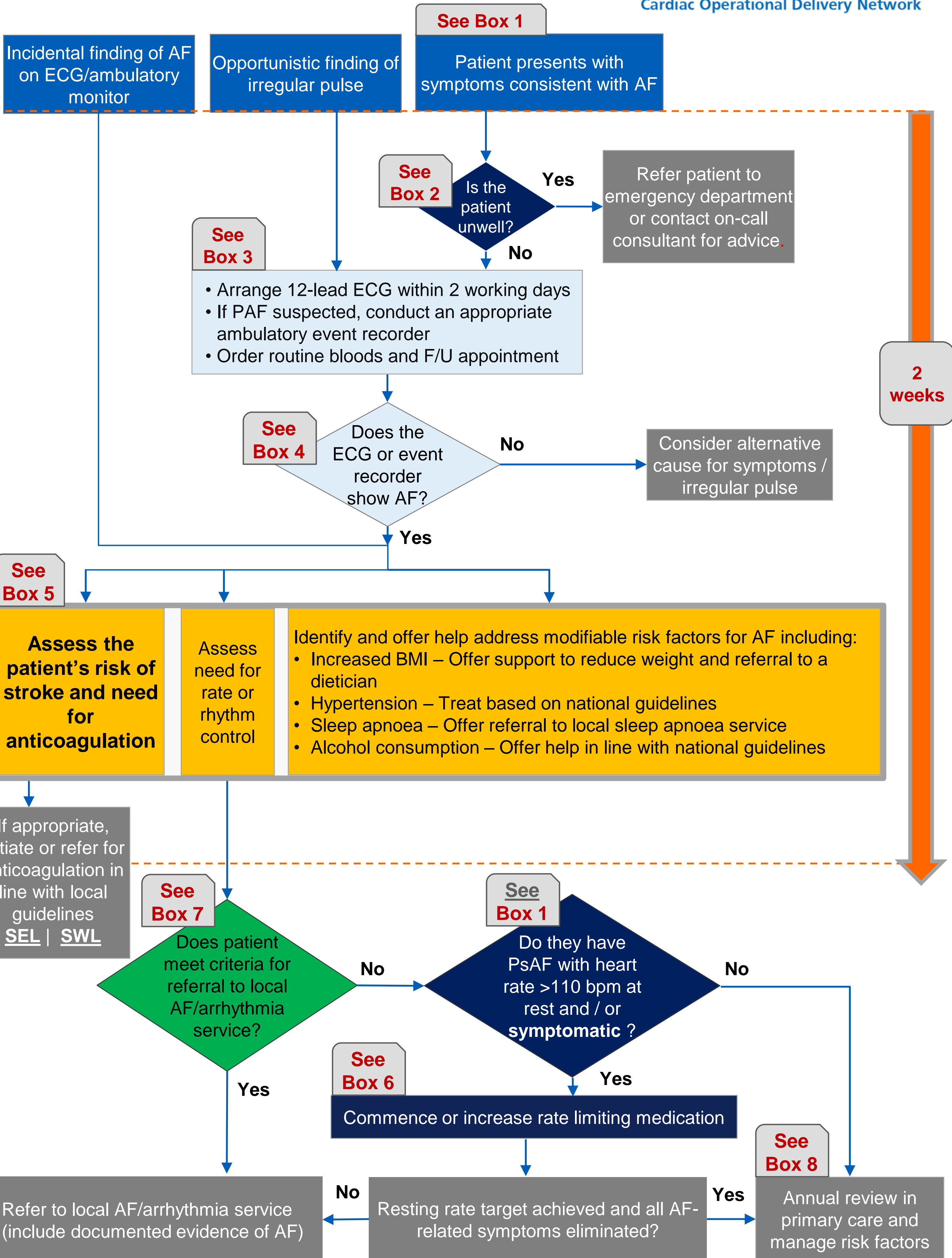
Atrial fibrillation (AF) primary care pathway

NHS South London
Cardiac Operational Delivery Network



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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	• Assess stroke and bleeding risks. • Use the CHA_2DS_2-VASc score to assess stroke risk. • Assess bleeding risk using a validated tool (eg ORBIT or HAS-BLED) and offer monitoring and support to modify risk factors for bleeding. • Discuss the results of the assessments of stroke / bleeding risk with the person taking into account their individual preferences. • Discuss with the person that for most, but not all, patients with an elevated stroke risk the benefit of anticoagulation outweighs the bleeding risk. • Offer anticoagulation to people with AF and a CHA_2DS_2-VASc score ≥ 2 and consider anticoagulation for men with a score of 1, taking into account bleeding risk. • If DOACs are contraindicated, not tolerated, or not suitable, offer a vitamin K antagonist. • Initiate anticoagulation if necessary, in line with local guidelines and arrangements: **South East London** | **South West London** • Do not withhold anticoagulation solely because of a person's age or their risk of falls. • Do not stop anticoagulation solely because AF is no longer detectable. • See www.dontwaittoanticoagulate.com

Box 6	• Offer a standard beta-blocker (e.g. bisoprolol) or a rate-limiting calcium-channel blocker (diltiazem or verapamil) as initial rate-control monotherapy and base the choice of drug on the person's symptoms, heart rate, comorbidities and preferences
	• Consider digoxin monotherapy for initial rate control where the person does no or very little physical exercise or other rate-limiting drugs options are ruled out
	• Aim for resting heart rate of:
	  • <110 bpm if asymptomatic
	  • <90 bpm if symptomatic
	• If rate control is 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, stroke/bleeding risk reassessment, signs of bleeding/anaemia, renal function if on a DOAC, body weight • Do not stop anticoagulation solely because AF is no longer detectable