



CLINICAL GUIDELINE

Atrial Fibrillation Management, Heart MCN

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Medicines Utilisation Subcommittee of ADTC

Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

GGC HEART MCN GUIDELINES FOR THE MANAGEMENT OF ATRIAL FIBRILLATION

OBJECTIVES

1. Prevention of stroke
2. Symptom relief
3. Optimal management of concomitant disease
4. Rate control
5. Restoration and maintenance of sinus rhythm (in some cases)

The initial strategy might differ from the long-term goal. For example, the initial strategy might be anticoagulation and rate control, while the long-term goal might be to restore sinus rhythm. If rate control improves symptoms, a decision might be taken not to restore sinus rhythm. Conversely, if AF recurs despite appropriate attempts to maintain sinus rhythm, a decision might be taken to accept long-term AF and control the ventricular rate.

SUMMARY OF INITIAL MANAGEMENT IN PRIMARY CARE

Consider hospital admission in acute onset AF, or rapid ventricular rate associated with severe symptoms such as chest pain, dyspnoea or hypotension.

In most patients, decisions regarding anticoagulant treatment and rate control drugs can be made on clinical grounds. An ECG (either 12-lead ECG or an ECG rhythm strip of at least 30 seconds from a handheld device or smartwatch) is essential to document AF before commencing therapy, but it is not essential to wait for an echocardiogram. Carry out a formal stroke risk assessment (see CHA₂DS₂-VASc score below) to determine if anticoagulant therapy is appropriate, and give a rate control drug (unless heart rate < 60/min). DO not delay treatment while awaiting investigations.

ESSENTIAL INVESTIGATIONS

1. Resting 12-lead ECG
2. U&E, Liver function tests, thyroid function tests, FBC
3. Echocardiogram

RATE CONTROL

1. Target ventricular (apex or ECG) rate < 110/min. If still symptomatic, aim for lower rate (<80/min)
2. Patients without heart failure should be started on EITHER
 - Beta-blocker, e.g. bisoprolol 2.5mg OD or atenolol 25mg BD and up-titrate to bisoprolol 5mg OD or atenolol 50mg BD if ventricular rate still >110/min.
 - In frail elderly patients, consider lower starting dose (bisoprolol 1.25 mg or atenolol 25mg OD)

OR

- Rate-limiting calcium channel blocker (CCB) e.g. verapamil MR 120mg daily; up-titrate to 240mg OD if ventricular rate still >110/min
- Digoxin has a limited role as first-line treatment. It is usually used second-line, in combination with beta-blocker or CCB
- Do not combine verapamil or diltiazem with beta-blocker
3. For patients with heart failure, consider digoxin or beta-blocker as appropriate and follow the NHS GGC heart failure guideline.

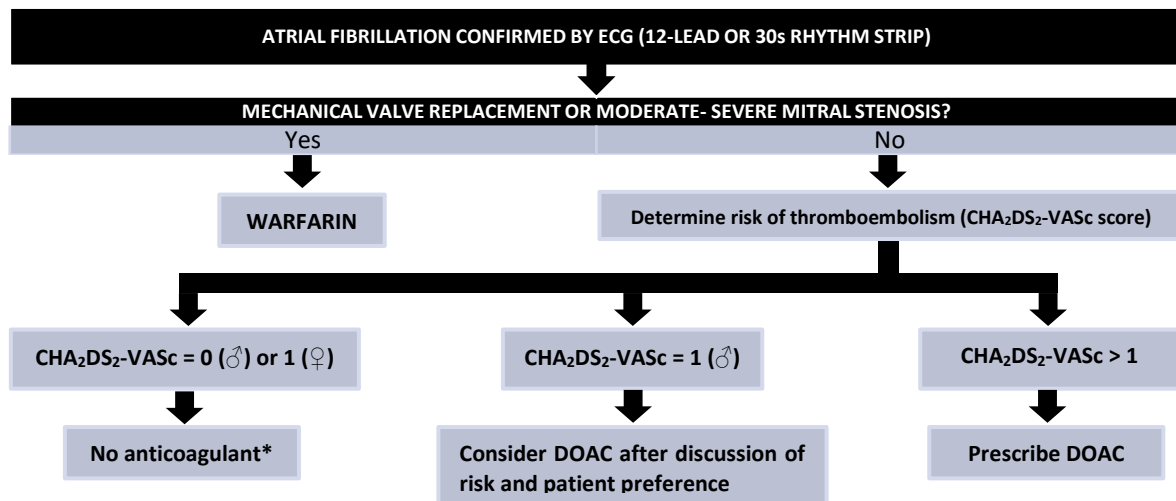
PATIENTS WHO SHOULD BE REFERRED FOR OUT-PATIENT SPECIALIST ASSESSMENT

- Symptomatic AF despite adequate rate control
- Young age (<65 years)
- Inadequate rate control despite the above measures, or intolerance of these
- Structural heart disease on echocardiography
- AF and co-existing heart failure
- Symptomatic paroxysmal AF requiring a "rhythm control" strategy

DATA COLLECTION AND AUDIT

General practitioners are encouraged to use the SPIRE software which includes an AF audit tool. It risk-scores the patients and presents the results to allow auditing of their AF register. Aggregate data also helps inform service provision at National level.

PREVENTION OF THROMBOEMBOLISM IN ATRIAL FIBRILLATION



*Some low-risk patients who are undergoing cardioversion or catheter ablation for AF will require short-term peri-procedural anticoagulation (at least 3 weeks pre-procedure and 4-8 weeks post-procedure)

Absolute contraindications to oral anticoagulant therapy

- Active bleeding
- Pregnancy

Relative contraindications

- Significant bleeding risk, e.g. active peptic ulcer, recent head injury
- Hepatic disease associated with coagulopathy
- Recent major bleed (within 6 months)
- Previous cerebral haemorrhage
- Stroke within 14 days

Caution

- Severe frailty
- Alcohol abuse

CHA ₂ DS ₂ -VASc	Score
CHF	1
Hypertension	1
Age >75	2
Diabetes mellitus	1
Stroke / TIA / thromboembolism	2
Vascular disease (PVD / IHD)	1
Age 65-74	1
Female	1 (only if other risk factors)

COMBINED ANTICOAGULANT AND ANTIPLATELET THERAPY

Continued antiplatelet therapy is not indicated in patients with stable coronary artery disease (> 1 year after acute coronary syndrome or coronary intervention) who also have AF and are on an anticoagulant. After percutaneous coronary intervention, short-term combined therapy is used according to cardiologist advice.

ATRIAL FIBRILLATION AND LIFESTYLE

Patients with atrial fibrillation who are significantly overweight (BMI > 27kg/m²) should be encouraged to try to lose weight. Studies have shown that overweight and obese patients who manage to lose at least 10% of their body weight are more likely to have successful outcomes from treatment for atrial fibrillation compared to those who fail to lose weight (or who gain weight).

Physical activity is encouraged. Patients should be encouraged to undertake moderate (or even high-intensity) exercise, and many patients will find that their exercise capacity improves and their symptom burden reduces with activity.

Moderate caffeine intake is not a risk factor for AF, and it is safe for patients with AF to take caffeinated drinks.

Alcohol, even in small amounts, might be a trigger for AF in some patients, and moderation or even abstinence should be discussed with the patient.

FREQUENTLY ASKED QUESTIONS

A document on "Safe Use of DOACs" is being prepared, and a link to this will be provided.