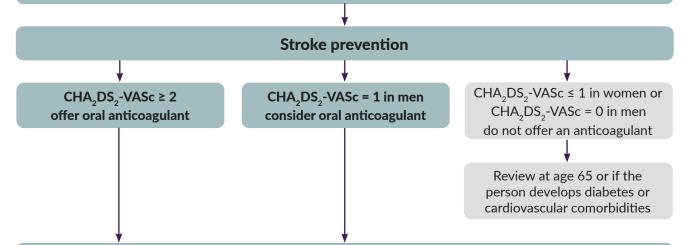
Atrial fibrillation: diagnosis and management

Diagnosis

- Perform manual pulse palpation if atrial fibrillation (AF) is suspected
- Perform a 12-lead ECG in people with an irregular pulse, with or without symptoms, to diagnose AF
- If paroxysmal AF is suspected and not detected on ECG, use a 24-hour ambulatory ECG monitor if episodes <24 hours apart or an ambulatory ECG monitor, event recorder or other ECG technology for an appropriate period if episodes >24 hours apart

Assessment

- Assess stroke risk using the person's CHA₂DS₂-VASc score
- Assess bleeding risk using the person's <u>ORBIT score</u>. The ORBIT bleeding risk tool has a higher accuracy in predicting absolute bleeding risk than other tools
- Discuss the results and offer monitoring and support to modify risk factors for bleeding
- Perform transthoracic echocardiography (TTE) if a baseline echocardiogram is important for long-term management, cardioversion is being considered, underlying heart disease is suspected or if refinement of clinical risk stratification for antithrombotic therapy is needed
- Do not routinely perform TTE solely for further stroke risk stratification if anticoagulation has already been agreed
- Perform transoesophageal echocardiography (TOE) if TTE shows an abnormality needing further assessment, or if TTE is technically unsuitable and cardiac abnormalities need to be excluded, or if TOE-guided cardioversion is being considered



Discuss risks and benefits of anticoagulation, including that for most people the benefit of anticoagulation outweighs the bleeding risk.

Direct-acting anticoagulants (DOACs)

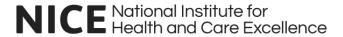
- Offer a DOAC as first-choice anticoagulant
- Discuss choice of DOAC, taking into account clinical features, contraindications and the person's preference. Follow guidance in the BNF and the MHRA advice on direct-acting oral anticoagulants
- For people already stable on a vitamin K antagonist, discuss switching at their next routine appointment, taking into account time in therapeutic range (TTR)

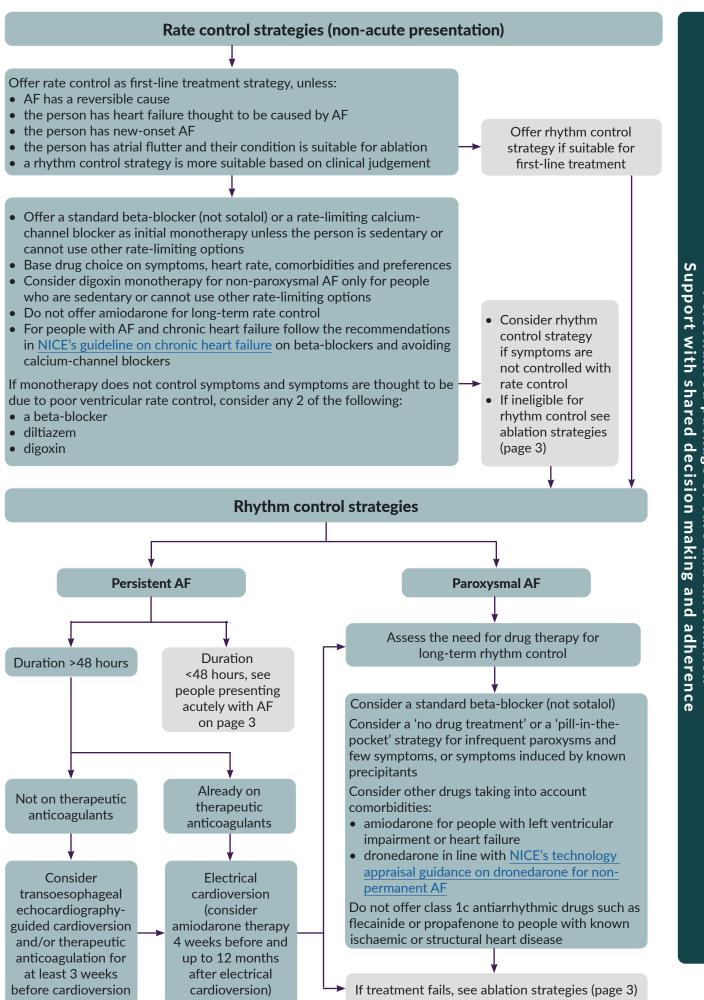
Vitamin K antagonists

- Use a vitamin K antagonist if DOACs are contraindicated or not tolerated
- Calculate the person's TTR at each visit. Reassess anticoagulation if poorly controlled (2 INR values >5 or 1 INR value >8 or 2 INR values <1.5 in past 6 months or TTR <65%)
- Take into account and address factors that may contribute to poor control
- Discuss the risks and benefits of alternative stroke prevention strategies with the person

Left atrial appendage occlusion

- If anticoagulation is contraindicated or not tolerated consider left atrial appendage occlusion
- Review anticoagulation at least annually for people taking an anticoagulant and follow the MHRA advice on direct-acting oral anticoagulants
- Review people who are not taking an anticoagulant because of bleeding risk at least annually





Left atrial ablation and pace and ablate strategies

Symptomatic AF and drug treatment unsuccessful, unsuitable or not tolerated

Left atrial ablation

- Consider radiofrequency point-by-point ablation
- If radiofrequency point-by-point ablation is unsuitable, consider cryoballoon ablation or laser balloon ablation
- Consider left atrial catheter ablation before pacing and atrioventricular node ablation for people with paroxysmal AF or heart failure caused by non-permanent AF
- Discuss the risks and benefits and take into account the person's preferences. Explain that ablation is not always effective or long lasting
- If other cardiac surgery is planned, consider carrying out ablation at the same time
- Consider antiarrhythmic drug treatment (see page 2) after ablation and reassess at 3 months

Pace and ablate

- Consider pacing and atrioventricular node ablation for symptomatic permanent AF or left ventricular dysfunction caused by high ventricular rates
- Reassess symptoms and the need for ablation after pacing and optimising drug treatment

People presenting acutely with AF New onset AF with New onset AF without life-threatening life-threatening haemodynamic haemodynamic instability instability If onset <48 hours offer Carry out emergency electrical If onset >48 hours or uncertain anticoagulation (see below) and offer anticoagulation (see below) cardioversion without delaying to and rate control achieve anticoagulation either rate or rhythm control If rhythm control is agreed, consider either pharmacological or electrical If acute decompensated heart cardioversion failure is suspected, seek senior If pharmacological cardioversion is agreed, offer: specialist input on using • a choice of flecainide or amiodarone if no evidence of structural or beta-blockers and do not use ischaemic heart disease calcium-channel blockers amiodarone if evidence of structural heart disease

Anticoagulation for acute presentation of AF

In people with new onset AF who are receiving no or subtherapeutic anticoagulation therapy, offer heparin at initial presentation and continue until stroke and bleeding risk are assessed (see page 1)

If onset <48 hours, offer oral anticoagulation if:

- stable sinus rhythm is not successfully restored within the same 48 hours after onset or
- there are factors indicating a high risk of recurrence or
- it is recommended after assessment of stroke and bleeding risks (see page 1)

If onset >48 hours and long-term rhythm control is being considered, delay cardioversion until maintained on therapeutic anticoagulation for at least 3 weeks and offer rate control during this time

If there is uncertainty over the time since onset, offer oral anticoagulation (see page 1)

Refer people promptly (within 4 weeks) at any stage if treatment does not control symptoms