Initiating oral anticoagulation in hospitalised AF patients: it's time to talk

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When the National Institute for Health and Care Excellence (NICE) clinical guideline 180 on atrial fibrillation (AF) was published in June 2014, out if its many recommendations, two points seemed paramount. First, it is the patient, and not the clinician, who should make the decision as regards the nature of the treatment they are to receive, whether this be for stroke prevention or for symptom management, and that all those with AF should be offered stroke preventive therapy, with the exception of those without risk factors (CHA_2DS_2-VASc 0 or 1 in females).

Honarbakhsh *et al.* highlight an important point in their paper (see pages 105–9): when should this be done and who should take responsibility. Their review of patients who have been admitted acutely with AF or atrial flutter, looking at the outcome of anticoagulation if risk factors are present, seems to provide lamentable data, with only 57% being referred for oral anticoagulation.

Of course, there may be a question as to whether, with patient-led decision-making, the acute hospital ward is the right environment for a considered and final decision as regards this important question. We need to consider the emotional state of the patient and their care network at this stage, but also the opinion of the consulting physician seeing the patient in an acutely unstable state and away from their normal environment, with understandable concerns regarding the adverse consequence of intervention with anticoagulants.

This situation is then amplified on discharge, when the patient is returned to the supervision of the general practitioner, who sees the patient not receiving intervention, or worse receiving antiplatelet agents, where the clinician has treated their own anxiety about leaving a patient unprotected from cardio-embolic stroke.

The issue here maybe more one of communication, through the system from acute care to chronic care, with clinicians understanding what has happened previously and what their role in ongoing management may be.

The outcome of admission to hospital with AF or atrial flutter, as regards stroke prevention, has four outcomes:

- The issues around AF stroke have been discussed and the patient has received an anticoagulant.
- The issues around AF stroke have been discussed and the patient has, through informed choice, declined an anticoagulant at this time, and should be highlighted for future discussion within the GP records.
- The issues around AF stroke have been considered but, in the acute situation, it was thought the bleeding risk of an anticoagulant was excessive, but this decision should be reconsidered once the patient is in a more stable situation.
- The patient is not competent to make the decision and the hospital-based team has discussed this within the multi-disciplinary team (MDT) and appropriate patient representatives, and a decision has been made to not anticoagulate the patient.

The clear comment from Honarbakhsh *et al.* is that the system, designed the way it currently is, will only continue to give the poor outcomes seen in their study. Better communication between key clinicians in the patient care pathway and appropriate implementation of the NICE recommendations for anticoagulation therapy may be the way forward

Conflict of interest

Westcliffe Medical Practice has been variously given by: Abbott, Bayer, Boehringer-Ingelheim, Bristol-Myers Squibb, 4S Dawn, INRstar, Medtronic, Oberoi Consulting, and Pfizer.

Editors' note

Please see the article by Honarbakhsh *et al.* on pages 105–9 of this issue.