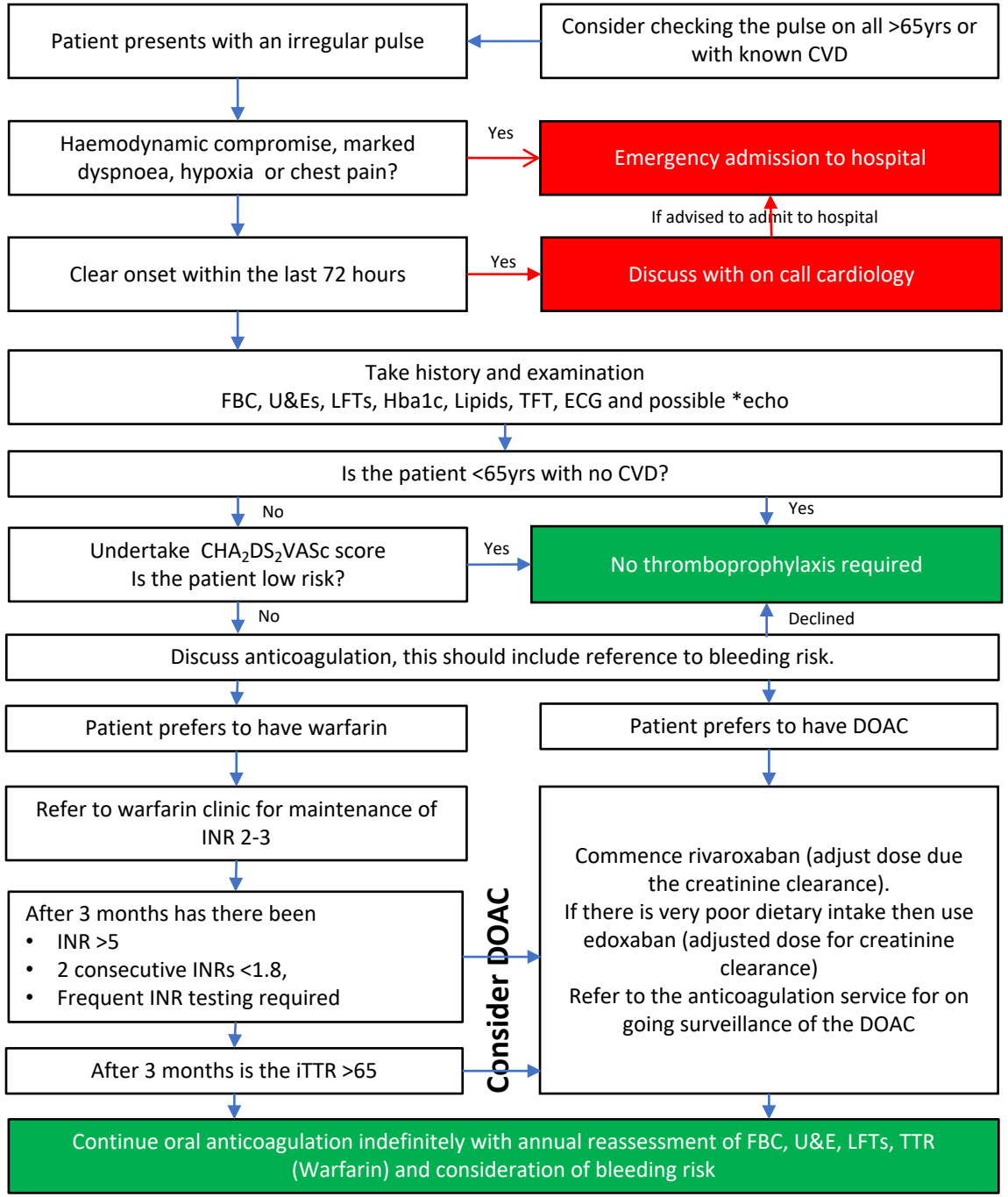
Guide to the Management of AF: Detection and stroke consideration



Bleeding Risk
Bleeding risk can be calculated using the HASBLED score
HASBLED score should not be used to preclude anticoagulation
Modifiable risk factors should be adjusted:
-Reduce blood pressure
-Reduce alcohol intake
-Review medication

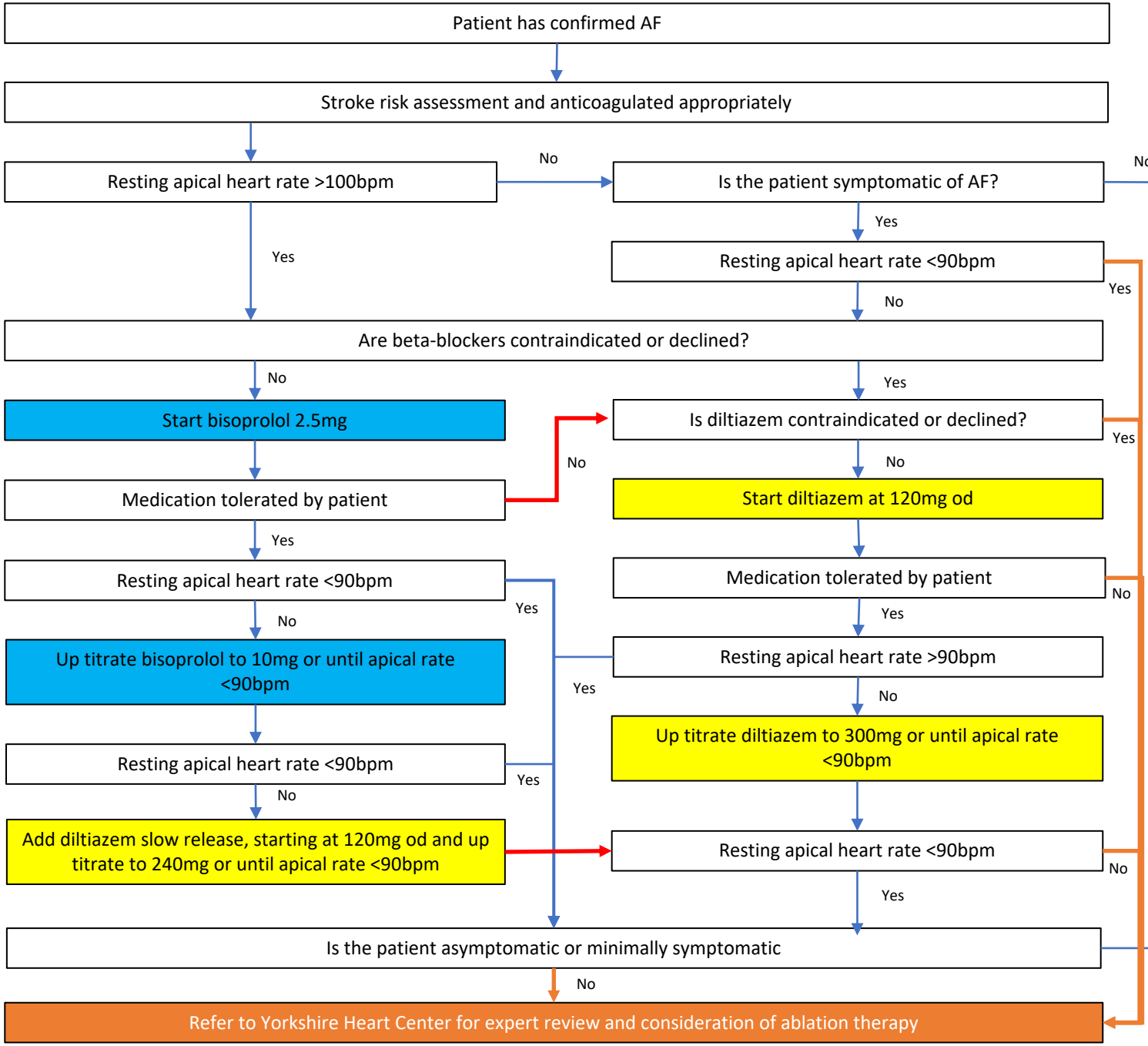
***Echocardiogram consideration**
The default option should be to undertake an echocardiogram however if due to the clinical setting the echo will not change management then it should not be undertaken

Contraindications to oral anticoagulation

Absolute Contraindications
- Known large oesophageal varices.
- Significant thrombocytopenia (platelet count < 50 x 10^9/L)
- Within 72 hours of major surgery with risk of severe bleeding - defer & reassess risk postoperatively.
- Previously documented hypersensitivity to either the drug or excipients.
- Acute clinically significant bleed - defer & re-assess stroke versus bleeding risk within 3 months.
- Decompensated liver disease or deranged baseline clotting screen (INR>1.5)
- Pregnancy or within 48 hours post partum

Relative Contraindications
- Previous history intracranial haemorrhage:-seek the opinion of a stroke specialist.
- Recent major extracranial bleed within the last 6 months where the cause has not been identified or treated –decision for oral anti-thrombotic therapy should be deferred.
- Recent documented peptic ulcer within last 3 months – decision for oral anti-thrombotic therapy should be deferred until treatment for PU completed & given PPI cover whilst on anti-thrombotic agent.
- Recent history recurrent iatrogenic falls in patient at higher bleeding risk.
  - **N.B. A risk of falls is not a contraindication to initiating oral anticoagulation.**
- Dementia or marked cognitive impairment with poor medicines compliance & no access to carer support.
- Chronic alcohol abuse – especially if associated with binge drinking.

Guide to the Management of AF: Rate and Rhythm consideration



Contraindications to medication

- Previous allergy or intolerance (both)
- Marked hypotension (systolic BP <90mmHg)

Beta-blockers

- Brittle asthma previously requiring hospitalization

Diltiazem

- Known moderate to severe LVSD
- Severe idiopathy constipation

If LVSD is identified and the aetiology is unknown or thought to be due to AF the prompt referral for specialist review is recommended as a rhythm correction option should be considered early

Rhythm management does not carry a significant prognostic advantage and should be considered only in the symptomatic or those with LVSD where the aetiology is thought to be due to the AF

There is no stroke risk advantage in rhythm management and anticoagulation should continue post rhythm correction as determined by the CHA_2DS_2VASc score

Aggressive rate control does not carry a prognostic advantage however persistent tachycardia can cause LVSD and should be corrected even in those who are asymptomatic

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