European, American and Japanese guidelines regarding atrial fibrillation (AF) limit the use of antiarrhythmic drugs (AADs, including class I drugs, sotalol or bepridil) to patients with no or minimal heart diseases. The main purpose of the clinical use of AADs is to relieve AF-related symptoms. The fact that the maintenance of sinus rhythm using AADs does not bring better prognosis should be widely penetrated. We are currently facing several other problems regarding AADs. Firstly, the long-term AADs (over 10 years) may have eventually resulted in their use in aged patients. In spite of high proarrhythmic risk in this population, it appears difficult to discontinue AADs especially in whom AADs are effective. Alternative strategy following discontinuation of AADs should be established. Secondly, AADs can be safely used in young symptomatic AF patients. However, this population is also suitable candidate for catheter ablation. Sticking to AADs therapy may lose a chance to receive catheter ablation with high success rate. Correct information about catheter ablation in terms of success rate and incidence of complications should be introduced. Finally, dronedarone is not available in Japan. The safety profile of dronedarone would be advantageous in patients without structural heart disease, in addition to those with heart disease.

**Keywords:** antiarrhythmic drugs, rhythm control