

key points

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NICE recommends the use of warfarin in AF patients at high risk of stroke, and aspirin 75-300mg for low risk.

The assessment of patients with AF requires a full history and clinical examination in order to identify additional comorbidities and assess stroke risk.

All patients who have an irregular pulse or symptoms suggestive of AF should have an ECG.

AF is the most common chronic cardiac arrhythmia. It is characterised by rapid and chaotic activation of the atria and accounts for 10-15% of all ischaemic strokes. Prevalence is higher among men and increases dramatically with age.

Digoxin is not recommended as monotherapy, except in elderly or very sedentary patients, as it is not good at controlling ventricular rate during exercise.

Management of AF revolves around the choice of treatments to control the ventricular rate or to achieve and maintain sinus rhythm – rate versus rhythm control.

AF is more likely to occur in patients with other common cardiovascular diseases, such as ischaemic heart disease, valvular heart disease, heart failure, diabetes and hypertension. Other risk factors for developing AF include congenital heart disease, hyperthyroidism, alcohol excess and sepsis. AF can develop without an overt underlying cause ('lone AF').

Echocardiography is recommended in selected patients to guide treatment decisions. These include patients for whom a rhythm control strategy is being considered and patients for whom there is a high clinical suspicion of structural heart disease that may influence management.

Beta-blockers or rate-limiting calcium channel antagonists, such as diltiazem and verapamil, are the first-line choice of drugs as part of a rate control strategy.

A rate control strategy would appear to be easier to achieve, but a rhythm control strategy is used first for those patients with paroxysmal AF, or those with persistent AF who are young (≤ 65 years), or present for the first time with lone AF or AF secondary to a treated precipitant or those with cardiac failure.