



## CLINICAL GUIDELINE

# Atrial Fibrillation Management

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

<b>Version Number:</b>	5
<b>Are there changes to the clinical content of this version:</b>	Yes
<b>Date Approved:</b>	11th January 2018
<b>Date of Next Review:</b>	1st October 2020
<b>Lead Author:</b>	David Murdoch
<b>Approval Group:</b>	Medicines Utilisation Subcommittee of ADTC

### Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

# 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 atrial fibrillation (AF) or rapid ventricular rate associated with chest pain, heart failure or hypotension.

In most patients, decisions regarding anti-coagulant treatment and rate control drugs can be made on clinical grounds. **An ECG is essential to document AF before therapy but it is not essential to wait for echocardiography.** Carry out a formal stroke risk assessment (see CHA<sub>2</sub>DS<sub>2</sub>-VASC below) to determine if anti-coagulant therapy is appropriate and give a rate control drug (unless heart rate < 60 bpm). **Do not delay treatment while awaiting investigation**

## ESSENTIAL INVESTIGATIONS

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

## RATE CONTROL

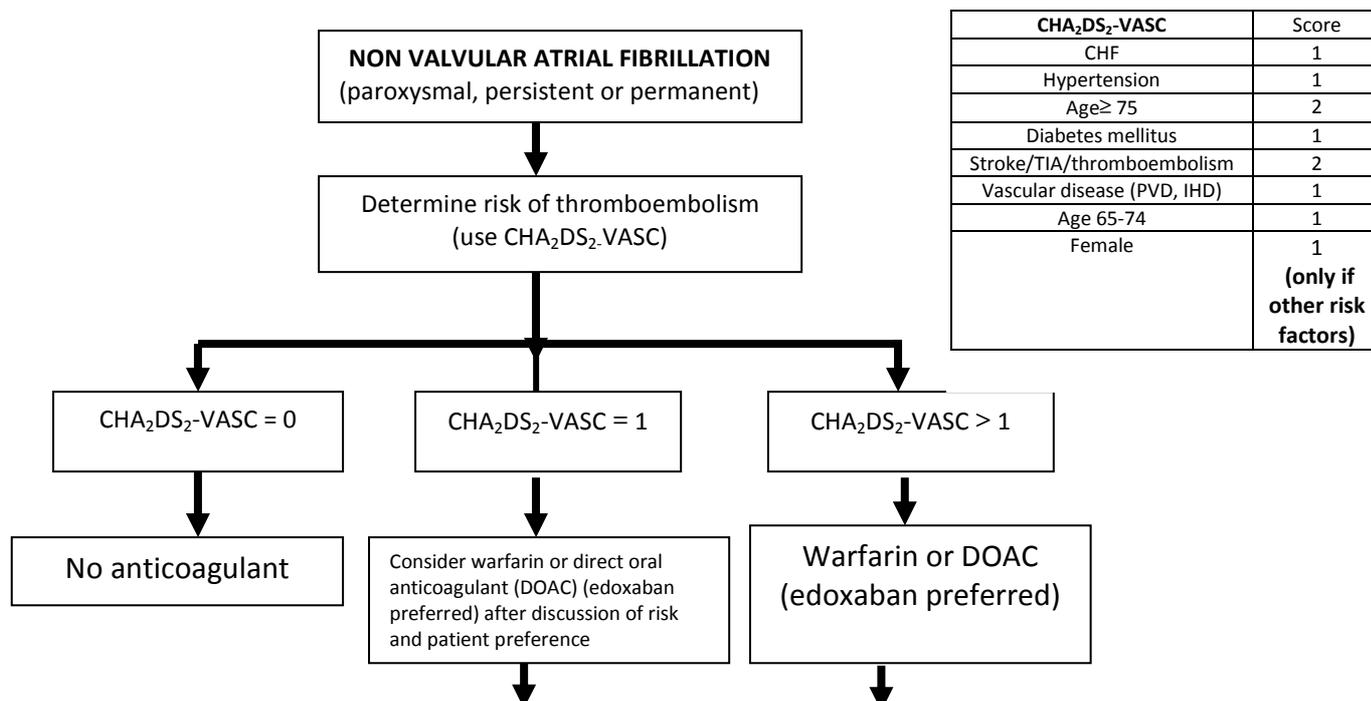
None of the rate vs. rhythm trials demonstrated the expected benefit of rhythm control therapy on mortality. More patients are now treated with rate control only. The optimal level of rate control with respect to morbidity, mortality, quality of life and symptoms remains unknown but 'lenient' rate control 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:
  - beta-blocker – start with bisoprolol 2.5mg o.d. or atenolol 25mg b.d. and up-titrate to bisoprolol 5 mg o.d. or atenolol 50mg b.d. if ventricular rate still > 110 bpm. In frail elderly, consider starting dose for bisoprolol of 1.25 mg daily or atenolol 25mg once daily.
  - OR
  - rate-limiting calcium channel blocker (CCB) i.e. verapamil. Start with verapamil M/R 120mg daily and up-titrate to 240mg daily if ventricular rate still > 110 bpm.  
**(DO NOT combine verapamil or diltiazem with beta-blocker)**
  - Digoxin has a limited role as first-line treatment for ventricular rate control. It is usually second line, in combination with beta-blocker or rate limiting CCB when control of ventricular rate is difficult.
3. For Patients WITH heart failure consider digoxin or beta blocker as appropriate and follow the NHSGGC 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 rate-limiting CCB and digoxin, or if intolerant of these
- structural heart disease on echocardiogram
- AF and co-existing heart failure

## PREVENTION OF THROMBOEMBOLISM IN NON-VALVULAR AF (NVAF)



### Absolute contraindications to anticoagulant therapy (including DOACs).

1. active bleeding
2. pregnancy
3. hepatic disease associated with coagulopathy

### Relative contraindications to anticoagulant therapy

1. significant bleeding risk e.g. active peptic ulcer or recent head injury
2. bleeding in the last six months
4. previous cerebral haemorrhage
5. stroke < 14 days

### Caution

1. recurrent falls e.g. weekly
2. alcohol abuse

### Choice of agent: DOAC vs. warfarin

#### Pros of DOACs

1. more stable anticoagulation
2. no requirement for anticoagulant monitoring
3. fewer food and drug interactions
4. fewer intracranial bleeds

#### Cons of DOACs

1. specific antidote only available for dabigatran
2. more GI bleeding with dabigatran and rivaroxaban, especially in the elderly
3. Requirement for assessment of renal function before starting and dose adjustment in renal impairment

**Remember:** DOACs are indicated only in those patients who have non-valvular AF; not those with mitral stenosis or a **mechanical** valve. Patients with a tissue valve or mitral valve repair can still be considered for DOAC therapy.

## Edoxaban dosing

60 mg once daily if CrCl >50ml/min or 30mg once daily if CrCl 15-50ml/min or <60kg or concomitant use of the following P-gp inhibitors: ciclosporin, dronedarone, erythromycin, ketoconazole

*Please refer to the latest version of the manufacturer's summary of product characteristics (SPC) for full prescribing advice*

For CrCl please use the following link:

<http://www.staffnet.ggc.scot.nhs.uk/Clinical%20Info/Documents/CrCl%20Online%20Calculator%20-%20Locked%20-%20160930.xls>

## Combined anticoagulant and anti-platelet therapy

Continued aspirin therapy is not indicated in patients with stable coronary artery disease who also have AF and are on an anticoagulant. After PCI, short term combined therapy is used according to cardiologist advice.

## Patient decision aid

A very helpful document is available to help both the patient and professional to make an informed decision

<https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797> .

## Frequently Asked Questions

For further information there is a FAQ document :

[http://www.ggcprescribing.org.uk/media/uploads/ps\\_extra/mu\\_extra\\_doac\\_-\\_1702.pdf](http://www.ggcprescribing.org.uk/media/uploads/ps_extra/mu_extra_doac_-_1702.pdf)