

AF CAP

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Initial Assessment & Treatment

Name:

NHS:

Date

Time

This ambulatory pathway is to be used for patients with suspected AF. Patients can be added to the pathway prior to or during admission. It does not replace the medical notes for the patient episode.

Patients must meet the inclusion criteria.

Inclusion criteria (must have all)	Tick
Confirmed AF or presumed PAF	
Patient able to attend ambulatory services	

Please check the exclusion criteria if known.

Absolute exclusion criteria (exclude if any)	Relative exclusion criteria (DW Cons)	Tick
Chest pain or suspected ACS	LOC	
Sats <94% following recovery	Abnormal ECG on recovery	
BP <100/60	Lives alone	

If a patient meets an exclusion criteria and cannot be managed as part of another AMap then please discuss with the medical SpR on-call for medical admission in AMU overnight for observation.

Initial Investigations

Bloods - FBC, UE, Ca, Mg, TFT (unless known), TnT

ECG

If indicated consider – CXR, cultures.

Medical review must look for underlying causes – ensure full history and examination is documented.

Initial Treatment

During suspected attack of AF

- If compromised (as per ALS) → DCC and medical review
- If not compromised and ventricular rate >100
 - Start bisoprolol 2.5 or 5mg as needed stat and then once a day thereafter
 - Consider diltiazem MR 60mg stat and then three times per day if beta-blocker contraindicated
 - Consider digoxin loading and 125mcg od thereafter in the frail elderly
- If not compromised and ventricular rate <100
 - No rate control needed

Following a resolved attack

- Start bisoprolol 2.5 or 5mg as needed stat and then once a day thereafter
 - Consider diltiazem MR 60mg stat and then three times per day if beta-blocker contraindicated

Treatment is aimed at keeping rate <100bpm.

If in doubt, please discuss with the medical SpR on-call at ESH.

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Assess need for oral anticoagulation therapy (OAC) for those with non-valvular AF

Modified CHA2DS2-VASc	Points	Score
Congestive heart failure	1	
Hypertension	1	
Age > 65 (1 point) Age >75 (2 points)	1-2	
Diabetes	1	
Stroke or TIA in past	2	
Vascular disease	1	
Total Higher scores have higher risk of stroke in non-valvular AF		

Patients with valvular AF or non-valvular AF with a CHA2DS2-Vasc score of 1 or more should be offered oral anticoagulation therapy (OAC), usually warfarin with an INR range of 2-3 although other agents are becoming available. PAF patients should also be offered OACs in the same way.

NB – there is no evidence that aspirin alone is useful in stroke prevention in AF and therefore in this context if warfarin (or alternative) cannot be used then do not offer aspirin as an alternate agent. Aspirin and clopidogrel in combination offer reasonable prevention, but a much higher risk of bleeding and therefore are therefore also not recommended.

Anti-platelet agents must not be stopped if they are required for another purpose, ie. following coronary stenting. If in doubt discuss with the Cardiology Consultant on-call. In some cases OAC and anti-platelets can be used together but must be led by a Consultant.

Assess bleeding risk on OAC

HAS-BLED score	Points	Score
Hypertension (SBP >160mmHg)	1	
Abnormal UE	1	
Abnormal LFT	1	
Alcohol (>8 drinks per week)	1	
Stroke in the past	1	
Bleeding (major bleed in the past)	1	
Labile INR (in range <60% of time)	1	
Elderly (defined as age >65!)	1	
Drugs that predispose to bleed (NSAIDS, antiplatelets)	1	
Total Higher scores have higher risk of bleeding on OACs		

Patients with a HAS-BLED score of 3 or more should have regular clinical review by their GP or anticoagulant clinic as they are at higher risk of bleeding. **This is not a contraindication for OACs.**

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Discharge decision

Patient can be discharged if all are met:	Tick
Patient is well with full recovery after 1-2 hours	
Pulse <110bpm	
BP >=100/60	
No other reason for admission	
Patient has a good understanding of management	
Patient will not be alone at home	
ECG now normal	

If all boxes are ticked please proceed to discharge and follow the pathway below.

If you feel that the patient may be able to go home and the above boxes are not all ticked please discuss with the medical SpR or Consultant and document conversation clearly in notes. If they are happy to proceed with discharge then write their name below:

Discussed with SpR/Cons who is happy for discharge: _____

Ensure that you tell patients/carers the following (contained in the patient leaflet)

Patient information:	Tick
Do not drive until symptoms controlled for 4 weeks (only applies if rhythm was or likely to be disabling)	
Consult their employer over health & safety issues	
Avoid situations that could be dangerous if they faint	
Avoid caffeine, smoking, excess alcohol, stimulants	
Read all drug leaflets to ensure triggers are avoided (e.g. cold and flu remedies)	
To re-attend GP or AMU if becomes unwell in any way	

Communication/Follow-up

1. Follow local guidelines if patient requires OAC.
2. Create EDS or other discharge note and send to GP with copy to patient.
 - a. Include CHA2DS2-Vasc and HAS-BLED scores and advice.
3. Consider referral to heart failure pathway or back to GP for Specialist Cardiology opinion.
4. Provide the patient with an information leaflet/patient passport and copy of the EDS
5. File this paperwork in the patients notes

RAC Doctor / GP responsible for patient:

I confirm that I have followed the patient pathway above and completed the steps required

Signed:

Grade:

Contact Details: