Atrial fibrillation secondary care outpatient pathway

NHS South London Cardiac Operational Delivery Network

See Box 1

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

Is the patient anticoagulated?

No → **See Box 2** Assess stroke risk

Yes

See Box 3 Address risk factor modification

Yes

Does echo cardiogram show LVEF <40%

Yes → Refer to / follow *AF with heart failure* pathway

No

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

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

Yes

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

No → Exit pathway; manage in primary care

Yes

Is patient still symptomatic?

No → **18 Weeks**

Yes

See Box 6

List for DCCV

Conduct DCCV

ECG at 4 weeks post DCCV

Review at 12 weeks (or before)

8 weeks

12 weeks

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

Last updated March 2022

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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.
- Decisions regarding anticoagulation, rate vs. rhythm control and the use of specific AF interventions, should be made in conjunction with the patient in line with NICE recommendations on shared decision making

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%) **follow AF and heart failure pathway and guidelines**

Box 2

Assess stroke and bleeding risk by calculating CHA_2DS_2-VASc and ORBIT/HAS-BLED scores. Discuss results with patient to decide 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.