months, but they persisted and were worse at night. She had an irregularly irregular pulse in a recent past visit with her PCP. She presented to us for a resting ECG which demonstrated persistent nonsinus rhythm, nonspecific ST changes, no arrhythmic beats. Follow-up 24-hour Holter monitoring revealed PACs, PVCs, and short periods of atrial tachycardia. Her history was significant for PTSD treated with quetiapine 12.5 mg, L-tyrosine 1000 mg, 5-HTP 300 mg, and methylfolate 3.75 mg, daily. MAP was initiated at stage 2 using 1000 mg pantethine and 4000 mg choline bitartrate.

Two weeks later, at the first follow-up visit, the patient reported "significant improvements" in her palpitations and her experience of discernible heartbeats.

Conclusion

MAP therapy has been successful in many patients with varying types of tachycardia and dysrhythmias over its years of use. We have successfully combined it with other natural, medical, and surgical interventions to equal success. There are patients who are nonresponders to MAP, but they can be identified and redirected to other therapies within a few weeks of MAP trial. MAP is our first line natural treatment for tachydysrhythmias, especially when comorbidities such as dyslipidemia or metabolic syndrome exist.

We have presented only a small sample of straightforward case data here. We will continue to publish on the successful use of MAP in more complex cases beginning with an upcoming peer-reviewed case series. Following that, we intend to begin comparative effectiveness trials of MAP plus usual therapy (conventional pharmaceutical rate and rhythm control agents) versus usual therapy plus placebo. The MAP is a promising treatment option that warrants further investigation.

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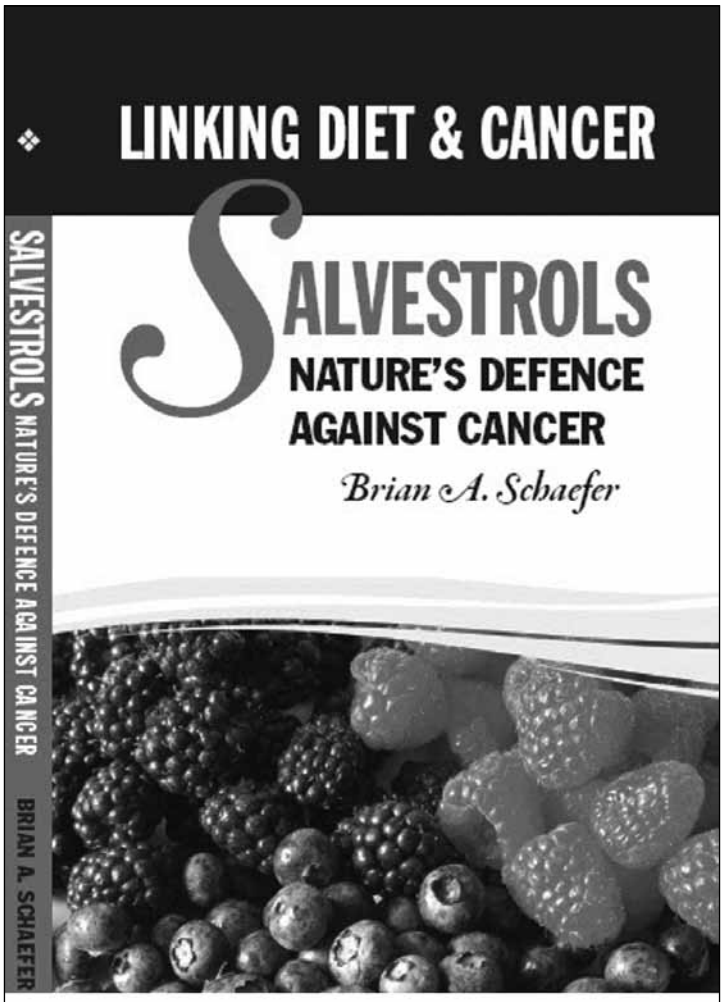

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