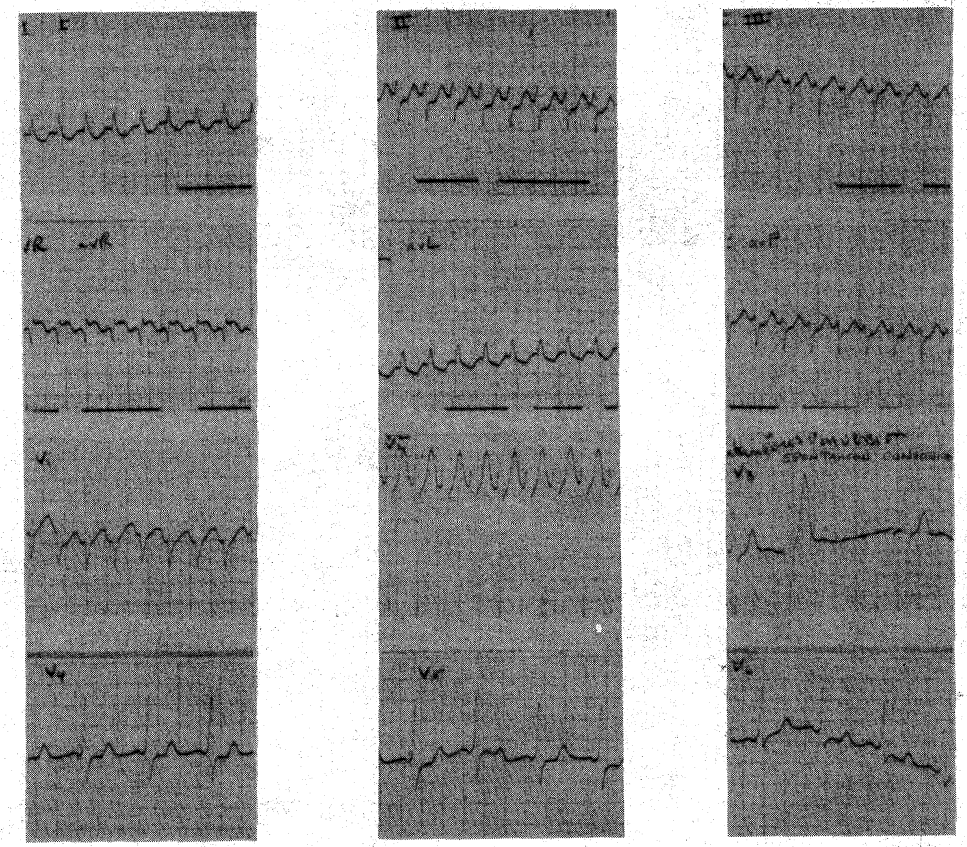
phasized. However, the combination of a very rapid (more than 240/min), irregular ventricular arrhythmia, particularly in younger individuals, that is unexpectedly well tolerated should suggest the correct diagnosis. Although this arrhythmia is usually well tolerated, prolonged attacks may lead to adverse hemodynamic consequences, and ventricular fibrillation and death may occur.

Pharmacologic therapy to slow the ventricular rate using intravenous procainamide or lidocaine may be tried; however, the treatment of choice for atrial fibrillation in the WPW syndrome that presents with a "pseudoventricular tachycardia" is cardioversion with DC countershock.

Digitalis should not be used in the presence of atrial fibrillation since it decreases conduction in the A-V node and enhances conduction through the accessory pathway. It may also shorten the refractory period of the accessory pathway and result in an increase in the ventricular rate.

For the treatment of atrial tachycardia, intravenous propranolol is very useful, and procainamide or lidocaine may also be tried. To prevent recurrent atrial tachycardia, quinidine or propranolol, or the combination of these two agents, has been most useful. □

FIGURE 1



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