Atrial fibrillation (AF) primary care pathway

NHS South London Cardiac Operational Delivery Network

Incidental finding of AF on ECG/ambulatory monitor

Opportunistic finding of irregular pulse

See Box 1

Patient presents with symptoms consistent with AF

See Box 2

Is the patient unwell?

Yes

Refer patient to emergency department or contact on-call consultant for advice.

No

See Box 3

- Arrange 12-lead ECG within 2 working days
- If PAF suspected, conduct an appropriate ambulatory event recorder
- Order routine bloods and F/U appointment

2 weeks

See Box 4

Does the ECG or event recorder show AF?

No

Consider alternative cause for symptoms / irregular pulse

Yes

See Box 5

Assess the patient's risk of stroke and need for anticoagulation

Assess need for rate or rhythm control

Identify and offer help address modifiable risk factors for AF including:

- Increased BMI – Offer support to reduce weight and referral to a dietician
- Hypertension – Treat based on national guidelines
- Sleep apnoea – Offer referral to local sleep apnoea service
- Alcohol consumption – Offer help in line with national guidelines

If appropriate, initiate or refer for anticoagulation in line with local guidelines

SEL | SWL

See Box 7

Does patient meet criteria for referral to local AF/arrhythmia service?

No

See Box 1

Do they have PsAF with heart rate >110 bpm at rest and / or **symptomatic** ?

No

Yes

See Box 6

Commence or increase rate limiting medication

Yes

Refer to local AF/arrhythmia service (include documented evidence of AF)

No

Resting rate target achieved and all AF-related symptoms eliminated?

Yes

See Box 8

Annual review in primary care and manage risk factors

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If referral is not indicated, advice and guidance can be obtained from the local AF/arrhythmia service via the **Advice and Guidance** function on ERS.

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AF is classified according to the pattern of episodes:

- **Paroxysmal AF (PAF)**— episodes lasting longer than 30 seconds but less than 7 days (often less than 48 hours) that are self-terminating and recurrent.
- **Persistent AF (PsAF)** — episodes lasting longer than 7 days (spontaneous termination of the arrhythmia is unlikely to occur after this time) or less than seven days but requiring pharmacological or electrical cardioversion.

Box 1	• **Typical AF symptoms include**: Fatigue, reduced exercise tolerance, shortness of breath, dizziness, chest discomfort, palpitation, syncope or pre-syncope
Box 2	Signs/symptoms of the unwell AF patient include: • HR >120 bpm at rest • Haemodynamically unstable • Severe breathlessness • Chest pain • Acute heart failure
Box 3	• For all patients arrange for 12 lead ECG within two working days • If symptoms are intermittent type of monitoring chosen should reflect frequency of symptoms (eg if symptoms are < 24 hrs apart, arrange a 24 hr tape; if symptoms are > 24 hrs apart, arrange an event recorder) • Bloods include: FBC, U&Es, TFTs, LFTs, HbA1c (if not done within the last year) • Check BNP/NT-proBNP ONLY if heart failure is suspected and refer to heart failure clinic if BNP/NT-proBNP raised • Consider echocardiogram if underlying structural/valve disease is suspected **OR** the findings are likely to alter management • Consider and investigate for underlying respiratory and metabolic causes
Box 4	• Episodes of AF are continuous for > 30 seconds • Frequent SVEs, short run atrial arrhythmia do not confirm diagnosis
Box 5	• Use the CHA_2DS_2-VASc score to determine if patient should be started on anticoagulation, and initiate anticoagulation if necessary, in line with local guidelines and arrangements: **South East London** | **South West London** • Anti-coagulate if score ≥ 2, and consider anticoagulation for men with a score of 1 • Consider risk factors for HAS-BLED and modify bleeding risk factors where possible • Do not withhold anticoagulation solely due to elevated risk of bleeding or falls • See www.dontwaittoanticoagulate.com

Box 6	• Commence rate control medication (eg bisoprolol 2.5mg, if tolerated, and titrate up to eg 5mg). If beta blocker is contraindicated, consider verapamil or diltiazem.
	• Aim for resting heart rate of:
	  • <110 bpm if asymptomatic
	  • <90 bpm if symptomatic
	• If rate control difficult to achieve, or patient remains symptomatic despite good rate control, refer to **local AF/arrhythmia service** (see box 7)

Box 7	**Refer to local AF/arrhythmia service promptly if:** • Patient has PAF (episodes last longer than 30 seconds and less than 7 days) AND is symptomatic • Patient has PsAF (episodes lasting longer than 7 days) AND is symptomatic despite rate control (resting HR <90 bpm) • Patient has inadequate rate control despite drug therapy (persistently > 110 bpm at rest) irrespective of symptoms • Patient is unable to tolerate necessary rate control medication • Concern about associated cardiac disease e.g. LV dysfunction, valve disease, bradycardia on 24 hr ECG • Patient has elevated, CHA_2DS_2-VASc score but is not suitable for anticoagulation e.g. high bleeding risk • Patient or doctor wish to discuss rhythm control options including DC cardioversion, ablation or drug therapy. ***Needs documented evidence of AF with referral.***
Box 8	• Annual review to include symptom control, CHA_2DS_2-VASc, HAS-BLED, signs of bleeding/anaemia, renal function if on a DOAC, body weight.