South East Coast Strategic Clinical Networks

PRIMARY CARE ATRIAL FIBRILLATION PATHWAY

Opportunistic finding of irregular pulse - refer to GP

Patient presents to GP/other with syncope, breathlessness/dyspnoea, palpitations, chest discomfort stroke/transient ischaemic attack – check for irregular/regularly irregular pulse
SUSPECT AF

Clearly Unwell
HR over 150
Breathless - NYHA Class III or IV or significantly worsened SOB OR Ongoing chest pains or critical perfusion OR Acute LVF

Secondary Care

Organise investigations: Urgent **ECG (within 48 hours),** Routine FBC, TFTs, U&Es, and LFTs/GGT. Organise appointment to discuss findings

ECG inconclusive - AF still suspected (paroxysmal) – Organise ECG monitoring for long enough to capture suspected episodes
Use a 24-hour ambulatory ECG monitor in those with suspected asymptomatic episodes or symptomatic episodes less than 24 hours apart
Use an event recorder ECG in those with symptomatic episodes more than 24 hours apart

AF Confirmed
Local mechanisms to explain condition and treatment – use NICE Patient Decision Aid
Calculate CHA2DS2VASc Score (Risk of Stroke)

CHA2DSDS2VASc Risk	Score
Congestive Heart Failure	1
Hypertension	1
Age>75	2
Diabetes	1
Previous stroke or TIA	2
Vascular Disease	1
Age 65-74	1
Female	1

HASBLED SCORE – Score 1 for each indication
- Abnormal renal function
-Abnormal liver function
-History of major bleeding (any cause)
-History of labile INR (time in therapeutic range <60%)
-Current "excess" use of alcohol
-Currently taking antiplatelet drug(s) or NSAID(s)
- Hypertension
-Stroke
- Aged over 65 years

CHA2DS2VASc
≥2 Warfarin or NOACs as per NICE Patient Decision Aid (local guidance may inform choice of NOAC). Consider anticoagulation if CHA2DS2VASc ≥ 1 in men. Assess Bleeding Risk using **HASBLED** score to identify modifiable risk factors. Estimate stroke risk and benefits & risks of antithrombotic therapy using SPARCtool. http://www.sparctool.com/

Does not meet ECHO criteria

Meets ECHO criteria as per below

Primary Care Management
Prescribe beta blocker as first line e.g. Bisoprolol 1.25 - 10mg daily
If beta blocker contraindicated and LV function is normal, prescribe rate-limiting calcium channel blocker: Diltiazem or Verapamil. Only consider Digoxin as monotherapy if patient is predominantly sedentary.
If beta blocker contraindicated and there is LV dysfunction, prescribe Digoxin as first line**.**
Amiodarone and Dronedarone should only be initiated by a Cardiologist. Monitor Apical HR and BP. If resting ventricular rate is ≥110 or is symptomatic consider ↑ dose of beta blocker, calcium channel blocker or add digoxin
Consider trial of sinus rhythm by cardioversion in 1st presentation of AF
Review stable patients every 6 months and after any change in treatment

Perform ECHO
On those for whom a baseline echocardiogram is important for long-term management
For whom a rhythm-control strategy that includes cardioversion (electrical or pharmacological) is being considered
In whom there is a high risk or a suspicion of underlying structural/functional heart disease (such as heart failure or heart murmur)
That influences their subsequent management (for example, choice of antiarrhythmic drug) in whom refinement of clinical risk stratification for antithrombotic therapy is needed. **ECHO to be interpreted by those with appropriate training**

No significant ECHO Abnormalities

Significant ECHO Abnormalities

Refer to Cardiology at any time if:
Symptomatic (SOB, dizzy, tired, palpitations) despite strict rate control (resting HR < 80bpm & exercise HR <110bpm), vagal AF suspected, Arrhythmias - WPW Syndrome, tachy-brady syndrome, uncontrolled ventricular rate, Heart Failure, Arrhythmia post AF ablation

Refer to Cardiologist