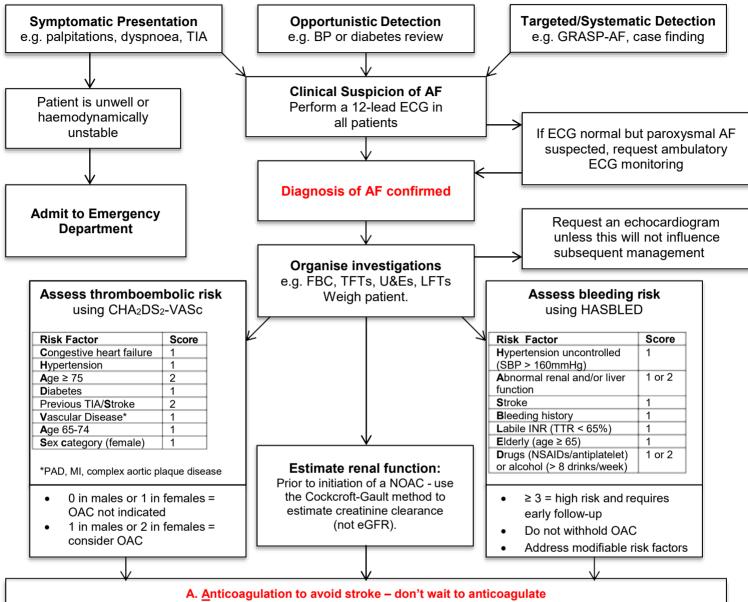


BSSE APC Primary Care Clinical Pathway for Atrial Fibrillation Detection & Management

Adapted from West Midlands Academic Health Science Atrial Fibrillation Advisory Board



Anticoagulation should be initiated ASAP after a diagnosis of AF has been made and can be initiated safely in primary care.

NOACs are considered first-line option. You should be aware of your local anticoagulation pathways.

Refer to NICE Atrial Fibrillation Patient Decision Aid if necessary to discuss risks/benefits of OAC.

B. Better symptom management

Initiate rate control if necessary e.g. beta-blocker, diltiazem, verapamil or digoxin (target resting HR <110 bpm). If patient remains symptomatic despite optimal rate control, or if a rhythm control strategy more appropriate – refer to Cardiology.

C. Cardiovascular risk factor management and lifestyle advice

e.g. BP, diabetes, cholesterol, OSA, weight, alcohol, smoking, etc.

Undertake a regular review

Offer personalised patient education and information, stroke awareness, etc.

Review quality of anticoagulation (for VKA, assess TTR and aim for TTR > 65%; for NOACs monitor renal function).

Assess adherence. Ensure NOACs prescribed in line with licensed indications and as per SmPC recommendations for age, weight, renal function and drug interactions.

Specialist Cardiology referral

If more specialised treatment is needed e.g. new onset AF (<48 hours) for consideration of cardioversion; when a rhythm control strategy would be more suitable; those with atrial flutter who may be suitable for ablation; heart failure caused primarily by AF; age <65 years for assessment of treatment strategy; when valve disease is suspected; management of paroxysmal AF.