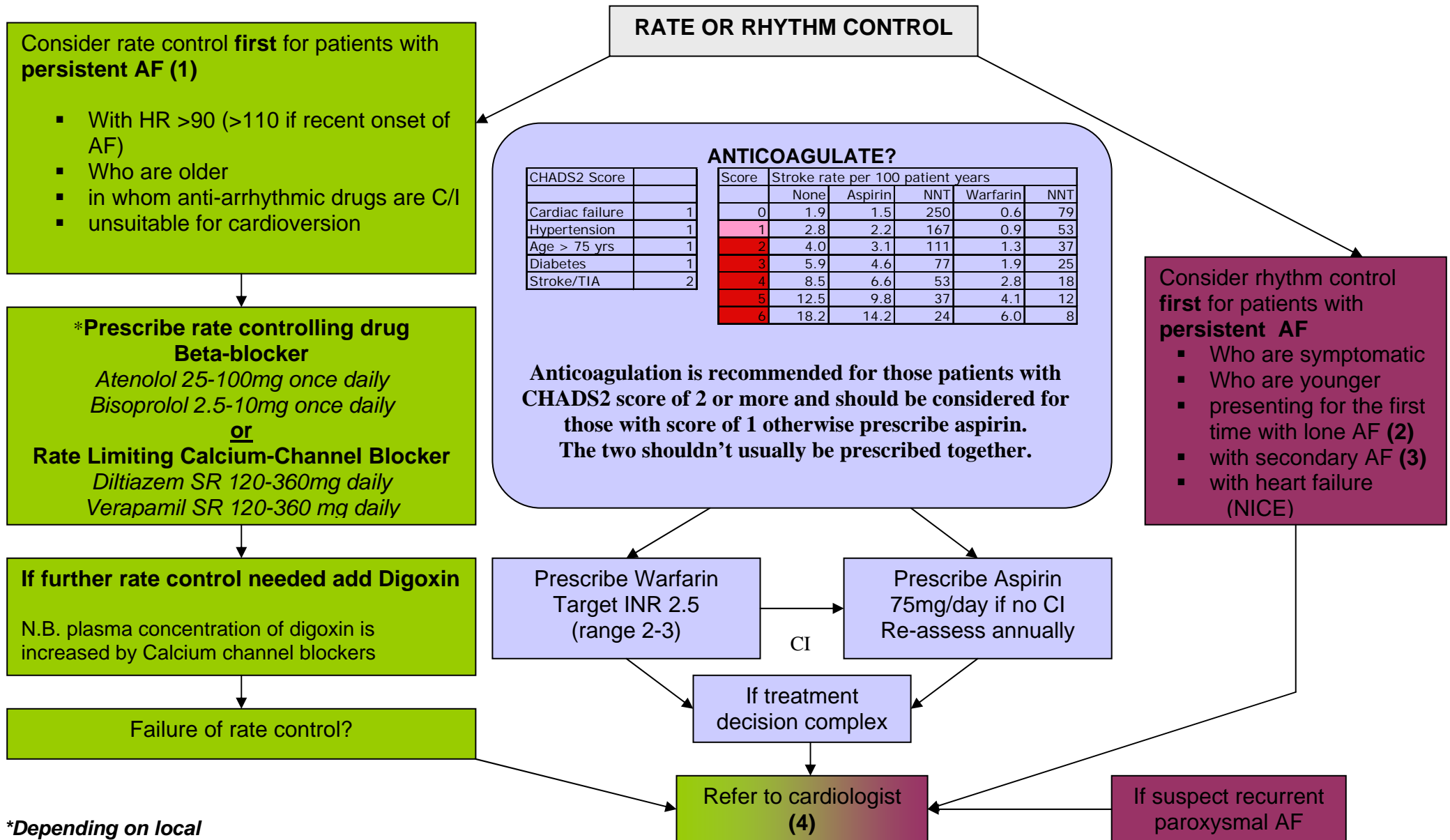


# ATRIAL FIBRILLATION ALGORITHM

Cardiac and Stroke Networks in Lancashire & Cumbria



\*Depending on local prescribing recommendations

**Paroxysmal AF (Recurrent)** Terminates spontaneously within 7 days and usually < 48 hours **Refer ALL cases to cardiology**

**Persistent AF (Recurrent)** Lasts >7 days, not self-terminating, requires electrical or pharmacological conversion.

**Permanent AF (Established)** No further cardioversion attempts.

#### **Acute Presentation of AF**

Immediate hospitalisation and urgent intervention is required for patients presenting with any of the following;

If onset of AF is known to be within 48hrs (for cardioversion)

A ventricular rate >150 beats per minute

Ongoing chest pain

Significant cardiac failure or clinical signs of low cardiac output

Haemodynamic compromise e.g. systolic blood pressure <90mmHg

Pre-syncope/syncope

#### **Patients unsuitable for Cardioversion (1)**

Contraindications to anticoagulation

Structural heart disease that precludes long term maintenance of sinus rhythm

A long duration of AF (Usually > 12 months)

A history of multiple failed attempts at cardioversion and/or relapses

An ongoing but reversible cause of AF (e.g. Thyrotoxicosis)

#### **Causes of secondary AF include: (3)**

thyrotoxicosis

rheumatic heart disease

valve disease

hypertension

sick sinus syndrome

Wolff-Parkinson-White

cardiomyopathy

pulmonary embolism

electrolyte depletion

chest infection

lung carcinoma

pleural effusion

#### **Indications for referral for Specialist opinion include : (4)**

Paroxysmal atrial fibrillation

Heart failure

Failure of pharmacological therapy

Significant valvular disease

ECG evidence of any underlying electrophysiological disorder eg WPW

**ECG** - An ECG should be performed in ALL patients, whether symptomatic or not, in whom AF is suspected because an irregular pulse has been detected.

**Investigations required** – FBC, biochemical profile, TFT, consider CXR

**Echocardiography should be performed...**

If you are considering “rhythm control”

If you suspect underlying structural or functional heart disease that would influence management, such as choice of anti-arrhythmic drug.

Where needed to help with stratifying stroke risk for antithrombotic therapy, but **only** where clinical evidence is needed for LVD or valve disease

**NB** Echo is not required in the elderly if anti-coagulation therapy is indicated/decided and there are no signs of structural heart disease

#### **Rate v Rhythm**

Some patients with Persistent AF will satisfy criteria for either an initial rate-control or rhythm control strategy i.e. age >65 but also symptomatic therefore the indications for each option should not be regarded as mutually exclusive, and the potential advantages and disadvantages of each strategy should be explained to patients before agreeing which to adopt.

Any co-morbidities that might indicate one approach rather than the other should be taken into account.

A greater attempt should be made to restore sinus rhythm in symptomatic patients

**Lone AF (2)** -This is defined as AF without overt structural heart disease and is confirmed only if there is no history of cardiovascular disease or hypertension, no abnormal cardiac signs on physical examination, a normal chest x-ray and, apart from the presence of AF, a normal ECG (i.e. no indication of prior Myocardial Infarction (MI) or LVD) or normal atria, valves and left ventricular size and function by echocardiography.