

GGC HEART MCN GUIDELINES FOR THE MANAGEMENT OF ATRIAL FIBRILLATION

OBJECTIVES

- (1) Prevention of stroke.
- (2) Symptom relief.
- (3) Optimal management of concomitant cardiovascular disease.
- (4) Rate control.
- (5) Correction of rhythm disturbance.



These goals are not mutually exclusive and the initial strategy may differ from the long-term therapeutic goal. For example, in patients with symptomatic AF lasting several weeks, initial therapy may be anticoagulation and rate control, while the long-term goal may be to restore sinus rhythm. Improvement of symptoms by rate control may lead to a decision not to restore sinus rhythm. However, if rate control provides inadequate symptomatic relief, then restoration of sinus rhythm becomes a long-term goal.

SUMMARY OF INITIAL MANAGEMENT IN PRIMARY CARE

Consider hospital admission in acute onset AF or rapid ventricular rate associated with chest pain, heart failure or hypotension.

Do not delay treatment while awaiting investigation. In most patients, decisions regarding anti-thrombotic treatment and rate control drugs can be made on clinical grounds. Carry out a formal stroke risk assessment (see CHADS2 below) to determine appropriate anti-thrombotic therapy and give a rate control drug (unless heart rate < 60 bpm).

ESSENTIAL INVESTIGATIONS

1. resting 12 lead ECG
2. thyroid function tests
3. echocardiogram
4. liver function tests

RATE CONTROL

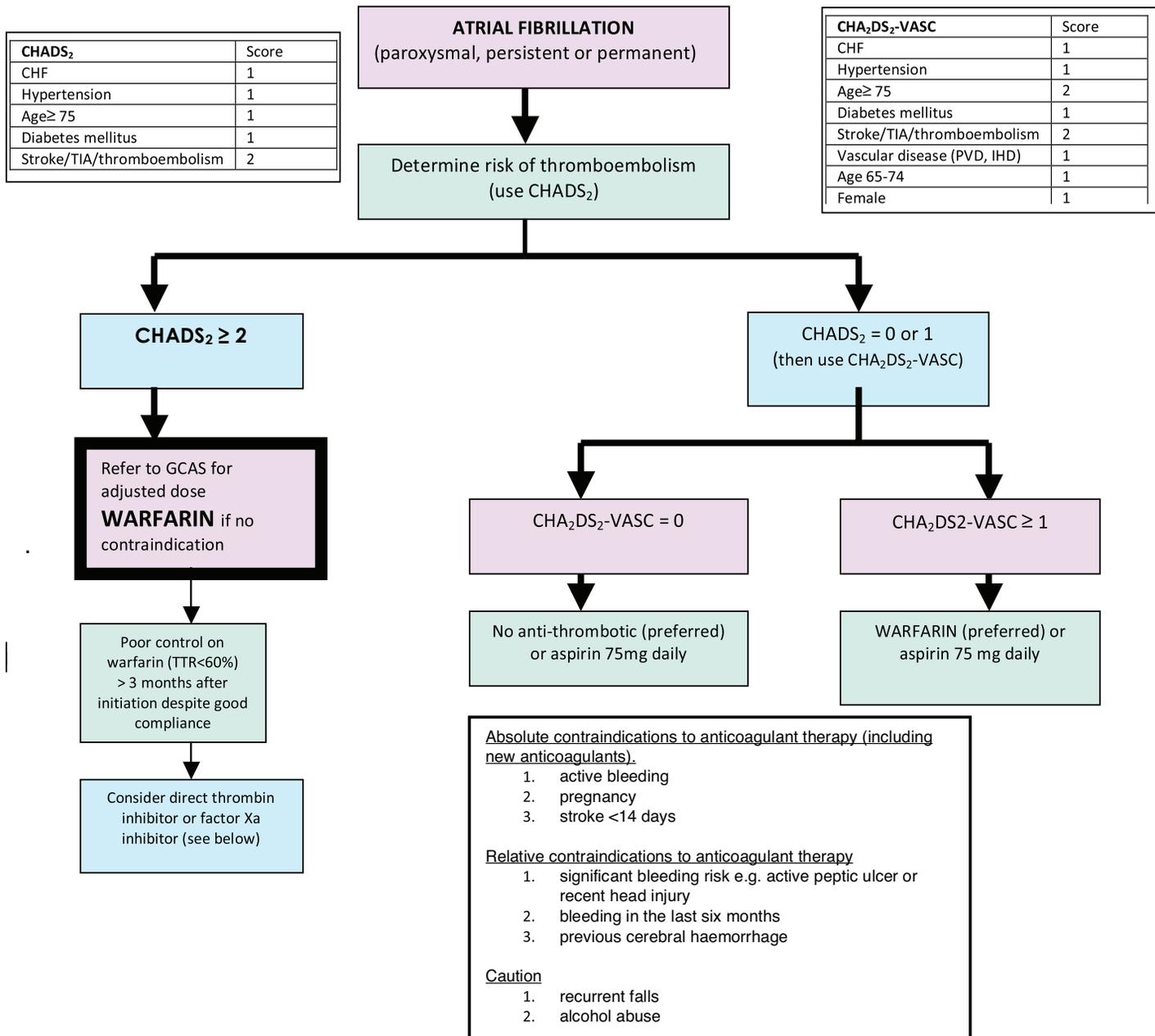
None of the rate vs. rhythm trials demonstrated the benefit of rhythm control therapy on mortality that was expected and more patients are now treated with rate control only. However, the optimal level of rate control with respect to morbidity, mortality, quality of life, and symptoms remains unknown but 'lenient' rate control is not associated with an increase in adverse cardiovascular events.

1. Target ventricular (apex or ECG) rate <110 bpm. If still symptomatic, aim for lower rate <80bpm.
2. Patients WITHOUT heart failure should be started on either:
 - A beta-blocker – start with atenolol 25mg bd and uptitrate to 50mg bd if ventricular rate still >110 bpm. In frail older people consider starting dose for atenolol of 25mg od. OR
 - A rate-limiting calcium channel blocker (CCB) i.e. verapamil or diltiazem. Start with verapamil (slow release) 120mg od and uptitrate to 240mg od if ventricular rate still >110 bpm.
(remember not to combine verapamil or diltiazem with beta-blocker)
 - Digoxin has a limited role as first-line treatment for ventricular rate control - usually, second line, in combination with beta-blocker or rate limiting CCB when control of the ventricular rate is difficult.
3. Patients WITH heart failure should be started on digoxin and follow the heart failure guideline.

PATIENTS WHO SHOULD BE REFERRED FOR OUT PATIENT SPECIALIST ASSESSMENT

- symptomatic AF despite adequate rate control
- young age (<60 years)
- inadequate ventricular rate control despite treatment with the combination of a beta-blocker and digoxin or a rate-limiting calcium channel blocker and digoxin, or if intolerant of these
- structural heart disease on echocardiogram
- Patients with AF and heart failure.

PREVENTION OF THROMBOEMBOLISM



COMBINED WARFARIN AND ANTI-PLATELET THERAPY

Adding aspirin to warfarin therapy does not reduce the risk of stroke but substantially increases the risk of bleeding. After PCI, short term combined double or triple therapy is used according to cardiologist advice.

NEW ANTICOAGULANTS (DIRECT THROMBIN AND FACTOR Xa INHIBITORS)

- Warfarin is still the anticoagulant of choice.
- New anticoagulants, e.g. dabigatran, should only be considered in patients at high risk of stroke who are poorly controlled on warfarin (TTR < 60%), despite good compliance. Glasgow and Clyde Anticoagulation service will identify these patients and ask the GP to consider one of the new anti-coagulants.