6(8,3)
A sense of concern that AF may worsen other health conditions in the long term	36(50)	8(11,1)	7(3,4)	3(4,1)	9(12,5)	6(8,3)	3(4,1)
Worrying about the side effects of medication	29(40,2)	9(12,5)	4(5,5)	11(15,2)	10(13,8)	7(3,4)	2(8,8)
Worrying about the side effects or potential complications of procedures such as catheterization, surgery, or pacemaker implantation	34(47,2)	14(19,4)	3(4,1)	5(6,9)	8(11,1)	6(8,3)	2(8,8)
Worrying about the side effects of blood thinners, which can cause	37(51,3)	11(15,2)	5(6,9)	4(5,5)	12(16,6)	3(4,1)	0(0)

nosebleeds, bleeding gums while brushing your teeth, heavy bleeding from cuts or bruising							
Worrying or feeling anxious about how treatment might interfere with your daily activities	35(48,6)	7(3,4)	5(6,9)	12(16,6)	10(13,8)	3(4,1)	0(0)

Table 7: Item response rates/percentage distributions of the AFEQT scale questions-Treatment Anxiety Subscale.

There is a statistically significant difference between the medians of the daily activities subscale scores according to the type of AF ($p=0.023$). The median score for those with paroxysmal AF was 56.3 and the median score for those with persistent AF was 29.2. This difference stems from the fact that the median score for those with paroxysmal AF was higher than that for those with persistent AF (Table 8).

		Symptoms Subscale	Daily Activities Subcategory	Treatment Anxiety Subscale	Treatment Satisfaction Subscale	Total score
Type of AF						
Paroxysmal	Mid. $\pm$ S.D.	71,9 $\pm$ 27,8	61,5 $\pm$ 32,8	72,1 $\pm$ 28,2	66 $\pm$ 26,2	67,2 $\pm$ 27,2
	Mid. (Min. - Maks.)	79,2 (8,3 - 100)	56,3 (0 - 100)	80,6 (11,1 - 100)	66,7 (0 - 100)	75 (13,3 - 100)
Persistent	Mid. $\pm$ S.D.	76,9 $\pm$ 24,9	38,4 $\pm$ 26,7	78,5 $\pm$ 22,2	64,4 $\pm$ 17,9	60,8 $\pm$ 20,3
	Mid. (Min. - Maks.)	79,2 (37,5 - 100)	29,2 (0 - 87,5)	88,9 (44,4 - 100)	58,3 (41,7 - 100)	53,3 (30 - 93,3)
	Test statistic	U=306	U=192	U=299,5	U=301	U=272,5
	p	0,637	0,023	0,561	0,581	0,323

U: Mann-Whitney U test statistic, χ^2 : Kruskal-Wallis test statistic, a-c: There is no significant difference between groups sharing the same letter.

Table 8: Comparison of scores by demographic characteristics; by type of AF.

When the effect of independent variables on the total score of the quality of life scale was examined using linear regression, the resulting regression model was found to be statistically significant ($F=7.471$; $p<0.001$). As AF duration increases, the total quality of life score decreases; specifically, for every one-unit increase in AF duration, the total score decreases by 0.130 ($p=0.005$). The total score of those who engage in regular walking is 10.894 higher than that of those who do not exercise ($p=0.040$). The total score of those requiring a caregiver is 16.836 lower than that of those who do not ($p=0.025$). The total score of those with poor general health is 17.517 lower than that of those with moderate general health ($p=0.021$). The total score for those whose health status was slightly worse compared to the previous year was 13,846 lower than those with the same status, the total score for those whose health status was better was 20,440 higher than those with the same status and the total score for those whose health

status was worse was 26,259 lower than those with the same status (p-values were 0.034, 0.009 and 0.003, respectively) (Table 9).

	Beta*(β)	Standard Error	Standardized Beta (%95 CI)	P
Fixed	78,740	19,969	(38,568-118,912)	<0,001
Gender (male)	7,095	4,757	0,138 (-2,475 - 16,666)	0,143
Age	0,225	0,217	0,091 (-0,212 - 0,663)	0,306
Educational background [Elementary and middle school]				
High School	1,004	5,100	0,018 (-9,256 - 11,263)	0,845
Bachelor's Degree	-3,761	5,443	-0,068 (-14,711 - 7,188)	0,493
BMI	-0,423	0,484	-0,069 (-1,396 - 0,55)	0,386
AF period	-0,130	0,045	-0,24 (-0,219 - -0,04)	0,005
Type of AF (Paroxysmal)	5,238	5,832	0,073 (-6,495 - 16,972)	0,374
Smoking [No]				
Has given up	-3,494	5,249	-0,061 (-14,054 - 7,067)	0,509
Yes	-7,014	8,490	-0,072 (-24,094 - 10,065)	0,413
Nutrition (Regular)	-5,836	5,104	-0,107 (-16,104 - 4,432)	0,259
Physical activity (Regular walking)	10,894	5,169	0,181 (0,495 - 21,294)	0,040
Dependency or restriction related to AF (Yes)	-10,863	5,476	-0,162 (-21,879 - 0,153)	0,053
Accompaniment (Yes)	-16,836	7,249	-0,223 (- 31,419 - -2,253)	0,025
Overall health status [Moderate]				
Good	4,659	5,646	0,09 (-6,699 - 16,018)	0,413
Bad	-17,517	7,329	-0,221 (-32,26 - -2,774)	0,021
Overall health status compared to last year [Same]				
A little better	5,466	5,551	0,091 (-5,701 - 16,633)	0,330
A little worse	-13,846	6,353	-0,207 (-26,627 - -1,066)	0,034
Better	20,440	7,553	0,284 (5,244 - 35,635)	0,009
Even worse	-26,259	8,295	-0,269 (-42,947 - -9,571)	0,003
F=7.471, p<0.001, R ² =0.751, Adjusted R ² =0.651, The Enter method was used to include independent variables in the model, [Reference category]				

Table 9: An analysis of the independent variables influencing the total score of the quality of life scale using linear regression analysis.

Discussion

The study aimed to assess the quality of life of patients receiving atrial fibrillation ablation and the influencing factors. The study's findings indicated that the participants' quality of life was not adversely impacted. The study's findings were analyzed under the sections titled "Discussion of the effects of participants' health status and habits on quality of life in accordance with literature-derived data" and "Discussion of statistics pertaining to the AFEQT scale on quality of life and the influencing factors for patients undergoing AF ablation".

Obesity is a major public health issue linked to heightened cardiovascular morbidity and mortality risk, as well as arrhythmia [11]. Research examining Atrial Fibrillation (AF) risk factors has identified obesity as a significant risk factor, with 25% of AF patients classified as obese. Chernyavskiy, et al., found that 31.7% of the patients who had ablation were obese. Boveda, et al., found that the average BMI of the patients was 28.2 ± 4.2 , which means they were overweight. Our study's results are consistent with existing research, indicating that obese patients exhibit a worse quality of life score (50.4%) compared to normal-weight

individuals (71.7%) and overweight patients (63.7%). These findings suggest that obesity significantly influences the quality of life in patients receiving ablation. Proper management of chronic diseases is crucial for the management of Atrial Fibrillation (AF) and its associated risk factors [14]. People with other chronic conditions are thought to have to work harder and use more energy to manage their diseases than people with AF who don't have any other ailments [15]. The literature predominantly indicates that individuals diagnosed with Atrial Fibrillation (AF) concurrently exhibit coronary artery disease and hypertension; nevertheless, the incidence of heart failure is elevated in the majority of cases [16, 17, 18, 19]. In research by Baskovski, involving patients who underwent ablation, it was shown that 58.5% of the subjects were diagnosed with hypertension [20]. The results concerning the incidence of chronic disorders align with existing literature, demonstrating that hypertension is the most prevalent comorbid chronic condition associated with Atrial Fibrillation (AF). Research on genetic transmission in Atrial Fibrillation (AF) has examined mutant genes within families and identified genes responsible for the condition. Nonetheless, genetic transmission has not been definitively established [21, 22]. Darbar, et al., reported that 5% of participants had a family history of AF [23]. The Framingham study indicated that one-third of AF patients had a familial history of AF, 9.7% had a mother with arrhythmia and individuals with a first-degree relative diagnosed with AF exhibited a 40% increased risk of developing AF. As technology has improved, more research has been done on genetic transmission and it has become clear that AF is quite hereditary, but its causality has not been confirmed beyond a reasonable doubt. These discrepancies in the data we collected resemble genetic studies that have failed to establish the heritability of AF, as numerous factors remain ambiguous.

Our study found that the daily activity subscale score for those who walked regularly was 15.297 points higher than that of people who didn't exercise. It is recognized that AF is linked to a decrease in exercise capacity when quality of life is low. Dabrowski, et al., found in their study that people with AF had less energy than healthy people and that their quality of life was damaged by becoming activity intolerant [25]. The results we obtained are consistent with existing literature and further substantiate the notion that persons who persist in exercising post-ablation will experience a great quality of life. People who don't exercise may be worried that their attacks and symptoms will get worse and it's likely that their symptoms will make it harder for them to exercise, which may make them avoid it or have trouble with it.

The literature indicates that palpitations, dyspnea, exercise intolerance, thoracic discomfort, vertigo and associated syncope may endure in patients during the post-ablation phase [26]. A study by Björkenheim, et al., on patients who had ablation indicated a decline in quality of life post-procedure, attributed to the observed symptoms [27]. The study by Wood, et al., reported that exercise intolerance was present in 100% of patients following ablation over the initial 3-4 months, with fatigue, presyncope, palpitations and sleeplessness being identified as the most distressing symptoms in the first 3 months. Our findings align with existing research. The participants' average total scale score on the AFEQT scale for quality of life symptoms was 79.2, which is high. This means that ablation techniques work to relieve symptoms in patients. Raine, et al., performed quality of life research involving 80 patients with Atrial Fibrillation (AF) slated for ablation therapy, revealing a mean AFEQT total score of 51.5 ± 22.0 . They stated that quality of life enhanced by 25.4 ± 19 following ablation therapy (excluding people with recurrent AF) [29]. Vintila and colleagues conducted a study on patients who had ablation, revealing that the average total AFEQT score for those with paroxysmal AF was 55.49 ± 20.90 [30]. Azizi and colleagues, conducted a study assessing the quality of life in patients who underwent ablation, revealing a 19.5-point rise in the AFEQT score during the 12 months post-ablation [31]. The outcomes of our investigation were comparable to those of worldwide studies utilizing the AFEQT scale, revealing similarly elevated quality of life scores. This result shows that people's quality of life gets better following ablation.

Limitations

The hospital was a tertiary care facility, which meant that there were a lot of people with AF. But the COVID-19 pandemic made it hard for patients to visit, even for follow-up, which made it hard to collect data.

Conclusion

The mean overall AFEQT score of 66.2 ± 26.2 indicates that individuals' quality of life was unaffected post-ablation. Palpitations, weariness, tiredness and dyspnea were the most significant complaints. Along with physiological and sociodemographic characteristics, obesity, food choices and exercise intolerance were identified as significant determinants of quality of life. Nurses need to look at things that are making AF patients' quality of life worse after ablation, teach them, make care plans and give them counseling. A comprehensive approach is necessary, taking into account sociodemographic and health-related behaviors in follow-up planning. To encourage healthy eating and regular follow-up, a multidisciplinary approach should be used.

Individualized dietary plans can improve quality of life. Patients on antiarrhythmic and anticoagulant therapy should receive educational programs and medication guides to alleviate anxiety and treatment-related concerns. To combat exercise intolerance, tailored exercise regimens and psychological support should be integrated into care plans to facilitate rehabilitation. Quality of life should be regularly evaluated before and after ablation using standardized instruments and evidence-based guidelines should be formulated accordingly.

Conflict of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Ethical Statement

Before starting the research, an application was made to the Hacettepe University Non-Interventional Clinical Research Ethics Committee for the ethical suitability of the research and the necessary approval (Protocol No: 2019/27-05) was received. Written consent was obtained from the Hacettepe University Cardiology Department, where the research would be conducted, the Hacettepe University Adult Hospital Chief Physician and the participants. Written consent has been obtained from all participants.

Informed Consent Statement

Informed consent was obtained from all participants included in the study.

Additional Information

This paper was delivered as an oral presentation at the 6th National and 2nd International Congress on Fundamental Nursing Care in 2022.

Authors' Contributions

Conceptualisation, A.D.; methodology, A.D. and E.D.; software, validation, formal analysis, investigation, data curation, writing, original draft, visualisation: E.D.; writing, review and editing and supervision: A.D.; project administration: A.D. All authors read and approved the final manuscript.

References

1. Crystal E, Connolly SJ. Atrial fibrillation: Guiding lessons from epidemiology. *Clin Cardiol.* 2004;22(1):1-8.
2. Cutugno C. Atrial fibrillation: Revised management protocols and nursing considerations. *J Nurs Am.* 2015;115(5):26-38.
3. European Society of Cardiology. Guidelines for the management of atrial fibrillation. *Eur Heart J.* 2010;31(19):2369-429.
4. Mark DB, Anstrom KJ, Sheng S, Piccini JP, Baloch K, Monahan KH, et al. The CABANA randomized clinical trial: The effect of catheter ablation vs medical therapy on quality of life among patients with atrial fibrillation. *JAMA.* 2019;321(13):1275-85.
5. Nielsen JC, Johannessen A, Raatikainen P, Hindricks G, Walfridsson H, Kongstad O, et al. Radiofrequency ablation as initial therapy in paroxysmal atrial fibrillation. *N Engl J Med.* 2012;367(17):1587-95.
6. Asad ZUA, Yousif A, Khan MS, Al-Khatib SM, Stavrakis S. Catheter ablation versus medication therapy for atrial fibrillation. *Circ Arrhythm Electrophysiol.* 2019;12(9):1-14.
7. Hoke L, Streletsky Y. Catheter ablation of atrial fibrillation. *Am J Nurs.* 2015;115(10):32-42.
8. Johnson T, Jadick E, Knippers L. Atrial fibrillation ablation. *Am J Nurs.* 2011;111(2):58-60.
9. Coyne KS, Edvardsson N, Rydén A. Development and testing of AF impact, a measure of patient-reported health-related quality of life specific to atrial fibrillation. *Value Health.* 2017;20(10):1355-61.

10. Spertus J, Dorian P, Bubien R, Lewis S, Godejohn D, Reynolds MR, et al. Development and validation of the Atrial Fibrillation Effect on Quality of Life (AFEQT) Questionnaire in patients with atrial fibrillation. *Circ Arrhythm Electrophysiol*. 2011;4(1):15-25.
11. Wang TJ, Parise H, Levy D, D'Agostino RB, Wolf PA, Vasan RS, et al. Obesity and the risk of new-onset atrial fibrillation. *JAMA*. 2004;292(20):2471-7.
12. Boveda S, Metzner A, Nguyen DQ, Chun J, Goehl K, Noelker G, et al. Report on single-procedure outcomes and quality-of-life improvement 12 months after cryoballoon ablation in persistent atrial fibrillation: Findings from the multicenter CRYO4PERSISTENT AF trial. *JACC Clin Electrophysiol*. 2018;4(11):1440-48.
13. Chernyavskiy A, Kareva Y, Pak I, Rakhmonov S, Pokushalov E, Romanov A. Quality of life following surgical ablation of persistent atrial fibrillation: A prospective assessment. *Heart Lung Circ*. 2016;25:378-83.
14. Şengül Ş. Assessment of the correlation between sleep quality and nutritional status in patients diagnosed with atrial fibrillation [master's thesis]. Istanbul: Istanbul University Institute of Health Sciences. 2018;119.
15. Karakuş N. Study of quality of life and contributing factors in chronic atrial fibrillation [master's thesis]. Isparta: Süleyman Demirel University, Institute of Health Sciences. 2014;87.
16. Ertaş F. An epidemiological approach to patients with atrial fibrillation. *Dicle Med J*. 2013;40(2):332-9.
17. Ertaş F, Kaya H, Kaya Z, Bulur S, Köse N, Gül M, et al. The epidemiology of atrial fibrillation in Turkey: Initial findings from the multicenter AFTER research. *Turk Kardiyol Dern Ars*. 2013;41(2):99-104.
18. Kannel W, Benjamin E. Present views on the epidemiology of atrial fibrillation. *Clin Cardiol*. 2009;27(1):13-24.
19. Lubitz SA, Sinner MF, Lunetta KL, Makino S, Pfeufer A, Rahman R, et al. Independent susceptibility markers for atrial fibrillation on chromosome 4q25. *Circulation*. 2010;122:976-84.
20. Baskovski E. The correlation between P wave dispersion and left atrial scar regions in patients undergoing atrial fibrillation ablation [medical specialization thesis]. Ankara: Ankara University Faculty of Medicine. 2020;68.
21. Chen YH, Xu SJ, Bendahhou S, Wang XL, Wang Y, Xu WY, et al. KCNQ1 gain-of-function mutation in familial atrial fibrillation. *Science*. 2003;299(5604):251-4.
22. Çetin M, Ceylan A, Çetin Z, Diker E. Atrial fibrillation ablation: What led us to mortality studies? *Turk J Arrhythm Pacing Electrophysiol*. 2010;8(2):79-89.
23. Darbar D, Herron KJ, Ballew JD, Jahangir A, Gersh BJ, Shen WK, et al. Familial atrial fibrillation is a genetically diverse condition. *J Am Coll Cardiol*. 2003;41(12):2185-92.
24. Benjamin E, Levy D, Vaziri S, D'Agostino R, Belanger A, Wolf P. Independent risk factors for atrial fibrillation in a population-based cohort: the Framingham Heart Study. *JAMA*. 1994;271(11):983-8.
25. Dąbrowski R, Smolis-Bąk E, Kowalik I, Kazimierska B, Wójcicka M, Szwed H. Quality of life and depression in individuals exhibiting various patterns of atrial fibrillation. *Kardiol Pol*. 2010;68(10):1133-9.
26. Dorian P, Angaran P. Symptoms and quality of life following atrial fibrillation ablation. *JACC Clin Electrophysiol*. 2017;3(10):1176-9.
27. Björkenheim A, Brandes A, Magnuson A, Chemnitz A, Svedberg L, Edvardsson N, et al. Evaluation of atrial fibrillation-specific symptoms before and two years post-ablation: are there discrepancies between patient and physician perceptions of symptom relief? *JACC Clin Electrophysiol*. 2017;3(10):1168-76.
28. Wood KA, Barnes AH, Paul S, Hines KA, Jackson KP. Difficulties with symptoms following atrial fibrillation ablation. *Heart Lung*. 2017;46(6):425-31.
29. Raine D, Langley P, Shepherd H, Lord S, Murray S, Murray A, et al. The impact of catheter ablation on the quality of life in patients with atrial fibrillation and its association with arrhythmia outcomes. *Open Heart*. 2015;2:1-7.
30. Vintila A, Stanciu A, Horumba M, Vintila V, Lupusoru M, Gurghean A. The effect of atrial fibrillation on quality of life. *J Hypertens*. 2019;37:184.
31. Azizi Z, Essebag V, Alipour P, Khaykin Y, Leong-Sit P, Sarrazin JF, et al. Identifiers of minimal clinically significant difference in quality of life and severity score following atrial fibrillation ablation. *Circulation*. 2019;140(1):173-4.

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