

**South Central Cardiovascular Network
Management of AF in Primary Care & Indications to
Refer**

The prevalence of AF in the UK is 1.3%. Prevalence is age dependant, rising to >10% in the 75+ age group. AF is a major risk factor for stroke. In England there are 16,000 strokes annually in patients with AF. The proportion of strokes that are caused by AF rises with age & approaches 25% above age 80. There is also compelling evidence that stroke caused by AF tends to be severe & disabling. (1)

Warfarin with target INR 2-3 reduces the risk of all stroke (thrombotic + haemorrhagic) in AF by 64%. Aspirin (150-300mg) achieves a 22% reduction. The risk of extra-cranial haemorrhage in elderly patients (mean age 82) is similar with the two treatments (1.4% Warfarin; 1.6% aspirin). (2)

Despite this, NICE estimate that at least 40% of patients who are already known to have AF AND are eligible for Warfarin are not receiving it.

Estimating Stroke Risk

The risk of stroke in non-valvular AF can be predicted using simple clinical algorithms such as CHADS₂. (3)

Risk Factor	CHADS ₂ Score
None	0
CCF	1
Hypertension	1
Age (>75yrs)	1
Diabetes	1
Stroke (or TIA)	2

Aggregate Score	Stroke Risk % PA
0	1.9
1	2.8
2	4.0
3	5.9
4	8.5
5	12.5
6	18.2

At CHADS₂ score 1 the benefit of Warfarin is less clear-cut, so decisions need to be individualised. It is sensible to review the INR record after 3 or 4 months as poor INR control may negate any risk benefit.

Red area Warfarin is clearly indicated

Improving complete identification of your AF patients

It is a simple matter to identify from a general practice IT system patients with documented AF and assess their stroke risk using the GRASP-AF tool. (4)

Detecting AF is also a straight forward matter. AF should be screened for opportunistically in the 65+ age group at new patient registration checks, attendances

for immunisation, BP monitoring etc. The detection of an irregular pulse should prompt a routine ECG.

Medication

Cardioselective betablockade e.g. either Bisoprolol or Nebivolol is the first line option. Care should be taken where symptoms suggest possible pre-syncope because excessive bradycardia may result. Digoxin may be added where rate control is not adequate or preferred in the very elderly who are essentially sedentary.

Diltiazem or Verapamil may be tried when beta-blockers are contraindicated or not tolerated.

Indications to refer to secondary care

1. AF complicating significant disease of either heart valve or muscle.-
2. AF with chest pain, acute heart failure or impairment of consciousness.
3. AF where rate control proves problematic
4. AF of recent onset in younger or symptomatic patients, when DC cardioversion may be considered.

REFERENCES:

- 1) Robert G. Hart, MD; Lesley A. Pearce, MS; and Maria I. Aguilar, MD "Meta-analysis: Antithrombotic Therapy to Prevent Stroke in Patients Who Have Nonvalvular Atrial Fibrillation". Ann Intern Med. 2007; 146:857-867
<http://www.annals.org/cgi/content/abstract/146/12/857>
- 2) Jonathan Mant, FD Richard Hobbs, Kate Fletcher, Andrea Roalfe, David Fitzmaurice, Gregory YH Lip, Ellen Murray , " Warfarin versus aspirin for stroke prevention in an elderly community population with atrial fibrillation (the Birmingham Atrial Fibrillation Treatment of the Aged Study, BAFTA): a randomised controlled trial" Lancet 2007; 370: 493-503
- 3) Gage BF, Waterman AD, Shannon W, et al. "Validation of clinical classification schemes for predicting stroke: results from the National Registry of Atrial Fibrillation". JAMA. 2001; 285:2864-2870
<http://jama.ama-assn.org/cgi/reprint/285/22/2864>
- 4) <http://www.improvement.nhs.uk/graspaf/>

Further information including information sheets for patients can be found at the atrial fibrillation website; <http://www.atrialfibrillation.org.uk/>

This sheet is has been produced by the South Central Cardiovascular Network as part of their prevention work programme. It aims to provide guidance to GPs on best practice in reducing stroke risk in patients with AF.

The South Central Cardiovascular Network takes an end to end approach to driving better services, by interpreting evidence about best practice and current local practice; providing commissioning and contracting advice to reflect that evidence and working with providers to implement the changes needed. Further details of all our work can be found on our website <http://www.scnetworks.nhs.uk>

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