Atrial Fibrillation Pathway

This pathway has been developed from published guidance, in collaboration with local cardiologists.

This guidance is to assist GPs in decision making and is not intended to replace clinical judgment.

NHS Camden Clinical Commissioning Group

Symptomatic presentation of AF

Most common presenting symptoms-breathlessness, chest pain, syncope/dizziness and palpitations also reduced exercise tolerance, malaise and polyuria. May present with associated complications- stroke, TIA, or heart failure
Often asymptomatic.

Opportunistic find of AF

Absence of an irregular pulse makes a diagnosis of AF unlikely, but its presence does not reliably indicate AF

Patient information leaflet

Also refer patients to www.atrialfibrillation.org.uk

NICE patient decision aid

Risk of stroke is 5 times higher in a person with AF
Anticoag treatment reduces risk of stroke by about 2/3
For most people the benefit of anticoag treatment outweighs the risk of bleeding

Does the patient have any red flags?
- Loss of consciousness
- Acute significant breathlessness and/or light-headedness
- Chest pain
- TIA/ Stroke
- Haemodynamic instability

Yes → Urgent/Emergency referral to secondary care as appropriate

No

AF diagnosis confirmed on 12 lead ECG?
Typical ECG - no p waves

No → Palpitations pathway

Yes

ALERT:
If major bleed or HAS-BLED score ≥ 3 . Do benefits of anticoagulants outweigh the risks of bleed?

Onset of symptoms <48 hrs?

Yes → Discuss with duty cardiologist

No

Assess stroke risk with CHA2DS2-VASc score

CHA2DS2-VASc score 0 → No antithrombotic/ antiplatelet therapy

CHA2DS2-VASc score ≥ 1for men – ≥2 for women and HAS-BLED score less than or equal to 2 - anticoagulation treatment indicated

JFC guidance

HAS-BLED score table

Commence anticoagulation or refer as apropriate (warfarin initiation- 20 care, DOAC initiation -10 care if trained clinician and patient suitable)

Further Investigations
- Bloods – FBC, U/E, LFT, TFT. Consider also Ca"+ Mg "+
- 24/48-hr/ 7-day ECG as appropriate if required to confirm diagnosis
- Echo (after rate controlled)
- Consider also Ca2+, Mg2+ and HbA1c
- Consider chest x-ray if suspected respiratory pathology
- Consider Echo if high risk of underlying structural heart disease
- Exclude underlying causes or triggers:
  - Cardiac causes, such as hypertension, valvular heart disease, heart failure, and ischaemic heart disease.
  - Respiratory causes, such as chest infections, pulmonary embolism, and lung cancer.
  - Systemic causes, such as excessive alcohol intake, thyrotoxicosis, electrolyte depletion, infections, and diabetes mellitus

Rhythm Control (i.e. cardioversion)
Patients who are:
- When pharmacological treatment has failed
- Moderate to severe symptoms
- <75 or by discretion
- Presenting for the first time with lone AF
- Secondary to a treated or corrected precipitant
- With congestive heart failure
- Suitable for AF ablation

Refer to Cardiology

Rate control in primary care (aim for rate control of 60-80 BPM)
(Best in elderly 75+, minimal symptoms, CHD)
- Target heart rate <90bpm
- Initial monotherapy beta blocker OR diltiazem
- B blocker – e.g. Bisoprolol, 1.25mg titrated upwards max 10mg OD
- Diltiazem 60mg tds –max 360mg OD (Verapamil 120-240mg possible off-label alternative)
- If poor rate control with single agent, combine B blocker + Diltiazem +/- Digoxin). Seek specialist advice before prescribing diltiazem with a beta-blocker
- Digoxin monotherapy poor for rate control to be used in non-paroxysmal AF and sedentary patients

Follow up 1 week later, assess:
- Tolerance to treatment
- Symptom control
- HR, BP

Refer to Cardiology if rate poorly controlled or ongoing symptoms

DVLA Recommendations:

Advise the person that it is their responsibility to inform the Driver and Vehicle Licensing Agency (DVLA) of any condition that may affect their ability to drive.
The latest information from the DVLA regarding medical fitness to drive can be obtained at https://www.gov.uk/government/collections/assessing-fitness-to-drive-guide-for-medical-professionals.

Reference
https://cks.nice.org.uk/atrial-fibrillation

Comments & enquiries relating to medication:
CCCG Medicines Management Team mmt.camdenccg@nhs.net
Refer to current BNF or SPC for full medicines information

Clinical Contact for pathway queries: Camden.pathways@nhs.net

Pathway created by NCL
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CHA_2DS_2Vasc	Score	HASBLED	Score
Congestive heart failure/LV dysfunct.	1	Hypertension (uncontrolled, > 160 mmHg systolic)	1
Hypertension	1	Chronic liver disease or Bili 2xULN with AST/ALT/ALP 3x ULN	1
Age = 75	2	Abnormal renal function (creatinine =200 umol/L, renal transplant or chronic dialysis)	1
Diabetes mellitus	1	Stroke	1
Stroke/TIA/systemic arterial embolism	2	History of major bleeding[1] or predisposition	1
Vascular disease (prev. MI, peripheral arterial disease, aortic plaque)	1	Labile INRs, time in range less than 60%	1
Age 65 -74	1	Elderly (age = 65 or frail condition)	1
Sex (male 0, female 1)	F 1	Drugs (concomitant antiplatelet, NSAIDs etc) or alcohol abuse (1 point each)	1 or 2
Total score *(maximum score 9)*		**Total score** *(maximum score 9)*	

[1]Bleeding requiring hospitalisation and/or causing decrease in Hb >20 g/L and/or requiring =2 units blood transfusion

CHA_2DS_2-VASc score	Adjusted stroke rate (%/year)
0	0%
1	1.3%
2	2.2%
3	3.2%
4	4.0%
5	6.7%
6	9.8%
9	15.2%
HAS-BLED score	Major bleed s per 100 pt years
0	1.13
1	1.02
2	1.88
3	3.74
4	8.70
5	12.50
6 -9	Insufficient data