**2PILL IN POCKET TREATMENT**

Suitable patients with infrequent attacks of paroxysmal AF. For prescription initially by cardiologists only. Can take medication at the onset of an attack if:

No history of LV dysfunction, ischaemic heart disease or valvular heart disease.

Systolic BP >100 and resting heart rate >70 bpm. Normal ECG.

Beta blocker (eg Bisoprolol 5 mg) **AND** Flecainide 100 mg at onset of attack.

Should attend A&E at once if unwell or if AF persists.

**1ANTITHROMBOTIC THERAPY: ASPIRIN OR WARFARIN?**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  |  | | --- | --- | --- | | **CHADS2 Scoring System** | | | |  |  | Points | | C | Chronic Heart Failure | 1 | | H | History of Hypertension | 1 | | A | Age>75 | 1 | | D | Diabetes Mellitus | 1 | | S**2** | previous Stroke or TIA | 2 |   2 points: Warfarin to INR 2.5  1 point: Consider warfarin to INR 2.5 or aspirin 75mg once daily  0 points: Aspirin 75 mg once daily.  Consider Warfarin in age 65-75 with otherwise low risk profile. | |  |  |  | | --- | --- | --- | | **CHA2DS2-VASc Scoring System** | | | |  |  | Points | | C | Chronic Heart Failure | 1 | | H | History of Hypertension | 1 | | A2 | Age>75 | 2 | | D | Diabetes Mellitus | 1 | | S**2** | previous Stroke, TIA or TE | 2 | | V | Vascular disease (previous MI, peripheral arterial disease or aortic plaque) | 1 | | A | Age between 65 and 74 years | 1 | | Sc | Sex category (female) | 1 |   Treatment to be agreed |
| . |  |

**4NOTES ON TREATMENT**

**Flecainide** should not normally be used where there is coronary artery disease, structural heart disease, a long QT interval (QTc > 440ms in men, > 460ms in women) or impaired left ventricular function. It can be commenced in primary care “under the direction of hospital consultant”, which this guidance constitutes.

**Sotalol** should also usually be used only in structurally normal hearts with normal QTc, although can be used in the context of ischaemic heart disease. The QTc should be checked before treatment, after 1 week’s treatment and after a dose increase. Stop if QTc is >470ms. A Local cardiologist will assist in interpreting QTc if necessary.

**Amiodarone** requires lung function testing and CXR at baseline, as well as TFTs and LFTs. TFTs and LFTs should be repeated 6 monthly. CXR and lung function testing should be repeated if breathless.

**Dronedarone** can be used where flecainide and sotalol are contra-indicated or have proven ineffective and where ablation is not thought suitable, prior to amiodarone. It should not be used in patients with significant heart failure.

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**5SELECTION FOR CARDIOVERSION**

|  |  |  |
| --- | --- | --- |
|  | **SUITABLE** | **LESS SUITABLE** |
| Age | <65 | >65 |
| BMI | <30kg/m2 | >30kg/m2 |
| Symptoms | Symptomatic | Asymptomatic |
| Structural heart disease | Absent | Present (esp. large LA) |
| Previous cardioversions | No | Yes |
| Clear precipitant, reversible cause | Yes | No |
| Duration | <1 year | >1 year |
| Contraindication to anticoagulant, anti-arrhythmic drugs | No | Yes |
| Heart failure | Yes | No |

Probably unsuitable if 2 or more adverse features. Asymptomatic patients over 65 with AF do not need cardioversion. Atrial flutter should be considered in the same way. Start on Warfarin if referring for cardioversion.

**6RATE CONTROL**

Aim for rate of <90bpm at rest, <150 on exercise. Beta-blockers/rate slowing calcium channel blockers should be the first line agents for rate control.

**4NOTES ON TREATMENT – These treatments should be initiated in Secondary care.**

**Flecainide** should not normally be used where there is coronary artery disease, structural heart disease, a long QT interval (QTc > 440ms in men, > 460ms in women) or impaired left ventricular function. It can be commenced in primary care “under the direction of hospital consultant”, which this guidance constitutes. Should generally be prescribed with a rate slowing agent eg Bisoprolol.

**Sotalol** should also usually be used only in structurally normal hearts with normal QTc, although can be used in the context of ischaemic heart disease. The QTc should be checked before treatment, after 1 week’s treatment and after a dose increase. Stop if QTc is >500ms. A Local cardiologist will assist in interpreting QTc if necessary.

**Amiodarone** requires lung function testing and CXR at baseline, as well as TFTs and LFTs. TFTs and LFTs should be repeated 6 monthly. CXR and lung function testing should be repeated if breathless. Please be aware of the new monitoring requirements.

**Dronedarone** can be used where flecainide and sotalol are contra-indicated or have proven ineffective and where ablation is not thought suitable, prior to amiodarone. It should not be used in patients with significant heart failure.

# 3STRUCTURAL HEART DISEASE

On basis of History and Examination: Previous MI, angina, known CAD; known impaired LV function, cardiomyopathy, valve disease; congenital heart disease.

Antithrombotic therapy

(see note (1) over)

**Do ECG**

**PERSISTENT (responds to cardioversion) or**

**CHRONIC AF (irreversible)**

# Rate uncontrolled6

# Rate uncontrolled6

Add digoxin

First line rate control with

“Standard” beta blocker e.g. Bisoprolol 1.25-10mg once daily or

calcium channel blocker e.g. diltiazem 200-300 mg once daily

**PAROXYSMAL AF**

**(Comes and goes spontaneously)**

Suitable for cardioversion?5

**REFER for consideration of AV node ablation and pacemaker**

# No

Flecainide 50-100 mg twice daily4

or Sotalol 40-80 mg twice daily4

Consider amiodarone

# No or ineffective: REFER

Consider AF ablation

**REFER**

# Yes

**REFER**

# Yeses

**TREAT IN PRIMARY CARE**

# Effective

Consider dronedarone 400mg bd

“Standard “ beta blocker

eg Bisoprolol 1.25-10mg once daily

# No or ineffective

Suitable for

pill in pocket treatment? 2

# Ineffective