A *Two Houses* consultation guide

New onset atrial fibrillation

The House of Discovery: work out what matters

To the patient

Are they aware that their heart rhythm has changed? AF can be an incidental and unexpected finding, or the patient may be very aware that something significant has happened. This will dramatically alter the dynamic of the consultation. If unaware then this could be unexpected bad news (finding dry rot – see below). If aware, then what do they think has happened? How worried are they? Do they think they are having a heart attack?

How will this diagnosis affect the patient? Are they working? Do they have caring responsibilities? Will they cope with new medication? Are there driving consequences (esp HGV driver, see Foundations)

How will they feel about medication? AF is likely to involve new medication, potentially for life, how will they feel about this?

To the doctor

Urgent things to check first

- Are they haemodynamically stable?
- Is there an illness that has triggered this and needs urgent treatment? eg pneumonia, CCF, thyrotoxicosis.
- Is the AF causing chest pain that might indicate IHD?
- Are there any signs of the AF causing thromboembolism at presentation? eg a PE, stroke, limb or mesenteric ischaemia (consider if unexplained abdominal pain, usually with fewer signs than you would expect)?
- If onset is < 48 hours would urgent cardioversion be appropriate?

There will be a lot to consider here, too much for one consultation:

- Confirming the diagnosis with an ECG (vital)
- Explaining the diagnosis
- Rate control v rhythm control
- Anticoagulation
- Tests to organise? eg blood tests, ECHO
- Whether or not to refer to cardiology

Consider what needs to be done in this consultation (rate control most important) and what could be discussed, but decided upon at a review

What to look out for in the *House of Discovery*

Finding dry rot

Finding AF incidentally, or unexpectedly, can be quite a shock and many patients are completely unaware, even with rapid AF. Give the patient time to catch up.

When patients hear about a problem with their heart they may think they are having a heart attack, or could have one. Reassuring them that AF is common and usually nothing to do with a heart attack can be helpful.

Tools for the toolbox

"Have you noticed that your heart is jumping about a bit?"

"Your heart has changed its rhythm…" (pause) "this is very common, but we do need to think about what to do about it."

"You've obviously been feeling quite unwell with this, what has been your main concern?"

Tending the garden

This is always a key part of an AF consultation. Measuring blood pressure is vital to assess haemodynamic stability and also suitability for medication.

AF can also be caused by excess alcohol, and episodes of AF can be reduced by reducing alcohol, weight loss and treating any underlying diabetes, sleep apnoea and hypertension. Smoking contributes to increased stroke risk. Stress, excess caffeine and poor sleep are also worth thinking about.

Foundations

Based on Based on NICE CKS May 2019

Urgent Admission is required if:

- Haemodynamically unstable (Pulse > 150; BP < 90)
- Severe symptoms eg dizziness, chest pain, breathlessness
- Serious underlying cause eg pneumonia

Urgent Admission is required if (cont):

- Serious complications of AF ie thromboembolism
- Also consider whether there is an opportunity to cardiovert if onset <48hrs, especially in younger, fitter people who will be more likely to maintain sinus rhythm

Consider underlying causes:

- Cardiac: valvular disease, IHD, hypertension, heart failure (esp if left atrial enlargement); consider an ECHO
- Respiratory: Pneumonia, lung cancer; consider a Chest x-ray
- Systemic: Infection, diabetes, thyrotoxicosis, electrolyte imbalance, excess alcohol; consider blood tests (U&E, TSH, HBA1c).

The House of Decision: decide together what to do

Rooms to look out for

Empty Rooms

Where rate control is the only option it can be difficult to accept that the underlying problem cannot be cured, especially if there are symptoms due to reduced cardiac output, or if episodes of Paroxysmal AF keep happening.

Locked Rooms

Rate control can be difficult in people with asthma, since it may not be possible to use a β-blocker. Bisoprolol may be able to be used as a trial with caution, otherwise use diltiazem or digoxin.

Room 101

There are several potential Room 101s to look out for:

- If hospital admission is required this may be unexpected. Many patients will be glad to know they are going to be sorted, but some will be scared of this.
- Rate control is usually with β-blockers and some people will have heard bad things about them (eg tiredness).
- People can have strong views on anticoagulation, especially warfarin ('rat poison'). They may have heard of friends who have had a bleed for instance.

Key decisions in the *House of Decision*

1. To admit to hospital or not (see Foundations)
2. Does the rate need to be controlled? Resting pulse should ideally be 60-100. If so, can a β-blocker be used? Is the BP high enough to tolerate it?
3. Do tests need to be arranged?
   - An ECG is always desirable to confirm that it really is AF, and to have documentation in case they revert to NSR (remembering that anticoagulation is as important in paroxysmal AF as in persistent AF)
   - ECHO and CXR (see Foundations)
   - Blood tests (see Foundations)
4. Anticoagulation. Use CHA_2DS_2VASC and HAS-BLED scores to assess risk, although essentially only people under 65 years and without other risk factors would not be recommended for anticoagulation unless contraindicated. This is not urgent, and people can go away with information and return the next week.
5. Warfarin or a DOAC? (See Foundations)
6. To refer to cardiology or not? (see Foundations)

The High Tech Room

AF is quite technical, but don't be afraid of using the proper term, just make sure you explain it.

Would the patient you are with appreciate an explanation of the atrium and the meaning of fibrillation, or would it be more helpful to explain that it is the most common heart rhythm problem and that the heart goes a bit too fast and loses its regular rhythm when AF occurs?

What really matters is to explain that treatment can either try to control the rhythm, or just control the rate.

Tools for the toolbox

"Your heart is going a bit too fast at the moment and I think you would feel better if we used a tablet to slow it down"

"Your heart is in a rhythm called Atrial Fibrillation, is that something you have heard of?"

"We could use a tablet like warfarin to reduce your risk of stroke. How would you feel about that?"

When explaining stroke risk, remember that you may need to explain what a stroke is.

Be wary of calling anticoagulants 'blood thinners' – that is not technically accurate and people often conclude that their blood will be in some way weaker or colder if it is thin. Describing them as 'making the blood less sticky' or 'less likely to make clots' may be better.

Foundations

Warfarin or a DOAC? No difference in terms of reducing stroke risk.
Advantages of warfarin: Tried and tested, few systemic side effects, longer half life so less risk if a tablet is missed. Clear antidote which has not yet been developed for DOACs.

Advantages of DOAC: Reduced risk of haemorrhage compared with warfarin. No need to come for monitoring.

NICE has produced a patient decision aid for anticoagulation decisions in AF – but it is 36 pages long!

Secondary care or primary care?

Many cases can be managed in primary care, but refer to cardiology if: Rhythm control preferred over rate control; Valvular heart disease, LVSD on ECHO or CCF; conduction abnormality such as WPW syndrome or prolonged QT; rate control not alleviating symptoms.