BSSE APC Primary Care Clinical Pathway for Atrial Fibrillation Detection & Management

Adapted from West Midlands Academic Health Science Atrial Fibrillation Advisory Board

Symptomatic Presentation
e.g. palpitations, dyspnoea, TIA

Opportunistic Detection
e.g. BP or diabetes review

Targeted/Systematic Detection
e.g. GRASP-AF, case finding

Patient is unwell or haemodynamically unstable

Admit to Emergency Department

Clinical Suspicion of AF
Perform a 12-lead ECG in all patients

If ECG normal but paroxysmal AF suspected, request ambulatory ECG monitoring

Diagnosis of AF confirmed

Request an echocardiogram unless this will not influence subsequent management

Organise investigations
e.g. FBC, TFTs, U&Es, LFTs
Weigh patient.

Assess thromboembolic risk
using CHA_2DS_2-VASc

Risk Factor	Score
Congestive heart failure	1
Hypertension	1
Age ≥ 75	2
Diabetes	1
Previous TIA/**S**troke	2
Vascular Disease*	1
Age 65-74	1
Sex **c**ategory (female)	1

*PAD, MI, complex aortic plaque disease

- 0 in males or 1 in females = OAC not indicated
- 1 in males or 2 in females = consider OAC

Assess bleeding risk
using HASBLED

Risk Factor	Score
Hypertension uncontrolled (SBP > 160mmHg)	1
Abnormal renal and/or liver function	1 or 2
Stroke	1
Bleeding history	1
Labile INR (TTR < 65%)	1
Elderly (age ≥ 65)	1
Drugs (NSAIDs/antiplatelet) or alcohol (> 8 drinks/week)	1 or 2

- ≥ 3 = high risk and requires early follow-up
- Do not withhold OAC
- Address modifiable risk factors

Estimate renal function:
Prior to initiation of a NOAC - use the Cockcroft-Gault method to estimate creatinine clearance (not eGFR).

A. Anticoagulation to avoid stroke – don't wait to anticoagulate
Anticoagulation should be initiated ASAP after a diagnosis of AF has been made and can be initiated safely in primary care. NOACs are considered first-line option. You should be aware of your local anticoagulation pathways.
Refer to NICE Atrial Fibrillation Patient Decision Aid if necessary to discuss risks/benefits of OAC.

B. Better symptom management
Initiate rate control if necessary e.g. beta-blocker, diltiazem, verapamil or digoxin (target resting HR <110 bpm).
If patient remains symptomatic despite optimal rate control, or if a rhythm control strategy more appropriate – refer to Cardiology.

C. Cardiovascular risk factor management and lifestyle advice
e.g. BP, diabetes, cholesterol, OSA, weight, alcohol, smoking, etc.

Undertake a regular review
Offer personalised patient education and information, stroke awareness, etc.
Review quality of anticoagulation (for VKA, assess TTR and aim for TTR > 65%; for NOACs monitor renal function).
Assess adherence. Ensure NOACs prescribed in line with licensed indications and as per SmPC recommendations for age, weight, renal function and drug interactions.

Specialist Cardiology referral
If more specialised treatment is needed e.g. new onset AF (<48 hours) for consideration of cardioversion; when a rhythm control strategy would be more suitable; those with atrial flutter who may be suitable for ablation; heart failure caused primarily by AF; age <65 years for assessment of treatment strategy; when valve disease is suspected; management of paroxysmal AF.