Kent Surrey Sussex Academic Health Science Network

NHS South East Clinical Networks

Secondary Care Atrial Fibrillation Pathway

Applies to all patients with AF in secondary care including newly diagnosed

Finding of irregular pulse (OPD, MAU etc)
SUSPECT AF

Patient presents clearly unwell (usually A&E)
Assess per ALS guidance

Patient presents with palpitations (Usually A&E)
Assess per palpitations guidance

Outpatient/discharged

Inpatient

Patient stabilised

REFER TO GP
Follow primary care AF pathway

AF SUSPECTED/CONFIRMED
Senior medical review required who should initiate treatment

Patients with previous stroke/ TIA in AF should be referred to the stroke service and be managed following stroke guidelines

ORGANISE INVESTIGATIONS
Immediate **ECG** and urgent CXR, Routine FBC, TFTs, U&Es, and LFTs/GGT.
Investigate for underlying/secondary causes

AF CONFIRMED
Explain condition and treatment – use NICE Patient Decision Aid
Calculate CHA2DS2VASc Score (Risk of Stroke)
https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797
https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-user-guide-243736093

CHA2DSDS2VASc Risk	Score
Congestive Heart Failure	1
Hypertension	1
Age>75	2
Diabetes	1
Previous stroke or TIA	2
Vascular Disease	1
Age 65-74	1
Female	1

ANTICOAGULATION as per CHA2DS2VASc score
- **Start prior to discharge in patients assessed to need anticoagulation**
- Score ≥2 Warfarin or DOACs as per NICE Patient Decision Aid (local guidance may inform choice of DOAC)
- Score ≥ 1 in men, consider anticoagulation
- Assess Bleeding Risk using **HASBLED** score to identify modifiable risk factors.
- Estimate stroke risk and benefits & risks of antithrombotic therapy. Keele university decision support tool: www.anticoagulation-dst.co.uk

Consider routine/ urgent ECHO
- Where electrical/ pharmacological cardioversion is being considered
- Where high risk/suspicion of underlying structural / functional heart disease eg heart failure / murmur

No significant ECHO abnormalities

Significant ECHO Abnormalities

TREATMENT
Heart Rate and Rhythm Control. Clinician to assess if IV or PO therapy indicated
1st line -Prescribe beta blocker e.g. Bisoprolol 1.25 – 10mg daily
2nd line- If beta blocker contraindicated and LV function is normal, prescribe Diltiazem or Verapamil.
Only consider – digoxin as monotherapy if patient is predominantly sedentary.
If beta blocker contraindicated and LV dysfunction – prescribe Digoxin as first line
Consider cardioversion
Refer to cardiologist if – patient symptomatic (SOB, dizzy, tired, palpitations) despite strict rate control (resting HR < 80bpm & exercise HR <110bpm)

HASBLED SCORE

H	Hypertension (>160 mm Hg systolic)	1
A	Abnormal renal (creatinine >200) and liver (bilirubin x2, ALT x3) function	1 or 2
S	Stroke	1
B	Bleeding history	1
L	Labile INRs (therapeutic time in range <60%)	1
E	Elderly (age> 65)	1
D	Drugs (NSAIDs /antiplatelet) or Alcohol (> 8 drinks/week)	1 or 2

Refer to Secondary Care Cardiology team
Amiodarone and Dronedarone can only be initiated by a Cardiologist. MonitorApical HR and BP. If resting ventricular rate ≥110 or is symptomatic consider ↑ dose of beta blocker, calcium channel blocker or add digoxin

When patient stable
Discharge to GP/ arrhythmia service with treatment plan
Patient should be seen 2-4 weeks post discharge

A hub of AF resources for clinicians and patients can be found on the resource page at **www.kssahsn.net/atrialfibrillation**

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