Primary Care Clinical Pathway for Atrial Fibrillation Detection & Management

Symptomatic Presentation
- e.g. palpitations
Patient is unwell or haemodynamically unstable

Opportunistic Detection
- e.g. flu, HTN, diabetes clinic

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

Clinical Suspicion of AF
Confirmation of AF usually requires demonstration on either a 12 lead ECG or presence for >30 seconds on ECG monitoring. Mobile device suggestion of AF should be confirmed on a 12 lead ECG

Symptomatic Detection
- e.g. palpitations

Assess thromboembolic risk using CHA\_DS\_2-VASc
- Risk Factor | Score
  | Congestive heart failure | 1
  | Hypertension | 1
  | Age ≥ 75 | 2
  | Diabetes | 1
  | Previous TIA/Stroke | 2
  | Vascular Disease* | 1
  | Age 65-74 | 1
  | Sex category (female) | 1
*PAD, MI, complex aortic plaque disease

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

Determine OAC strategy using SAMe-TT\_R2
- Risk Factor | Score
  | Sex (female) | 1
  | Age (< 60) | 1
  | Medical history | 1
  | Treatment strategy (interacting drugs) | 1
  | Tobacco use (current) | 2
  | Race (non-caucasian) | 2

- 0 in males or 1 in females = No antithrombotic therapy
- 1 = Consider OAC (men only)
- ≥2 = Offer OAC

Don’t wait to anti-coagulate ie. Avoid stroke with Anticoagulation (‘A’)
Oral anti-coagulation should be initiated as soon as a diagnosis of AF has been made and can be initiated safely in primary care. You should have an awareness of your local anti-coagulation pathways.

Better symptom management (‘B’)
Initiate rate control e.g. with a beta-blocker (aim for a target resting heart rate that renders the patient asymptomatic). If the patient remains symptomatic despite optimal rate control refer to secondary care for consideration of a rhythm control strategy

Optimise management of co-morbidities and reinforce lifestyle advice i.e. Cardiovascular and other risk factor management (‘C’)
(e.g. manage HTN, diabetes, cardiovascular disease, weight loss, sleep apnoea, etc)

Undertake a regular/annual review
Review quality of OAC (For VKA, assess TTR and aim for TTR > 65%. For NOACs, assess renal function). Assess adherence, symptom control, general health and well-being. Ensure NOACs are prescribed in line with licensed indications and as per manufacturers recommendations regarding age, weight, renal function and drug interactions. Ensure patient &/or carer involvement in decision making regarding treatment options

Specialist Cardiology Input/Secondary Care if:
- Haemodynamic instability, breathlessness at rest, syncpe, dizziness, chest pain, stroke, TIA, resting heart rate > 150bpm
- Recent onset AF (<48hours) for consideration of electrical cardioversion
- Still symptomatic, despite optimal rate control