key points

SELECTED BY

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Atrial fibrillation (AF) is often diagnosed as an incidental finding during a routine medical check. The prevalence increases with age and the presence of CVD further increases the risk of AF. Around 15-30% of patients with AF are asymptomatic. When patients present to their GP the most common symptoms of AF include: palpitations, chest pain, breathlessness and a reduction in exercise/functional capacity. To establish a diagnosis of AF, rhythm documentation with an ECG showing at least 30 seconds of AF is required. This can be in either a standard 12-lead ECG, single lead ECG or rhythm recording device. The new ESC guidelines recommend that all newly diagnosed AF patients should undergo echocardiographic studies.

The risk of stroke in patients with AF is increased five-fold. Stroke risk is independent of the degree of symptoms and the burden of AF. As soon as AF is diagnosed, the CHA_2DS_2-VASc score should be calculated, and anticoagulation initiated in appropriate patients. A vitamin K antagonist e.g. warfarin, should only be offered to patients with a new diagnosis of AF if a direct oral anticoagulant is contraindicated, not tolerated, or not suitable.

Rhythm control should be considered in new onset AF, when there is a reversible cause for AF, when heart failure is present and thought to be due to AF, and in young patients or others in whom a rhythm control strategy appears suitable. In other patients (typically the elderly and truly asymptomatic), rate control is an appropriate first-line strategy, with no survival disadvantage compared with rhythm control and some potential advantages, such as lower risk of adverse drug effects.

In patients with persistent AF that has lasted longer than 48 hours, electrical cardioversion is usually the option of choice for rhythm control. Left atrial catheter ablation is indicated for patients with symptomatic paroxysmal or persistent AF in whom drug treatment is unsuccessful, unsuitable, or not tolerated, and may also be considered as an alternative to antiarrhythmic drugs in patients with paroxysmal AF.

After a diagnosis of AF has been confirmed and stroke risk stratification performed, control of symptoms will generally drive further management; routine monitoring of rhythm or AF burden is usually not required. Anticoagulation should not be stopped simply because sinus rhythm appears to be maintained. Any decision to discontinue anticoagulation should be based on reassessment of both stroke and bleeding risk, AF burden and a discussion of the patient's preferences. Most AF patients benefit from annual review, mainly focused on updating thromboembolic risk stratification and monitoring of oral anticoagulation, which can usually be delivered within primary care.