

MONITORING GUIDE FOR AMIODARONE

This document has been created as supportive guidance on the monitoring requirements of amiodarone. Please use in conjunction with local formulary and interface prescribing agreements.



North East London

INTRODUCTION

- Amiodarone is used for the treatment of severe arrhythmias when other treatments cannot be used or have failed.
- There is a risk of serious adverse effects so strict monitoring is required.
- Licensed indications:
 - Tachyarrhythmias associated with Wolff-Parkinson-White Syndrome.
 - Atrial flutter / atrial fibrillation (AF).
 - Paroxysmal tachyarrhythmias.
- As an adjunct to National and local agreements, this guidance on the monitoring requirements of amiodarone should be followed to ensure that the medication is used safely and effectively.

SPECIALIST INITIATION RESPONSIBILITIES:

- Assess the patient and provide diagnosis.
- Assess for contraindications, cautions and interactions.
- Shared decision-making: discuss risks/benefits, obtain informed consent, provide a patient information leaflet and/or alert card.
- Conduct baseline investigations and review results (**see page two**).
- Initiate and optimise therapy. Prescribe until stable on maintenance dose.
- Ensure planned review after initial stabilisation (~4 weeks) for tolerability/effectiveness.
- Provide clear communication to primary care on indication, intended duration and follow-up plans.

DOSAGE AND ADMINISTRATION

Refer to [BNF](#) & [SPC](#) for full prescribing information.

Initial stabilisation:

- 200mg orally three times a day for one week → 200mg orally twice a day for one week.
- A loading dose is used to achieve rapid tissue levels. Rarely specialists may use an alternative regimen.

Maintenance dose:

- 200mg orally daily (or lowest effective dose).
 - The minimum dose required to control the arrhythmia should be used.
- Please note that amiodarone has a long half life: typically, 50 days.

PRIMARY CARE FOLLOW-UP RESPONSIBILITIES:

- Prescribe on-going treatment and adjust dose as per specialist advice.
- Conduct monitoring & refer abnormal results (**see page two**).
- Review regularly and take appropriate action: efficacy, side effects, adherence, drug interactions.
- Stop & urgently refer if: hyperthyroidism, pulmonary toxicity, severe skin reaction, hepatotoxicity, arrhythmia/heart block, eye toxicity.
- Regular re-discussions of risks/benefits of treatment including around pregnancy.
- Refer to specialist if pregnancy (planned or confirmed).

REFERENCES

- NHS England. [National shared care protocol: Amiodarone for patients within adult services](#). Version 1, July 2022. B1612_i_amiodarone-for-patients-within-adult-services.docx.
- NHS England and NHS Clinical Commissioners. [Items which should not routinely be prescribed in primary care: Guidance for CCGs](#). August 2019.
- NHS England policy guidance.
- NICE. [Atrial fibrillation: diagnosis and management \(NG196\)](#). April 2021. NICE guideline overview page.
- Specialist Pharmacy Service. [Amiodarone monitoring](#). July 2021. SPS Medicines Monitoring.
- Medicines and Healthcare products Regulatory Agency (MHRA). [Amiodarone \(Cordarone X\): reminder of risks of treatment and need for patient monitoring and supervision](#). March 2022 (updated May 2026). GOV.UK Drug Safety Update.
- London North West University Healthcare NHS Trust. Amiodarone for patients within adult cardiac services. LNWH/CD0099/DEC/2025. Approved November 2025. Internal document.

This guideline is intended to support decision making by trained clinicians and must be interpreted appropriately in the clinical context. It covers management for **adult (non-pregnant) patients only**. The authors are not responsible for clinical decision making in individual cases.

Monitoring Parameters	Baseline	6 monthly	Annually	6 months after stopping
ECG (SR/AF/Other)	✓		✓	
Heart Rate	✓		✓	
U&E (K+), Mg2+	✓	✓		✓
Thyroid Function	✓	✓		✓
Liver Function (transaminases)	✓	✓		✓
Chest X-ray	✓	As indicated		
Eye Exam	Due to potential micro-deposits affecting vision, should be encouraged to visit an optician once a year.			
Drug Interactions	✓	Ongoing		

Diagnosis & Management

Stop & seek specialist advice if new/worsening arrhythmia or heart block.
• ≤50 bpm, or ≤60 bpm with symptoms → seek specialist advice. • If 50–60 bpm & asymptomatic → continue treatment and monitor as appropriate
Correct low K+/Mg2+ as per local guidance; continue treatment.
• Hypothyroid: treat with levothyroxine if criteria met. • Hyperthyroid: stop & refer if TSH suppressed; repeat if borderline. • See table below.
• 1.5-3 × ULN: can occur at start of therapy and may normalise. • >3× ULN: continue amiodarone and repeat in 2 weeks. If still elevated → seek specialist advice / dose reduction. • >5× ULN or hepatic symptoms → stop & refer urgently.
If dyspnoea/cough → consider pulmonary function tests / CT scan.If suspect pneumonitis, then refer.
For patients with underlying risk factors e.g. glaucoma→ ophthalmology for baseline r/v. Blurred/decreased vision → ophthalmology review. Optic neuritis → seek specialist advice for amiodarone withdrawal. Consider using A&G.
Metabolised by CYP3A4 and P-gp inhibitor – always check for drug-drug interactions when initiating new medications e.g. warfarin, digoxin.

MANAGEMENT OF AMIODARONE-ASSOCIATED THYROID DYSFUNCTION

Note: these recommendations are adapted from SPS guidance following endocrinology input and include specified cut-offs for ease of use. Clinical judgement and local policies should be applied.

Condition	Laboratory Findings	Guidance
Hypothyroidism	TSH 4.5-10 mU/L	Repeat TSH measurement in 3 months.
	TSH > 10 mU/L	Consider treating with levothyroxine.
	Free T4 elevated; TSH > 4.5 mU/L	Seek urgent endocrinology review.
Hyperthyroidism	TSH < 0.01 mU/L	Arrange for thyroid uptake scan (technetium) or colour-flow doppler ultrasound and refer to endocrinology.
	TSH 0.01-0.25mU/L	Repeat TFT in 12 weeks if asymptomatic, but 6 weeks if symptomatic. Refer to endocrinology if TSH is persistently suppressed.