done on the day of admission to confirm the presence of atrial fibrillation. Patients were commenced on NOACs for a minimum of four weeks prior to the day of cardioversion. Patients were specifically listed as first case in our elective cardiac catheterization laboratory. Coronary angiography was performed via transradial approach using a 5Fr sheath. Intra-arterial cocktail of Verapamil (2.5 mg) without unfractionated heparin was administered in each case. Hemostasis at the transradial access site was achieved by applying TR band and long protocol (2.5 mls slowly released every 5 mins after four hrs of TR band application, provided there is no bleeding).

Cardioversion was performed under conscious sedation with intravenous diazepam after coronary angiography was performed in the cardiac catheterization laboratory.

Results A total of 26 patients were scheduled for elective coronary angiography and cardioversion on the same day. 2 patients were excluded; patient 1 after omission of repeated doses of NOAC and patient 2 after presence of normal sinus rhythm on admission. A total of 24 patients were eligible for the study. Baseline demographics are provided in table 1. Normal sinus rhythm was restored in 75% of patients (18/24). None of the patients had peri-procedural complications during or after coronary angiography or cardioversion.

Only one patient was re-admitted with symptomatic atrial fibrillation within 30 days requiring repeated cardioversion to establish normal sinus rhythm. 37.5% of patients had concomitant moderate to severe coronary artery disease.

All patients were discharged on the same day from the day ward once the TR band was removed following the long protocol for TR band deflation. None of the patients had any immediate radial artery complication including access site bleeding or radial artery haematoma requiring intervention or represented within 24 to 48 hours with any radial artery access site complications.

Conclusion In patients suffering from atrial fibrillation who have high suspicion of underlying coronary artery disease it is safe to perform coronary angiography and cardioversion on the same day with uninterrupted NOACs.