Clinical Effectiveness Southwark

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NHS Southwark Clinical Commissioning Group

The Health Foundation

Atrial Fibrillation

A guide for Southwark General Practice

Key Messages

1. Routinely offer pulse checks to patients at high risk of AF
2. Use the CHA_2DS_2VASc score to identify patients for anticoagulation
3. Stop aspirin/clopidogrel monotherapy

Always work within your knowledge and competency

May 2018 (review May 2020, or earlier if indicated)

Opportunistic Manual Pulse Checks

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Opportunistic manual pulse checks in those over 65 years, those with long-term conditions (e.g., hypertension, diabetes, CKD, PAD, stroke or COPD) and anyone with symptoms suggestive of AF (breathlessness, palpitations, chest discomfort, syncope or dizziness, stroke or TIA)

Confirmation and Assessment of AF diagnosis

Check for pre-disposing factors and complications

Arrange blood tests :
U&Es, FBC, HbA1c, TFTs, LFTs.

Check BNP ONLY if you suspect heart failure

Consider echocardiogram if there is suspicion of underlying heart failure (raised BNP), structural heart disease and / or valvular heart disease or if patient being considered for cardioversion

Perform a **12-lead ECG** for anyone found to have an irregular pulse within 48 hours and arrange follow up appointment to assess results. Once AF diagnosis confirmed code correctly

If paroxysmal AF suspected, do a 24 / 48 hour or 7-day ECG depending on frequency of symptoms

Consider urgent referral to emergency department or medical team (via Talk Line) if haemodynamic instability or severe AF-related symptoms (chest pain, severe breathlessness, light-headedness or syncope, stroke/TIA, severe tachycardia or acute heart failure)

Patients should be considered for immediate cardioversion if there is a clear history of AF onset within 48 hours

Rate control is suitable for the majority of patients

Rate Control in primary care

Start rate limiting treatment if fast AF (>90bpm) or symptomatic AF

Use a beta-blocker such as **bisoprolol 2.5mg** (or rate limiting calcium channel blocker) – start at low dose and titrate up (e.g., to **bisoprolol 5mg**) if rate >90bpm at rest or symptomatic

Aim for a ventricular rate of less than 90 bpm at rest

If rate control is suboptimal on maximum tolerated dose of monotherapy, consider a combination of calcium channel blocker, beta-blocker or digoxin (digoxin monotherapy should only be considered for sedentary patients or those with reduced LV function)

If heart rate remains > 110bpm at rest or symptoms remain uncontrolled –referral to cardiology would be appropriate

OR

Rhythm Control in secondary care

Consider non-urgent referral to cardiology for rhythm control (cardioversion) in :

new onset AF (based on history), mixed arrhythmias, young patients, or lone AF in absence of any history or echo evidence of CVD, reversible cause, paroxysmal AF, heart failure caused or exacerbated by AF or persistent symptoms despite rate control

Discuss with cardiology if required: Use **Choose and Book Advice or Consultant Connect**

Assess stroke and bleeding risk to guide treatment

Assess Stroke Risk: use CHA2DS2VASc

Risk Factor	Score
Congestive Heart failure	1
Hypertension	1
Age ≥ 75 years	2
Age 65-74 years	1
Diabetes Mellitus	1
Stroke/TIA	1
Vascular Disease	1
Female	1

Score	Adjusted Stroke Risk per year (%)
0	0%
1	1.3%
2	2.2%
3	3.2%
4	4.0%
5	6.7%
6	9.8%
7	9.6%
8	6.7%
9	15.2%

Assess Bleeding Risk: use HASBLED

Risk Factor	Score
Uncontrolled systolic BP >160mmHg	1
Abnormal Liver Function	1
Abnormal renal function Creatinine>200µmol/L	1
Prior Stroke / TIA	1
Bleeding Tendency	1
Labile INRs	1
Elderly >65 years	1
Drugs increasing bleeding risk	1
Alcohol	1

Score	Bleeds per 100 patient years
0	1.13%
1	1.02%
2	2.2%
3	3.2%
4	4.0%
5	6.7%

Refer for Anticoagulation

Refer appropriate patients using local referral form on DXS. (If uncertain after risk assessment: refer to anticoagulation). Ensure patients are reviewed with respect to cardiovascular risk (including blood pressure, tobacco, weight, exercise and lipid control) using the Q-Risk score.

Do not use aspirin/clopidogrel monotherapy for stroke prevention in AF
Do not withhold anticoagulation solely due to a person being at risk of a fall
Risk of stroke is 5-6 times greater in people with AF than those with a normal heart rhythm. Paroxysmal AF confers the same stroke risk as persistent AF

Individualised patient information leaflets can be generated here summarising the benefits and risks of anticoagulation

Shared decision making

When discussing the benefits and risks of anticoagulation, use this table to compare the benefit to the risk. Follow the process described below

CHADS Vasc Score: calculate this using the table	AF related strokes prevented by anticoagulation per 1000 pt/yr	Major bleeds caused by anticoagulation per 1000 pt/yr	HASBLED Score: calculate this using the table
1	4	4	1
2	17	12	2
3	25	15	3
4	28	21	4
5	57		

Calculate the patient's **CHADSvasc** score and then read across to see **how many strokes are prevented** each year by anticoagulation

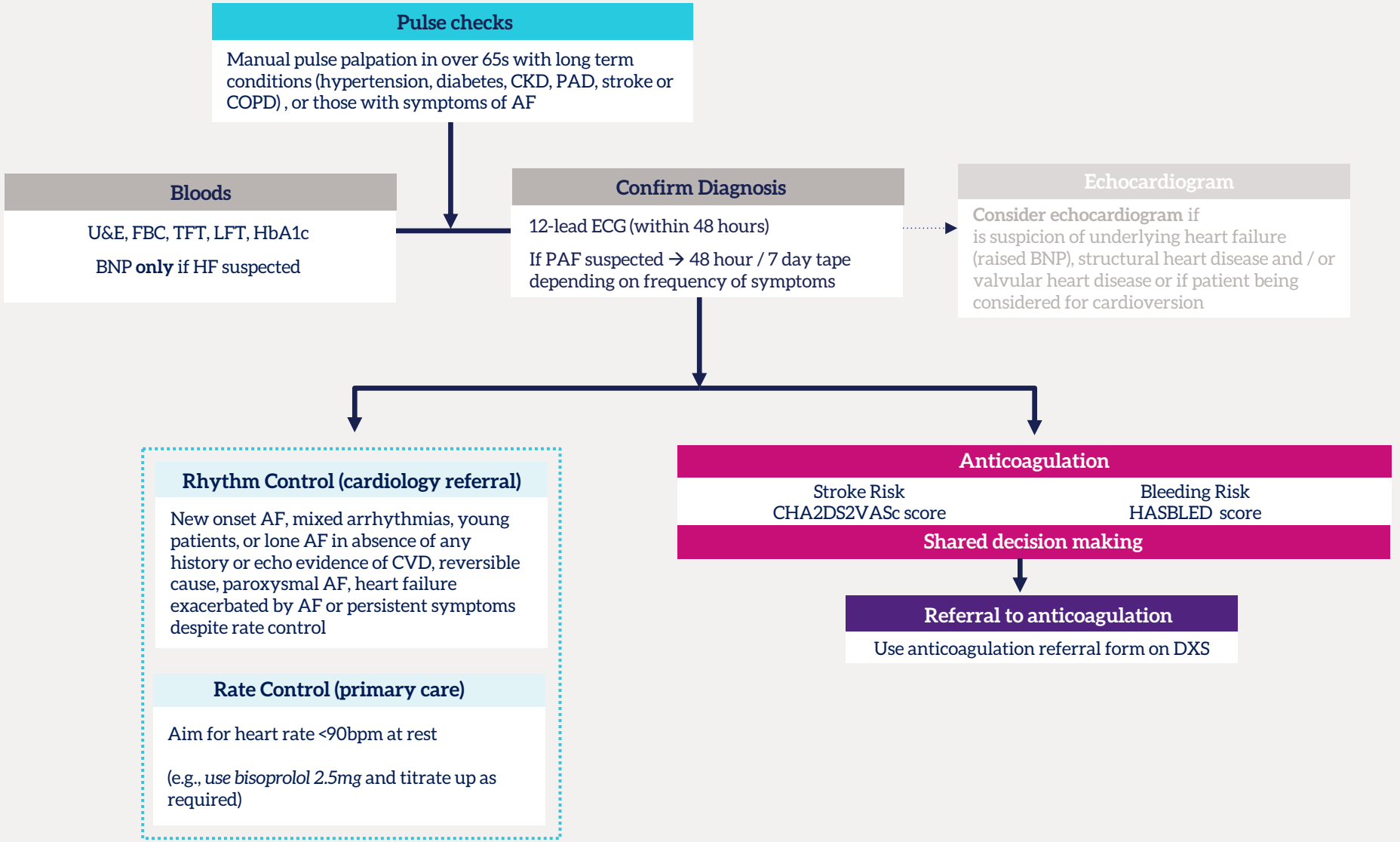
Review each risk factor in **HASBLED** to minimise the risk of bleeding. After **minimising each of these risks**, check the **risk of anticoagulation.**

The difference between the benefit and the risk represents the net benefit for the patient

Annual Review

If adequate control in primary care – for **annual follow up** by appropriate clinician – including manual BP, drug review, review of stroke prevention and appropriateness of rate/rhythm control strategy.

Patients on anticoagulation will need a minimum of **annual review in General Practice**. Patients on DOACs (also known as NOACs) whose care has been transferred to the GP after three months should have renal function monitoring as per South East London DOAC guideline for each DOAC .
Annual review includes CHA2DS2VASc/HASBLED scores, signs of bleeding and anaemia, renal function testing (using Cockcroft-Gault formula) and bodyweight and interactions with other medications


Pulse checks
Manual pulse palpation in over 65s with long term conditions (hypertension, diabetes, CKD, PAD, stroke or COPD) , or those with symptoms of AF
Bloods
U&E, FBC, TFT, LFT, HbA1c
BNP only if HF suspected
Confirm Diagnosis
12-lead ECG (within 48 hours)
If PAF suspected → 48 hour / 7 day tape depending on frequency of symptoms
Echocardiogram
Consider echocardiogram if is suspicion of underlying heart failure (raised BNP), structural heart disease and / or valvular heart disease or if patient being considered for cardioversion
Rhythm Control (cardiology referral)
New onset AF, mixed arrhythmias, young patients, or lone AF in absence of any history or echo evidence of CVD, reversible cause, paroxysmal AF, heart failure exacerbated by AF or persistent symptoms despite rate control
Rate Control (primary care)
Aim for heart rate <90bpm at rest
(e.g., use bisoprolol 2.5mg and titrate up as required)
Anticoagulation
Stroke Risk CHA2DS2VASc score
Bleeding Risk HASBLED score
Shared decision making
Referral to anticoagulation
Use anticoagulation referral form on DXS

References

1. *A randomised controlled trial and cost-effectiveness study of systematic screening (targeted and total population screening) versus routine practice for the detection of atrial fibrillation in people aged 65 and over. The SAFE study.* **Hobbs, FD, et al., et al.** 40, 2005, Health Technol Assess, Vol. 9, pp. 1-74.
2. **NICE.** *Atrial fibrillation: management.* (2014)
3. **London Strategic Clinical Network.***Atrial Fibrillation (AF) Toolkit: Detect, Protect, Perfect* (2017)
4. South London Cardiac and Stroke Network Atrial Fibrillation Pathway for Primary Care (2012)
5. South East London Area Prescribing Committee Guidelines for Apixiban, Edoxaban, Dabigatran and Rivaroxaban (2016)
6. South East London Area Prescribing Committee DOAC initiation checklist (2016)
7. Pan London Position Statement: Prevention of Atrial Fibrillation Related Stroke (2016/17)
8. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Atrial Fibrillation (2015)

Consultant Connect enables GPs to dial a single number in order to immediately reach an appropriate local specialist at GSTT or KCH. Your practice should already have its individual access number. Please stay on the line when you complete your call, to record an outcome.

Guide developed by CES Southwark :
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Abbreviations

AF – Atrial Fibrillation

BNP – brain natriuretic peptides (heart failure blood test)

BP – blood pressure

bpm – beats per minute

CKD – Chronic Kidney Disease

COPD – Chronic Obstruction Pulmonary Disease

CVD – cardiovascular disease

DOAC – direct oral anticoagulant (also known as NOAC – new oral anticoagulant)

DXS – point-of-care tool for EMIS Web

LV function – left ventricular function

ECG – Electrocardiogram

HbA1c – Haemoglobin A1c % (diabetes test)

HF – Heart Failure

INR – international normalised ration (warfarin monitoring)

LFT - liver function blood tests

PAD – Peripheral Arterial Disease

PAF - paroxysmal atrial fibrillation

TFT – thyroid function blood tests

TIA – Transient Ischaemic Attack

U&E – Urea and Electrolytes (kidney function blood tests)

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