NHS
Vale of York
Clinical Commissioning Group

Referral Support Service

Cardiology

CAR02
Atrial Fibrillation

Definition

Patient has evidence of AF on a rhythm strip or 12 lead ECG

It is expected that the majority of people with AF will be managed in the community and do not require cardiology referral.

Exclude the following Red Flag Symptoms and Signs where the Clinician should consider URGENT Hospital Advice or Admission

- Severe SOB **and** AF see Heart Failure Pathway
- Chest Pain and AF with a rapid ventricular rate
- Syncope with AF (please advise not to drive)
- Wolff Parkinson White Syndrome and AF

General Points

- Atrial fibrillation is extremely common in the elderly population affecting 10% of the over 80s
- At least 30% of cases are asymptomatic, this is more frequent in the elderly and can present with stroke in these higher risk individuals.
- AF is usually associated with other cardiovascular conditions, IHD, hypertension and less commonly valvular heart disease.
- It can also be associated with pulmonary disease, thyroid disorders and alcohol intake, and acutely with sepsis especially pneumonia: pulmonary embolism and cardiac surgery.

Management: recommended for all patients with AF

- 12 lead ECG to confirm the diagnosis and identify other cardiac problems
- Blood tests:- FBC, U & Es, TFTs, LFTs,
- An assessment of thromboembolic risk using CHADSVASc and of bleeding risk using HASBLED

Pharmacological Rate Control

- If ventricular rate is > 100 the patient should be started on a **beta blocker (bisoprolol 2.5mg OR atenolol 25mg once daily**) or rate limiting **calcium channel blocker - as diltiazem**, starting 120mg daily (unlicensed indication). Please note **diltiazem** - must be prescribed by brand name, as a ONCE DAILY preparation, either **Adizem XL® or Tildiem**

Responsible GP: Dr Kathryn E Griffith
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LA®

- **Digoxin** should be reserved for second line use.
- Do not offer **amiodarone** for long term rate control
- People with a CHADSVASc score of 2 or more should be counselled about their thromboembolic risk and the benefits of anticoagulation. When agreed they should be commenced on appropriate anticoagulation either by the practice or referred to the anticoagulant clinic. To view the CCG's CHADSVASc and HASBLED score information leaflet please click here.
- Counsel the patient about the risks and benefits and initiate therapy if appropriate or refer to the anticoagulant clinic. Please see dontwaittoanticoagulate or sparctool.com as these show the risks and benefits of different treatments well.
- People with a CHADSVASc score of 1 should also be made aware of their risk of stroke and of the balance between risk of bleeding with anticoagulation and stroke risk reduction. They may wish to opt for anticoagulation.
- CHADSVASc score of 1 in a woman related to gender alone is not an indication for anticoagulation.
- The **DOACs** (Direct Oral Anticoagulants) are **NOT** indicated for valvular AF with **significant** mitral stenosis or metallic valve replacement

NICE guidelines state that there is no role for aspirin or other antiplatelet therapy to prevent thromboembolic stroke in AF.

The risk of bleeding rises with combination of antiplatelet and anticoagulant therapy. The need for antiplatelet therapy in combination should be assessed on initiation of therapy and at medication review.

Indications to request a consultant opinion

- Recent (< 3 months) onset of s**ymptomatic** AF where cardioversion may be considered
- AF with poor ventricular rate control (> 100) despite maximally tolerated doses of a **betablocker** or **diltiazem (as Adizem XL® or Tildiem LA®)**. Where possible, poor rate control should be confirmed by 24hr ECG before referral.
- AF which has followed an acute event
- AF in a young person with no obvious cause
- Atrial Flutter

Rhythm control – for information only, treatment for rhythm control would be initiated by secondary care:

- Consider pharmacological and/or electrical rhythm control for people with atrial fibrillation whose symptoms continue after heart rate has been controlled or for whom a rate-control strategy has not been successful.
- Pharmalogical rhythym control may include: **amiodarone; beta-blockers; and dronedarone** (dronedarone is amber shared care).

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Additional Indications for Echocardiogram

- AF in a person with a murmur suggestive of a structural problem where a **DOAC** may be contraindicated

Information to include in the referral letter

- Please clearly indicate the indication for which you are referring the patient
- Please include the CHADSVASC and HASBLED scores
- Please include the values of the investigations prior to referral: ECG, FBC, U& E, TFT, LFT
- Please attach ECG evidence of AF
- Please **do not wait** until after a clinic visit before offering anticoagulation.
- **Send through the RSS for booking into York Hospital Foundation Trust eReferrals** The service is listed under Cardiology Not Otherwise Specified (NOS)

Other important points

- Patients with AF and symptoms and signs of Heart Failure should be referred via the Heart Failure Pathway.
- All people with AF (paroxysmal, persistent and permanent) and atrial flutter should be assessed and managed for thromboembolic risk in the same way.
- Where the ECG diagnosis is not clear a reporting service is available via the Cardiorespiratory Department at York Teaching Hospital FT.

Patient information leaflets/ PDAs

- AF on Patient choices
- Patient Decision Aid for AF
- Patient information leaflet
- Information for patients and professionals from AFA
- British Heart Foundation

References

- NICE Clinical Guideline 180 Atrial Fibrillation Management 2014
- Clinical Knowledge Summary 2015
- An online tool to demonstrate risks and benefits of treatment

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