

The NICE guidelines on atrial fibrillation: a personal view

The guidelines on atrial fibrillation (AF) produced by the National Institute for Health and Clinical Excellence (NICE) and published by the Royal College of Physicians are impressive in their scope and details. They are overtly evidence based and whilst there is some debate over some issues within the guidelines, there is no doubt that they represent much hard work from the Guidelines Development Group.

They follow the standard format of NICE guidelines with a background to the problem, a statement of the evidence, a section entitled 'from evidence to recommendations', and finally a set of recommendations with the appropriate evidence level stated. The guidelines cover identification and diagnosis, treatment, monitoring, and referral. The main thrust of the guideline is to ensure accurate diagnosis using an electrocardiogram (ECG) and to utilise risk stratification on an individual patient basis, in order to ensure optimum treatment – either medical or surgical – for each patient. This is the challenge to all of us but particularly those of us working in primary care, who may have seen AF as a benign condition treated with a touch of digoxin. If nothing else, the guidelines demonstrate the need to take AF seriously and to intervene in the majority of cases with some form of antithrombotic therapy.

The executive summary gives five key recommendations:

- ECG diagnosis for all patients
- individual assessment for rate or rhythm control
- beta blockers as first line for rate control
- antithrombotic therapy to be initiated with minimal delay
- use of a stroke risk stratification algorithm.

Whilst we may debate the role of rhythm control (i.e. cardioversion) for patients with AF and the choice of specific risk stratification algorithm, it is difficult to disagree with these sensible recommendations.

Identification and diagnosis

The identification and diagnosis section is straightforward, recommending pulse palpation if patients present with dizziness or other symptoms of AF, and an ECG to be performed in all patients in whom AF is suspected because an irregular pulse has been detected. This falls short of recommending routine ECG screening, presumably because of lack of evidence, although the rather awkward wording, which implies that pulse taking should be used as a triage test before pro-

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ceeding to ECG, carries the implication that it might be a good idea to undertake ECG recording on, for example, all patients aged over 65 years. The evidence to recommendations section also appears to contradict itself, stating that "The diagnosis of AF does not require a 12-lead ECG recording" but I think this implies a rhythm strip is sufficient to make the diagnosis. Recommendations for use of 24-hour ambulatory ECG monitoring or an event recorder are sensible but, as yet, impractical because of lack of access to the technologies.

The role of echocardiography remains debatable, demonstrated by the low level of evidence associated with the recommendations. The recommendations are sensible, if a little biased towards its use, with a relatively long list of indications, including suspicion of structural abnormality.

Cardioversion

The cardioversion section is, for me, the most controversial. The specific section compares electrical with pharmaceutical cardioversion, before the issue of whether cardioversion should be used at all is discussed. This section appears to me to use selective data and is biased towards the use of cardioversion. This is highlighted by the recommendation within the section on persistent AF, given the lowest evidence level, that each patient should be considered for either a rate or rhythm strategy. Most primary care clinicians would only consider cardioversion for the acute situation or for patients who are symptomatic. Even then, it is likely that antithrombotic therapy needs to be continued for life.

Treatment

The treatment section is very detailed covering appropriate drugs for rate control (first-line beta blockers), antithrombotic therapy, and possible surgical interventions. The main take-home message is that paroxysmal AF should be treated the same as persistent AF, and that patients should be risk assessed for stroke prevention. It is not clear why the CHADS₂ risk stratification was ignored – the included algorithm is sensible, however, and has been used before.

There are no real shocks within the guidelines and it is unclear whether they will have much of an impact at a primary care level. It is clear that diagnosis needs to be improved, but my fear is that the risk stratification algorithm chosen will enable clinicians to opt for aspirin therapy too easily. Thus, whilst the guidelines certainly raise awareness of the issues surrounding treatment of AF, they have, in my opinion, come down too strongly in favour of cardiological interventions (cardioversion and echocardiography) and not strongly enough in favour of antithrombotic, in particular anticoagulant, therapy.

Conflict of interest

None declared.

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MINAP: FROM NATIONAL AUDIT TO RESEARCH

Tuesday 27 March 2007

There is considerable interest in the MINAP database to which all 230 hospitals in England and Wales now contribute. Its national reach is unparalleled. Each month MINAP accrues over 7000 definite ACS events. This is the largest and most successful myocardial infarction database in the world. The main aims of this conference are:

- To communicate the importance of national registry data for audit and research.
- To provide all MINAP contributors (i.e. all cardiologists throughout England and Wales) with information about the fruits of their labours, and thereby to reinforce the importance of their continuing contribution.

Audience: Cardiologists, General Physicians, Epidemiologists, Public Health Physicians and other Healthcare Professionals involved in MINAP

METABOLIC SYNDROME: FATTY LIVERS AND ARTERIES

Thursday 7 June 2007

This meeting will focus on the cardiovascular and hepatic aspects of the metabolic syndrome which is due to insulin resistance resulting from excessive hepatic synthesis of triglycerides and their deposition in liver, muscle and central adipose tissue. The prevalence of this disorder has increased enormously in recent years; it is already a major health problem and is set to become a huge drain on health services not only in Europe and North America, but also Asian countries as their economies develop. The factors which determine the progression of non-alcoholic steatohepatitis, now the commonest cause of abnormal liver function tests, to cirrhosis are poorly understood. The metabolic syndrome, which is largely orchestrated by abnormalities of liver function, represents a state of pre-diabetes in which cardiovascular risk is already increased due to dyslipidaemia, hypertension and newly emerging risk factors. Progression to type 2 diabetes, occurring in younger age groups than hitherto, is a major problem. Recent advances in our understanding of the subject and nutritional and pharmacological interventions will be discussed.

Audience: Cardiovascular Physicians, Gastroenterologists (Hepatology), Diabetologists, Lipid Clinic Physicians, Metabolic Physicians, Nutritionists, Chemical Pathologists, Cardiologists, Epidemiologists, Clinical Pharmacologists, Public Health Physicians, Paediatricians.

Both of the conferences will be held at the
Royal College of Physicians,
11 St Andrews Place, Regent's Park, London NW1

Programmes and booking forms are available on-line at
www.rcplondon.ac.uk/conferences or from:

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