Atrial fibrillation secondary care outpatient pathway

NHS South London Cardiac Operational Delivery Network

Receive referral with confirmed AF diagnosis
(via 12 lead ECG or > 30 secs on appropriate ambulatory event recorder)

See Box 1

Is the patient anticoagulated?

No → Assess stroke risk (See Box 2)

Yes → See Box 3: Has risk factor modification been addressed?

Yes → Does the patient have symptoms secondary to AF?
Symptoms may include:
- Fatigue/tiredness/lethargy
- Exertional SOB
- Palpitations and chest pain
- Feeling faint/dizzy

No → If PsAF, is resting heart rate <110pbm?

Yes → Exit pathway; manage in primary care

See Box 4: Can rate control be achieved?

No → Offer EP referral

Yes → Is AF par-oxysmal?

Yes → Offer EP referral

Yes → Is AF persistent AND heart rate <90bpm at rest?

No → Optimise rate control medication - aim for <90 bpm

See Box 4: Is rate control achieved?

No → Offer EP referral

Yes → See Box 5: Is the patient suitable for rhythm control strategy?

No → Exit pathway; manage in primary care

Yes → Is patient still symptomatic?

Yes → See Box 5: Is the patient suitable for rhythm control strategy?

No → Exit pathway; manage in primary care

Yes → See Box 6

List for DCCV

Conduct DCCV

ECG at 4 weeks post DCCV

Review at 12 weeks (or before)

See Box 7: Is there symptomatic improvement in sinus rhythm?

No → Exit pathway
Stop anti-arrhythmic drugs (AADs) if relevant

Unclear → Discuss with EP team

Yes → Offer EP referral

18 Weeks

8 weeks

12 weeks

Last updated 6 November 2019

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General guidance

- In patients with symptomatic paroxysmal AF (PAF), early referral to an electrophysiologist should be offered, as outcomes from a rhythm control strategy in this group are good.
- In patients with persistent AF (PsAF), outcomes from a rhythm control strategy are significantly worse where AF has been continuous for > 12 months. Therefore, referral for these patients should be performed in a timely manner.
- In selected symptomatic PsAF patients, where it is clear a rhythm control strategy is likely to be followed, early referral to an electrophysiologist prior to cardioversion may be considered.
- In patients with PsAF, often the only way to determine whether a patient's symptoms are due to AF is cardioversion to enable a period of time in sinus rhythm to assess symptom improvement.

Box 1

- Episodes of AF are >30sec of sustained AF: an irregularly irregular rhythm in the absence of P waves. Frequent SVEs, short run atrial arrhythmia do not confirm diagnosis.
- Ensure all investigations are complete including: FBC, U&Es, coagulation, HbA1c, TFTs, LFTs.
- Check BNP ONLY if heart failure is suspected.
- Arrange transthoracic echocardiogram at first outpatient visit if not already done.
- If significant reduction in LVEF (<40%) **refer to HF specialist.**

Box 2

Assess stroke risk by calculating CHA_2DS_2-VASc and HAS-BLED scores to determine whether patient should be started on anticoagulation, and initiate anticoagulation if necessary, in line with local guidelines and arrangements (South East London / South West London)

- Offer oral anticoagulants if CHA2DSVasc ≥ 2.
- In men consider oral anticoagulants if CHA2DSVasc ≥ 1.

Box 3

Risk factor modification should include:

- Obesity
- Hypertension
- Sleep apnoea
- Alcohol consumption

Box 4

Rate control is considered *not* achieved if:

- Asymptomatic >110 bpm at rest.
- Symptomatic >90 bpm at rest.

OR

- Patient is unable to tolerate rate control medication.

If there is uncertainty about the best approach discuss with the local EP team.

Box 5

Factors associated with a good rhythm control candidate:

- Continuous AF <12 months.
- LA size <5 cm.
- No major structural heart disease.
- No major life-limiting comorbidity.
- Able to take oral anticoagulants.

If unsure, discuss with EP team.

Box 6

Attempt no more than two DCCVs before offering referral to an EP consultant.

Pre DCCV – Commence oral anticoagulants, if patient not already anticoagulated

- Consider pre-treatment with anti-arrhythmic drugs (amiodarone preferred) if:
  - Previous DCCV failure.
  - Large LA >5cm.
  - AF present > 6 months.
  - Patient has heart failure.

Post DCCV

- ECG 4 weeks post DCCV to document rhythm.
- Appointment 12 weeks (or before) post DCCV to assess rhythm and symptom response.

Box 7

Stop anti-arrhythmic drugs (if relevant) UNLESS management plan is to maintain patient on AADs for rhythm control.