



## Atrioventricular Block: A Complicated Condition-Diagnosis, Treatment, Nursing Interventions, And Medical Secretary Documentation

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### Abstract:

**Background:** Atrioventricular (AV) block is a cardiac conduction disorder characterized by delayed or impaired transmission of electrical impulses between the atria and ventricles. The severity of AV block is classified into three degrees: first-degree, second-degree (with Mobitz types 1 and 2), and third-degree. The condition can result from various causes, including ischemic heart disease, cardiomyopathies, infections, and medications. In higher-degree AV blocks, timely diagnosis and intervention are critical due to the risk of life-threatening arrhythmias and sudden cardiac arrest.

**Aim:** This paper aims to explore the diagnosis, treatment, nursing interventions, and the role of medical secretary documentation in managing patients with AV block.

**Methods:** A comprehensive review of literature focusing on the causes, classification, diagnostic methods (particularly electrocardiography), and treatment strategies for AV block was conducted. Additionally, the nursing diagnoses associated with AV block, such as ineffective tissue perfusion, risk for falls, and impaired cardiac function, were examined. The role of medical secretary documentation in ensuring accurate patient records, facilitating communication among healthcare teams, and supporting quality patient care was highlighted.

**Results:** The review found that AV block, particularly in its second- and third-degree forms, can lead to severe clinical manifestations and requires prompt medical management, including medication adjustments and pacemaker insertion. Medical secretaries play a vital role in documentation, ensuring that patient histories, treatment plans, and clinical updates are accurately recorded and communicated to the healthcare team.

**Conclusion:** AV block is a complex condition that demands early detection and appropriate management to avoid serious complications. Nursing interventions, such as monitoring vital signs and providing patient

education, are crucial in managing the condition. Furthermore, medical secretary documentation is integral to patient care, enhancing communication and supporting treatment efficacy.

**Keywords:** Atrioventricular block, electrocardiogram, nursing interventions, pacemaker, medical secretary documentation, patient management, cardiac conduction system.

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### **Introduction:**

Atrioventricular (AV) conduction is evaluated by assessing the relationship between P waves and QRS complexes on an electrocardiogram (ECG). In normal cardiac function, a P wave precedes each QRS complex by a fixed PR interval, which typically ranges from 120 to 200 milliseconds. The AV node serves as a critical pathway in transmitting electrical impulses from the atria to the ventricles. When this conduction is delayed, it results in an AV block, which refers to the impaired transmission of electrical signals. This delay may occur due to anatomical or functional issues in the heart's conduction system. AV block can be transient, resolving over time, or permanent. The severity of AV block is classified into three degrees: first degree, second degree (with subtypes Mobitz type 1 or 2), and third degree. First-degree AV block is typically considered benign, while second-degree and third-degree AV blocks often indicate more significant conduction issues, which may lead to life-threatening arrhythmias or require medical intervention. AV block can sometimes be observed in athletes or individuals with congenital heart conditions, although further studies are required to fully understand the relationship between AV block and demographic factors such as age, race, or gender. Currently, there are no large-scale studies available that explore these relationships in depth [1][2][3].

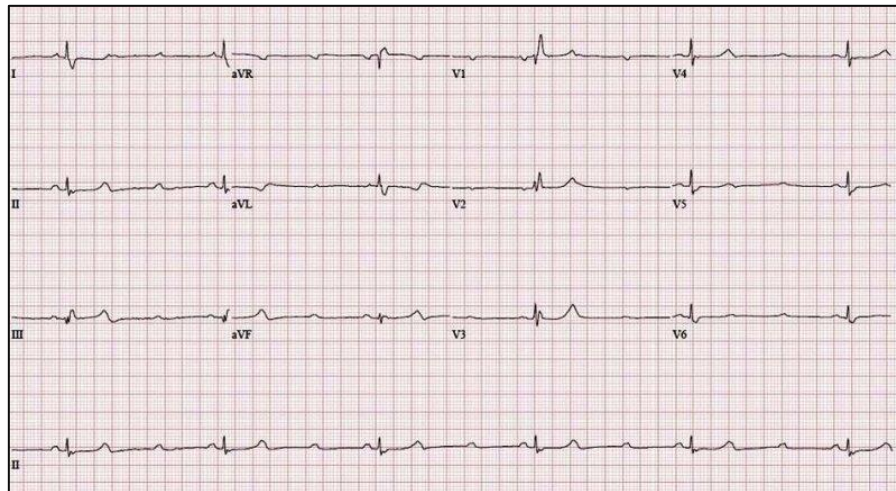
### **Causes:**

The causes of AV block are diverse and vary depending on the degree and severity of the conduction delay. In the case of higher degrees of AV block, underlying pathophysiological conditions are often present. The majority of such cases are attributed to chronic idiopathic fibrosis and sclerosis, which affect the conduction system of the heart. Ischemic heart disease is another significant contributor, responsible for approximately 40 percent of AV block cases [4]. The loss of blood supply to the heart's conduction pathways can lead to delayed or absent electrical impulses, particularly in the AV node or bundle branches. Other causes include various cardiomyopathies, such as hypertrophic obstructive cardiomyopathy, as well as infiltrative conditions like sarcoidosis and amyloidosis. Infectious diseases, including Lyme disease, rheumatic fever, and endocarditis, can also disrupt the normal conduction pathways, leading to AV block. Viral infections, such as those caused by Coxsackievirus, can further exacerbate the issue. Additionally, autoimmune diseases, such as systemic lupus erythematosus, can also play a role in the development of AV block by causing inflammation and damage to the heart's electrical system [5][6][7][8]. In some cases, AV block may occur as a result of surgical interventions on the heart, especially after cardiac surgery. Medications such as beta-blockers, calcium channel blockers, and digoxin are known to influence the AV node's function and may contribute to the development or exacerbation of AV block. Genetic factors and inherited conditions can also predispose individuals to AV block [9].

### **Risk Factors:**

AV block can originate from various locations within the conduction system, which includes the atrium, AV node, Bundle of His, bundle branches, fascicles, and the Purkinje system. The specific location of conduction delay influences the type and severity of the block. In first-degree AV block, the delay typically occurs at the AV node, which results in a prolonged PR interval on an ECG without the absence of any QRS complexes. The delay in impulse conduction is generally mild, and the condition is often asymptomatic. Second-degree AV block is further divided into Mobitz type 1 and Mobitz type 2. Mobitz type 1 is most commonly due to a blockage within the AV node, while Mobitz type 2 often originates below the AV node, either at the Bundle of His or in the bundle branches. In type 2, the conduction is more often intermittent, with some atrial impulses failing to reach the ventricles. Third-degree AV block, also known as complete block, is the most severe form and occurs when no atrial impulses are conducted to the ventricles. This can happen within

the AV node or in the infranodal conduction system, such as the Bundle of His or below. Various medications can affect the conduction system and contribute to AV block. For instance, increased parasympathetic tone, as seen with the administration of digoxin, enhances vagotonic effects and can slow conduction in the AV node. Calcium channel blockers, which block the inward calcium current essential for depolarization, can also delay conduction at the AV node. Beta-blockers have similar effects by reducing the heart rate and decreasing the conduction velocity at the AV node. Medications such as procainamide, quinidine, and disopyramide, which block sodium channels, can delay conduction in the Bundle of His and, more rarely, in the infra-Hisian conduction system [10].



**Figure 1: Electrocardiogram Showed Two Consecutive P Wave Block.**

#### **Nursing Diagnosis:**

In patients with atrioventricular (AV) block, several nursing diagnoses are essential for addressing the complications associated with this condition. One common nursing diagnosis is "Ineffective tissue perfusion." This diagnosis refers to inadequate blood flow to tissues due to the disruption of normal cardiac conduction, which can impair the heart's ability to efficiently pump blood. As a result, tissues may not receive adequate oxygen and nutrients, potentially leading to organ dysfunction. The severity of the block directly impacts the effectiveness of tissue perfusion. For instance, higher degrees of AV block, such as second-degree Mobitz type II or third-degree AV block, may lead to more significant reductions in blood flow, which could result in symptoms like dizziness, fatigue, or syncope. Another critical nursing diagnosis for patients with AV block is "Risk for falls." The compromised conduction and the potential for bradycardia (abnormally slow heart rate) can lead to dizziness, weakness, or even fainting, which increases the likelihood of falls. This is particularly concerning in patients with higher-degree AV block, where the electrical signals from the atria do not properly reach the ventricles, resulting in inadequate cardiac output. In such cases, nurses should monitor the patient's vital signs closely and take preventive measures to ensure patient safety.

"Impaired cardiac function" is another diagnosis that may be relevant for patients with AV block. This diagnosis highlights the inability of the heart to pump blood effectively due to electrical conduction delays. As the degree of AV block increases, cardiac output may decrease, leading to symptoms such as shortness of breath, fatigue, and chest pain. Nurses must assess the patient's cardiovascular status regularly and collaborate with the healthcare team to manage the underlying cause of the conduction block, whether it be ischemic heart disease, cardiomyopathy, or another pathology. Lastly, "Anxiety" is a potential diagnosis in patients experiencing AV block, particularly those who are aware of their condition or who are experiencing symptoms such as dizziness or palpitations. Anxiety can exacerbate physical symptoms and impact overall well-being. Nurses should provide emotional support, offer education about the condition, and ensure the patient understands their treatment plan, all while fostering a sense of comfort and trust in the healthcare team.

**Assessment:**

When evaluating a patient suspected of having atrioventricular (AV) block, it is essential to take a detailed history. Key aspects of the history should include any known history of heart disease, including both congenital and acquired conditions. A comprehensive list of the patient's current medications, including dosages, is also crucial, particularly for medications that can affect conduction such as beta-blockers, calcium channel blockers, antiarrhythmic drugs, and digoxin. It is important to assess any recent cardiac procedures that might have impacted the conduction system, as well as symptoms that may be related to systemic diseases associated with heart block, such as amyloidosis and sarcoidosis. Information regarding baseline exercise capacity can provide insight into how the patient's heart function might be affected by conduction issues. Additionally, any potential exposure to tick bites should be explored, as certain infections like Lyme disease can contribute to AV block. Several symptoms should raise concern for potential AV block, including dyspnea (difficulty breathing), fatigue, and chest pain, which may indicate decreased cardiac output. Presyncope or syncope, or even sudden cardiac arrest, are serious signs that should not be overlooked. These symptoms could signal worsening conduction block or a progression to more severe types of AV block. Identifying these warning signs is essential for timely intervention and appropriate treatment, as untreated AV block can lead to significant complications like hemodynamic instability, syncope, or sudden death.

**Evaluation:**

In first-degree AV block, the P waves consistently precede the QRS complexes, but there is a prolonged PR interval greater than 200 milliseconds, which occurs without any dropped beats. This delay is a result of impaired conduction between the atrium and ventricle, typically occurring at or below the AV node. Despite the delay, all atrial impulses are eventually transmitted to the ventricles. This type of AV block is often caused by minor conduction defects. First-degree AV block can occur due to various factors, such as inferior myocardial infarction (MI), increased vagal tone (as seen in athletes), post-cardiac surgery, myocarditis, hyperkalemia, or medications like beta-blockers, non-dihydropyridine calcium channel blockers, adenosine, digitalis, and amiodarone. Although first-degree AV block is generally considered benign and does not cause hemodynamic instability, it does not require specific treatment. Patients are usually monitored without the need for any intervention, as this form of block typically does not progress to more severe conduction abnormalities. However, careful monitoring is still necessary to ensure that the condition does not worsen. If the patient is symptomatic, such as experiencing dizziness or lightheadedness, it may be necessary to consider interventions like adjusting medications or addressing any underlying causes.

Second-degree Mobitz type 1 AV block, or Wenckebach, is characterized by a progressive lengthening of the PR interval until a P wave is not conducted, resulting in a dropped beat. The PR interval before the dropped beat is the longest, while the PR interval after the drop becomes the shortest. This progressive delay in conduction is usually reversible and typically occurs at the level of the AV node, which results in a temporary failure to transmit electrical impulses to the ventricles. Causes of Mobitz type 1 include reversible conditions such as ischemia, myocarditis, increased vagal tone, and medications that slow AV conduction (e.g., beta-blockers, non-dihydropyridine calcium channel blockers, adenosine, digitalis, and amiodarone). In many cases, Mobitz type 1 is benign, with minimal hemodynamic effects. Asymptomatic patients generally do not require any treatment and can be monitored on an outpatient basis. If symptoms are present, such as lightheadedness or syncope, the condition may respond to atropine. However, this form of block rarely progresses to third-degree heart block. Management may include discontinuing any medications that impair AV conduction or addressing reversible causes, and monitoring for any worsening symptoms. For most patients with Mobitz type 1, no permanent intervention is necessary, and the condition often resolves on its own.

In contrast, second-degree Mobitz type 2 AV block is more concerning. Unlike Mobitz type 1, the PR interval remains constant, and non-conducted P waves occur intermittently without any warning or progressive PR interval prolongation. This form of AV block occurs lower in the conduction system, usually below the AV node, and is associated with structural damage. The block can be located in the Bundle of His or the bundle

branches, with the conduction defect sometimes leading to wide, bizarre QRS complexes. Common causes include anterior MI (which causes septal infarction of the bundle branches), idiopathic fibrosis of the conduction system, autoimmune diseases (e.g., systemic sclerosis or lupus), infections (e.g., Lyme disease or rheumatic fever), infiltrative diseases (e.g., hemochromatosis, sarcoidosis, amyloidosis), electrolyte imbalances (e.g., hyperkalemia), and medications like beta-blockers, non-dihydropyridine calcium channel blockers, and amiodarone. Mobitz type 2 carries a higher risk of progressing to third-degree AV block or even asystole. This form of block can result in severe bradycardia and hemodynamic instability, leading to symptoms such as syncope and, in severe cases, sudden cardiac death. Due to the unpredictability of the conduction failure, patients with Mobitz type 2 often require a permanent pacemaker for treatment. Atropine, which can be effective for Mobitz type 1, is contraindicated in Mobitz type 2 because it may exacerbate the block and increase the risk of complete heart block or asystole. Therefore, prompt diagnosis and management, including pacemaker insertion, are critical to prevent life-threatening complications.

Lastly, third-degree (complete) heart block is characterized by the complete dissociation between the atria and ventricles, with no atrial impulses being transmitted to the ventricles. In this condition, the P waves occur at their normal rate, while the QRS complexes are generated by a junctional or ventricular escape rhythm. The ventricular rhythm can be driven by either a junctional pacemaker (if the block occurs above or at the level of the AV node) or a ventricular pacemaker (if the block is infranodal), leading to either narrow or wide QRS complexes, respectively. Complete heart block is often a result of the same causes as Mobitz types 1 and 2, including inferior MI, degeneration of the conduction system, and AV-nodal blocking agents like beta-blockers and calcium channel blockers. This condition is associated with significant risk, including sudden cardiac death, asystole, and ventricular arrhythmias. It often requires the insertion of a permanent pacemaker to ensure adequate ventricular pacing. Patients with third-degree heart block are at immediate risk for severe bradycardia and hemodynamic collapse, and therefore require urgent intervention to prevent fatal outcomes.

### **Medical Management:**

For patients presenting with first-degree or second-degree Mobitz type 1 AV block, the treatment approach is generally conservative. These conditions usually do not require active medical interventions unless an underlying cause, such as medication-induced conduction delay, is identified. The primary management strategy for such patients includes discontinuing any medications that may be exacerbating the AV block. These patients are typically monitored on an outpatient basis and do not require hospitalization unless symptoms worsen. However, patients with higher degrees of AV block, such as Mobitz type 2 or third-degree (complete) heart block, often have more severe conduction system damage, which places them at a much higher risk for progressing to asystole, ventricular tachycardia, or sudden cardiac death. This necessitates more urgent management, including admission to a hospital for cardiac monitoring and possibly temporary pacing. The definitive treatment for these higher-degree AV blocks is the insertion of a permanent pacemaker to restore normal rhythm and prevent life-threatening arrhythmias. The pacemaker acts as a backup to the heart's natural pacemaking system, providing electrical impulses to maintain an appropriate heart rate. Urgent treatment is vital to prevent complications, such as hemodynamic instability or sudden cardiac death, associated with untreated higher-degree AV blocks. Clinical studies have emphasized the role of cardiac pacing in significantly improving outcomes for patients with advanced AV block, reducing the risk of mortality due to arrhythmias [11-14]. Patients receiving pacemakers require lifelong follow-up care to monitor device function and ensure adequate pacing thresholds are maintained.

### **Nursing Management:**

Nursing management for patients with AV block focuses on vigilant monitoring and supportive care to manage symptoms and detect any potential complications. The first step in nursing management is to monitor vital signs regularly, especially heart rate and blood pressure, to identify any significant changes in cardiac function. Given the nature of AV block, patients may present with bradycardia or hypotension, which necessitates frequent monitoring. In addition, all patients with suspected or confirmed AV block should be placed on a cardiac monitor to continuously assess for rhythm disturbances. This real-time monitoring

allows for early detection of any worsening of the conduction defect or the onset of life-threatening arrhythmias. Obtaining an ECG is also a critical step in diagnosing the specific type of AV block, as it can provide insight into the length of the PR interval, which is key to distinguishing between first-degree, second-degree, and third-degree blocks. The ECG can also reveal whether the conduction defect occurs at the level of the AV node or below it, guiding further management decisions. Assessing oxygenation is also important, especially in patients with hemodynamic instability. Hypoxia can exacerbate cardiac arrhythmias, making it crucial to ensure that oxygen saturation levels are adequate. Additionally, lab tests to check electrolyte levels are essential, as imbalances in electrolytes such as potassium or calcium can worsen AV conduction abnormalities. Medications that may interfere with heart rhythm, such as beta-blockers or antiarrhythmic agents, should be held, as they can exacerbate the block. For patients who require a pacemaker, patient education becomes a crucial part of the nursing role. Patients must be informed about what to expect from the procedure and post-operative care, including restrictions on arm movement and the need to avoid electromagnetic interference. The nurse should also educate the patient on the importance of wearing a medical alert bracelet and communicating with healthcare providers about the pacemaker before undergoing any procedures [11].

### **When to Seek Help:**

Patients with AV block require careful monitoring for any signs of deterioration that might indicate the need for urgent medical intervention. Loss of consciousness is a red flag that should prompt immediate evaluation, as it can signify severe bradycardia or other arrhythmic events that may compromise cerebral perfusion. Similarly, an altered mental status may suggest insufficient blood flow to the brain due to poor cardiac output, a common complication of advanced AV block. Patients who experience persistent low blood pressure should also be evaluated promptly, as hypotension can occur in patients with higher-degree AV block, particularly if there is associated bradycardia. These patients are at risk for hemodynamic instability, which can lead to shock if left untreated. Bradycardia is another critical symptom to watch for, as it often accompanies AV block and may progress to a more severe rhythm disturbance, such as complete heart block, in the absence of appropriate treatment. Patients presenting with these symptoms should be assessed immediately for the possibility of higher-degree AV block, as early intervention can prevent potentially life-threatening complications. In clinical practice, healthcare providers are trained to recognize these warning signs and initiate appropriate diagnostic tests, including an ECG, to confirm the diagnosis and guide management decisions. Recognizing the severity of AV block early on and intervening promptly is critical in preventing serious outcomes such as sudden cardiac death or ventricular arrhythmias [14].

### **Outcome Identification:**

The prognosis for patients with AV block varies widely depending on several factors, including the type of AV block, the presence of underlying comorbidities, and the patient's age. Patients with first-degree AV block generally have an excellent prognosis, as the condition is usually asymptomatic and does not cause significant hemodynamic disturbances. In contrast, patients with higher-degree AV block (such as Mobitz type 2 or third-degree heart block) may face more severe outcomes, including syncope, cardiac arrest, and sudden cardiac death if left untreated. The prognosis is also influenced by the presence of chronic conditions such as diabetes mellitus, chronic kidney disease, and underlying heart disease, which can worsen the overall outcome. For example, patients with coronary artery disease or myocardial infarction may have a more complicated course due to the potential for ischemic damage to the conduction system. The type of AV block is another important consideration, as third-degree heart block and Mobitz type 2 are more likely to progress to life-threatening arrhythmias than Mobitz type 1. Age is also a significant factor, as older patients are more likely to have multiple comorbid conditions that can impact recovery and treatment outcomes. With timely intervention, such as the insertion of a permanent pacemaker, the prognosis can be significantly improved, especially for patients with higher-degree AV block. However, the long-term management of patients with pacemakers involves regular follow-up to monitor device function and ensure that the heart rate remains stable [15].

### **Coordination of Care:**

Managing patients with AV block requires a multidisciplinary approach, involving coordination between cardiologists, nurses, and other healthcare professionals to ensure optimal outcomes. The role of the cardiologist is central, particularly in diagnosing and treating patients with higher-degree AV block, as the condition can have serious consequences if not managed appropriately. For patients with first-degree AV block, the condition is typically benign, and no specific intervention is required, although a cardiologist should still be consulted for a full workup if the cause is unclear. For second-degree Mobitz type 2 and third-degree heart block, referral to a cardiologist is essential to assess the need for pacemaker implantation. A pacemaker is a life-saving intervention for patients with severe conduction defects, and its placement requires careful monitoring and follow-up to ensure that the device is functioning correctly. Following pacemaker insertion, cardiology nurses play a key role in ensuring the patient is stable and that the heart rate has returned to normal. They also provide ongoing education and support for patients, helping them adjust to living with a pacemaker. Surgical intervention may be required for some patients, such as those who undergo mitral valve repair, and in these cases, it is essential to consult with a cardiologist before proceeding with any other surgical procedures. Coordination between the various members of the healthcare team ensures that the patient receives comprehensive care, improving both short-term and long-term outcomes [15].

### **The Role of Medical Secretary Documentation:**

The role of a medical secretary in case documentation is pivotal to ensuring the accuracy, efficiency, and organization of patient records, which are essential for providing quality healthcare. The medical secretary is responsible for managing and maintaining detailed patient records, which include medical history, diagnostic test results, treatment plans, and patient interactions. These records must be meticulously organized to facilitate easy access by healthcare providers, ensuring that they have up-to-date information to make informed decisions about patient care. The medical secretary is often the first point of contact for patients, making them integral in gathering initial patient information, which is crucial for accurate documentation. This includes recording personal details, medical complaints, and insurance information, which are then entered into the system or filed manually according to healthcare institution protocols.

In addition to recording patient information, the medical secretary also plays a role in updating case files with new documentation, such as doctor's notes, progress reports, and laboratory results. The medical secretary ensures that all necessary paperwork is completed, signed, and filed in a timely manner, minimizing delays in care. They are also responsible for organizing referral letters, test orders, and communication between the healthcare team, ensuring that all documentation is readily available when needed. One of the core duties of a medical secretary is to ensure that patient records are handled in accordance with privacy regulations such as the Health Insurance Portability and Accountability Act (HIPAA) in the United States. Confidentiality and data security are paramount, and medical secretaries must ensure that patient information is accessible only to authorized personnel, maintaining both physical and electronic security protocols. Furthermore, medical secretaries often assist in preparing discharge summaries, patient consent forms, and other documentation required for patient transitions. They may also coordinate the preparation of medical records for legal purposes, such as when records are requested for litigation or insurance claims. Through their organizational skills and attention to detail, medical secretaries contribute to the seamless operation of healthcare facilities, ensuring that case documentation is accurate, timely, and compliant with legal and regulatory standards. Their role in case documentation not only supports clinical decision-making but also enhances the overall efficiency and effectiveness of patient care delivery.

### **Conclusion:**

Atrioventricular (AV) block is a significant cardiac condition that varies in severity and can result in life-threatening complications if not adequately managed. The severity of AV block is classified into three degrees, with first-degree block typically being benign and second- and third-degree blocks requiring urgent intervention. The condition is most commonly caused by ischemic heart disease, cardiomyopathies, infections, and certain medications. In severe cases, AV block can lead to symptoms such as dizziness,

syncope, and even sudden cardiac arrest, necessitating immediate treatment. Nursing interventions are essential in the care of patients with AV block. Key nursing diagnoses, including ineffective tissue perfusion, risk for falls, and impaired cardiac function, are critical in guiding nursing care. Nurses must closely monitor vital signs, assess for symptoms of bradycardia or syncope, and provide interventions such as medication adjustments and education on the importance of adhering to treatment regimens. Additionally, patient safety is paramount, with precautions taken to prevent falls and ensure a stable environment for patients experiencing dizziness or fatigue. The role of medical secretary documentation is crucial in the management of AV block. Medical secretaries ensure that patient histories, diagnostic results, treatment plans, and nursing notes are accurately documented. This facilitates effective communication between healthcare providers, ensuring continuity of care and reducing the likelihood of errors. Furthermore, medical secretaries play a vital role in maintaining a comprehensive record of patient progress, which can inform treatment decisions and improve patient outcomes. In conclusion, the management of AV block requires a multidisciplinary approach that includes accurate diagnosis, timely treatment, diligent nursing care, and proper documentation. By addressing the medical, nursing, and administrative aspects of care, healthcare providers can optimize outcomes for patients with this potentially serious condition.

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توقف الأذنين البطيئي: حالة معقدة - التشخيص، العلاج، تدخلات التمريض، وتوثيق السكرتير الطبي

#### الملخص:

**الخلفية:** توقف الأذنين البطيئي (AV) هي اضطراب في التوصيل القلبي يتميز بتأخر أو ضعف في نقل النبضات الكهربائية بين الأذنين والبطينين. يتم تصنيف شدة توقف الأذنين البطيئي إلى ثلاث درجات: الدرجة الأولى، الدرجة الثانية (مع أنماط موبس 1 و2)، والدرجة الثالثة. يمكن أن تنشأ الحالة نتيجة لأسباب متنوعة، بما في ذلك أمراض القلب الإقفارية، وأمراض عضلة القلب، والعدوى، والأدوية. في التوقف عالية الدرجة، يكون التشخيص والتدخل في الوقت المناسب أمرًا بالغ الأهمية نظرًا لخطر حدوث اضطرابات نظم تهدد الحياة والسكتة القلبية المفاجئة.

**الهدف:** يهدف هذا البحث إلى استكشاف التشخيص، العلاج، تدخلات التمريض، ودور توثيق السكرتير الطبي في إدارة مرضى توقف الأذنين البطيئي.

**الطرق:** تم إجراء مراجعة شاملة للأدبيات تركز على الأسباب، التصنيف، طرق التشخيص (خصوصًا تخطيط القلب الكهربائي)، واستراتيجيات العلاج لتوقف الأذنين البطيئي. بالإضافة إلى ذلك، تم فحص التشخيصات التمريضية المرتبطة بتوقف الأذنين البطيئي، مثل ضعف التروية الدموية، خطر السقوط، وضعف وظيفة القلب. تم تسليط الضوء على دور توثيق السكرتير الطبي في ضمان دقة سجلات المرضى، وتسهيل التواصل بين فرق الرعاية الصحية، ودعم تقديم الرعاية الجيدة للمرضى.

**النتائج:** وجدت المراجعة أن توقف الأذنين البطيئي، خصوصًا في أشكالها من الدرجة الثانية والثالثة، يمكن أن تؤدي إلى مظاهر سريرية شديدة وتتطلب إدارة طبية سريعة، بما في ذلك تعديل الأدوية وزرع جهاز تنظيم ضربات القلب. يلعب السكرتير الطبي دورًا حيويًا في التوثيق، حيث يضمن أن تكون تاريخ المرضى، خطط العلاج، والتحديثات السريرية مسجلة بدقة ويتم التواصل بها إلى فريق الرعاية الصحية.

**الخلاصة:** توقف الأذنين البطيئي هي حالة معقدة تتطلب الكشف المبكر والإدارة المناسبة لتجنب المضاعفات الخطيرة. تعد تدخلات التمريض، مثل مراقبة العلامات الحيوية وتقديم التعليم للمرضى، أمرًا حيويًا في إدارة هذه الحالة. علاوة على ذلك، يعد توثيق السكرتير الطبي جزءًا أساسيًا من رعاية المرضى، حيث يعزز التواصل ويدعم فعالية العلاج.

**الكلمات المفتاحية:** توقف الأذنين البطيئي، تخطيط القلب الكهربائي، تدخلات التمريض، جهاز تنظيم ضربات القلب، توثيق السكرتير الطبي، إدارة المرضى، نظام التوصيل القلبي.