Kent Surrey Sussex Academic Health Science Network

NHS South East 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

Secondary Care

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.

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)
https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797
https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-user-guide-243736093

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

CHA2DS2VASc

≥ 2 Warfarin or DOACs as per NICE Patient Decision Aid (local guidance may inform choice of DOAC). 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 Keele university decision support tool: (www.anticoagulation-dst.co.uk)

HASBLED SCORE

H	Hypertension (>160 mm Hg systolic)	1
A	Abnormal renal (creatinine >200) and liver (bilirubin x2, ALT x3) function	1 or 2
S	Stroke	1
B	Bleeding history	1
L	Labile INRs (therapeutic time in range <60%)	1
E	Elderly (age> 65)	1
D	Drugs (NSAIDs /antiplatelet) or Alcohol (> 8 drinks/week)	1 or 2

Does not meet ECHO criteria

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 or where there is additional training and shared care protocol for other clinicians. Monitor Apical HR and BP: Aim for heart rate < 80 bpm at rest; accept resting heart rate up to 110 bpm. If resting ventricular rate is ≥110 or is symptomatic consider increasing 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.

Meets ECHO criteria as per below

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 suspected 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

A hub of AF resources for clinicians and patients can be found on the resource page at **www.kssahsn.net/atrialfibrillation**

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