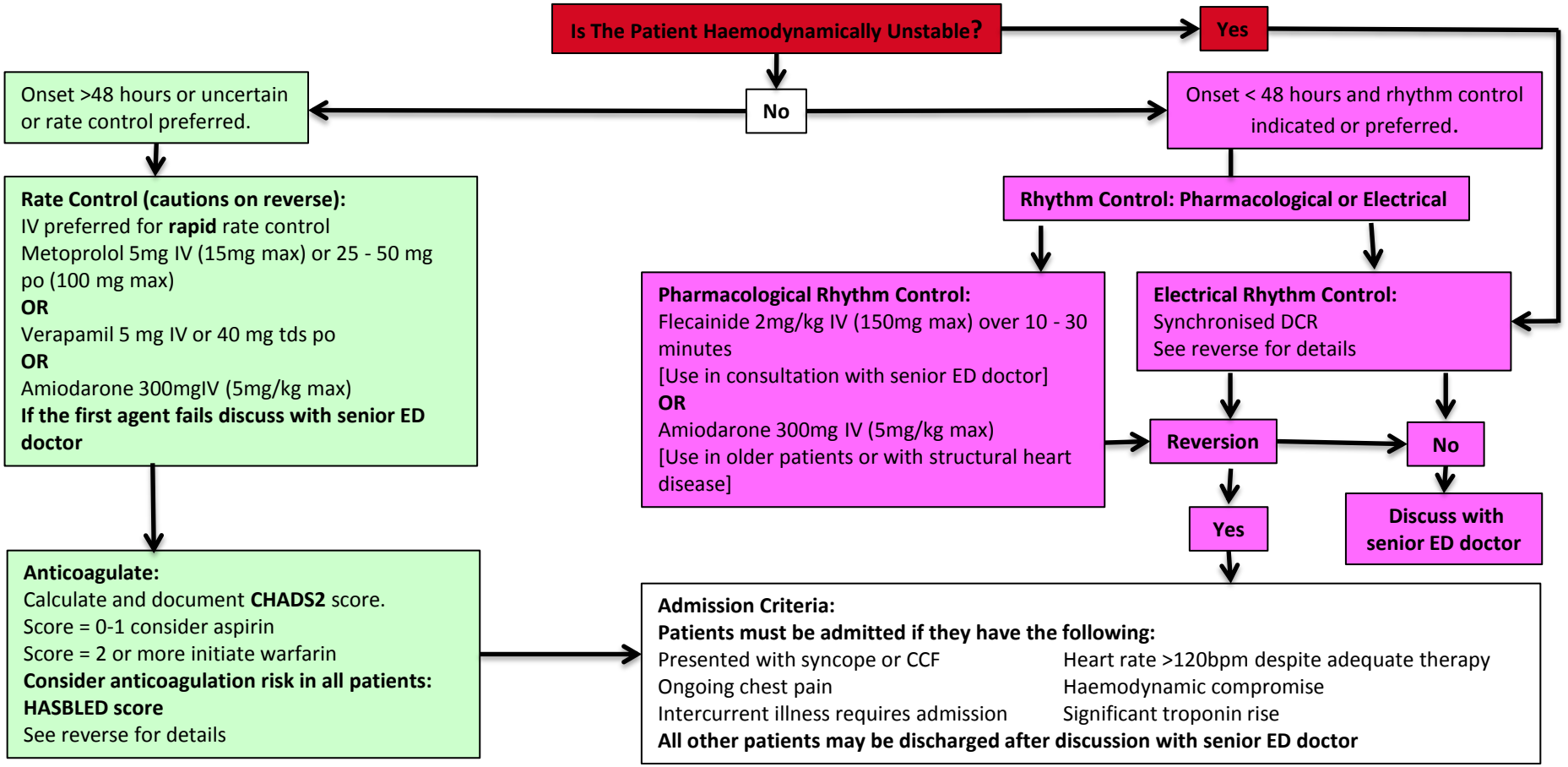
Treatment of Rapid AF in the Bendigo Health ED.

For all patients presenting with rapid AF, evaluate for underlying cause and treat appropriately. If heart rate is still uncontrolled (>120bpm) consider using the following pathway.
All patients who present to ED with AF must have the following: ECG,UEC, FBE, TFT (if not checked in 6months), add Trop if ischemic chest pain is present, CXR if cardiac failure is suspected.



Discharge Documentation:

All patients discharge must have documented:

- Symptom chronicity and/or duration
- CHADS2 score
- Risk factors for anticoagulation
- Warfarin or aspirin discharge plan
- Discharge medications (see reverse for details)
- Review by cardiology in clinic or private in 6 weeks (+/- TTE and holter monitor)
- Provided patient with AF information leaflet

Anti-arrhythmics – cautions & contra-indications:
All may be negatively inotropic, especially in combination. Check for drug interactions.
Amiodarone: Sino-atrial block and conduction disturbances, severe hypotension, thyroid disease, CCF, pregnancy & breast-feeding.
Flecainide: Atrial flutter, CCF, structural heart disease, recent MI.
B-blockers: asthma / COPD, uncontrolled heart failure, sick sinus syndrome, heart block, hypotension, severe peripheral vascular disease
Ca channel blockers: heart failure, hypotension, sick sinus syndrome, heart block, AF with WPW, VT, pregnancy & breast-feeding

Instructions for synchronised DCR:
- Procedural sedation as per ED guideline
- >4 hours fasted unless unstable
- 150-200 joules
- If a patient is not fasted or resources are not available stable patients may be admitted to SOU or return the next morning if not compromised

CHADS2 Score:

Congestive heart failure (or left ventricular systolic dysfunction) = 1 point.

Hypertension (blood pressure consistently above 140/90 (or treated hypertension on medication) = 1 point.

Age ≥75 years = 1 point.

Diabetes mellitus = 1 point.

Stroke/TIA/Thromboembolism = 2 points.

Anticoagulation risk:
The following may be useful when assessing bleeding risk for patients who are started on anticoagulation. Documentation is recommended in the discharge summary:

H Hypertension (systolic Blood pressure >160mmHg)= 1 point
A Abnormal renal (dialysis/transplant or creatinine >200) =1 point
or liver function (cirrhosis/bilirubin > 2x normal w enzymes > 3x normal)=1 point
S Stroke (history of) =1 point
B Bleeding=1point
L Labile INRs (<6 in 10 INRs in therapeutic range)=1 point
E Elderly (e.g. Age >65 years)= 1 point
D Drugs -antiplatelet agents, NSAIDs= 1 point
or alcohol ≥8 units per week) =1 point

A score >3 indicates significant bleeding risk if anti-coagulated. Discuss with senior ED doctor.
Also consider:
-Can the patient/family members manage the dosage changes required for warfarin?
-Does the patient engage in high risk activities? E.g. contact sports
-Is this patient at a high risk of falls, and if so, can the risk be minimised if anticoagulation is required?

Discharge Medications: +/- aspirin or warfarin (unless contraindicated)

For rhythm control:
Patients receive no medication if first episode.
Amiodarone 200mg bd for 1 month then 200mg daily thereafter
or
Sotalol 40-80mg bd.

For rate control:
Metoprolol 25-50mg bd
or
Amiodarone 200mg bd for 1 month then 200mg daily thereafter.