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Insights from the RCPE UK Consensus Conference on approaching the comprehensive management of atrial fibrillation

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Consensus Conference on approaching the comprehensive management of atrial fibrillation Edinburgh, UK, 1–2 March 2012

This article provides some insights from the Royal College of Physicians of Edinburgh UK Consensus Conference on approaching the comprehensive management of atrial fibrillation. The four key questions addressed by the conference were: how can we best detect atrial fibrillation (AF)? Should the treatment of AF be targeted towards control of rhythm, rate or both? What is the most effective and safest delivery of thromboprophylaxis in AF? And what are the differences between physician and patient expectations with regard to the management of AF? The key recommendations from the consensus conference were that detection of AF must be improved; a national screening programme should be introduced; uptake of oral anticoagulants must be increased and methods of engaging patients in their AF management should be improved; aspirin should not be used for stroke prevention in AF; and in relation to rate and rhythm control for AF, relief of symptoms should be the goal of treatment. The Consensus Statement and its background papers are recommended reading for the development of local guidelines for management, and for the management of individual patients.

KEYWORDS: anticoagulation therapy • aspirin • atrial fibrillation • comprehensive management • consensus conference • screening • stroke prevention

A meeting of over 120 specialists was convened by the Royal College of Physicians of Edinburgh (RCPE) on 1–2 March 2012 to address the topic of atrial fibrillation (AF). This consensus conference by the RCPE is the second one to cover AF, the first one being successfully held as a joint venture by the RCPE and the University of St Andrews (Scotland, UK) on 3–4 September 1998 [101]. The field of AF management has greatly advanced since the 1998 conference, and in 2012, the four key questions addressed by the conference were as follows [102]:

- How can we best detect AF?
- Should the treatment of AF be targeted toward control of rhythm, rate or both?

- What is the most effective and safest delivery of thromboprophylaxis in AF?
- What are the differences between physician and patient expectations with regard to the management of AF?

The methodology for convening RCPE Consensus Conferences is published on the RCPE website [103]. It is worth highlighting that the RCPE is the only UK College of Physicians that organizes Consensus Conferences with a standard, evidence-based, multiprofessional consensus methodology. Over the course of a 2-day conference, the multidisciplinary consensus panel reviews all the evidence before drafting

the Consensus Statement, that is finally agreed at the end of the conference and published.

Why AF?

AF is the most common sustained cardiac rhythm disorder, affecting at least 1.8% of the population, rising to over 6% in people aged above 65 years. The prevalence and incidence of AF is increasing, partly due to the increasing age of the general population and the better management of conditions such as myocardial infarction, leading to more patients surviving with cardiac impairment.

Patients with AF have a fivefold increased risk of stroke, and importantly, strokes in the setting of AF are associated with a higher mortality, greater disability, longer hospital stays and lower rates of discharge to their own homes [1].

Patients with AF are frequently underdiagnosed and often have associated comorbidities, such as hypertension and heart failure, which need to be addressed as part of a holistic approach to the management of this condition [2]. Irrespective of whether AF is paroxysmal, persistent or permanent, stroke prevention is central to its management. Effective stroke prevention requires oral anticoagulant (OAC) drugs – usually warfarin – but more recently, new anticoagulants have been introduced that offer important advantages over warfarin [1]. Given the limitations and disadvantages associated with warfarin – including the various food/drug interactions, need for regular monitoring at anticoagulation clinics, and so on – the use of warfarin has been suboptimal, and the new agents may address this issue.

The key recommendations from the consensus conference are summarized as follows [102]:

- Detection of AF must be improved; a national screening program should be introduced;
- Uptake of OAC must be increased and methods of engaging patients in their AF management should be improved;
- Aspirin should not be used for stroke prevention in AF;
- In relation to rate and rhythm control for AF, relief of symptoms should be the goal of treatment.

The four key questions addressed by the conference are discussed further in the following sections and based on the final Consensus Statement available from the RCPE webpage [102], as well as the background papers published online in the *Journal of the Royal College of Physicians of Edinburgh* [3–6].

How can we best detect AF?

Many patients have AF and it is frequently asymptomatic. The panel made an important call that “...the detection and thromboprophylaxis of AF should be a UK NHS priority for the prevention of disabling cardioembolic stroke, with all of its consequences for individuals and for health and social care resources” Also, screening for AF in people aged 65 years or older satisfies the UK National Screening Committee criteria for a screening program, and thus, such a national screening program should be initiated in the UK [3].

The most cost-effective method for the detection of AF in primary care is by opportunistic screening of people aged ≥ 65 years by pulse

palpation, and if an irregular pulse is found, the arrhythmia should be confirmed with an ECG [3]. Where paroxysmal AF is suspected, including after ischemic stroke or transient ischemic attack, longer ECG monitoring periods (at least 24 h) or event recorders should be used [1]. This is pertinent given that only one in 12 paroxysms of AF are symptomatic. Also, if one looks hard enough, AF can be found in one in 20 patients presenting with an acute ischemic stroke [7].

Should the treatment of AF be targeted toward control of rhythm, rate or both?

There has been much debate over which is the best strategy for managing AF – rate control or rhythm control [4]. The management of AF has evolved to become a patient-centered, symptom-directed approach, whereby the relief of symptoms should ultimately be the goal of treatment [8,9]. Patient values and preferences are key to this. Patients who remain symptomatic despite initial therapy should be referred to a specialist for consideration of other antiarrhythmic strategies [4].

For patients with persistent AF, the consensus panel recommended that treatment should aim to achieve a resting heart rate of <100 beats per minute. Elective electrical cardioversion was considered to be useful in selected patients, but it was noted that the recurrence rate of AF is high, despite the use of antiarrhythmic therapy. Given that stroke prevention is a major issue, OAC should be continued postcardioversion especially where stroke risk factors are present and/or the risk of AF recurrence is high [9].

Specialized procedures, such as left atrial catheter ablation, should be considered in patients who remain symptomatic despite antiarrhythmic drug treatment. Of note, there was only limited evidence that ablation improved prognosis, but ongoing trials may answer this question [10]. Given that AF may recur after ablation, OAC should be continued postablation dependent upon the presence of stroke risk factors [10].

What is the most effective & safest delivery of thromboprophylaxis in AF?

Stroke prevention is a key message repeatedly highlighted during the consensus conference. The consensus panel re-emphasized the need that all patients with AF should have a formal stroke risk assessment using a scoring tool such as CHA₂DS₂-VASc, which has now been well validated to be the best at identifying ‘truly low risk’ patients [11]. Such low-risk patients (i.e., CHA₂DS₂-VASc = 0) should not receive long-term antithrombotic therapy. Patients with paroxysmal, persistent or permanent AF who are over the age of 65 years with at least one risk factor for stroke should be considered for effective stroke prevention with OAC, either as well-controlled warfarin or one of the new agents (oral direct thrombin and factor Xa inhibitors) [12]. Women aged <65 years with AF and no other stroke risk factors (i.e., age <65 and lone AF) have a relatively low stroke risk, and antithrombotic therapy would not usually be recommended [5].

Another important conclusion from the consensus panel was that aspirin should not be used for stroke prevention in AF as it is ineffective therapy and may potentially cause harm from major bleeding and intracranial hemorrhage, especially in the elderly where rates of major bleeding with aspirin are not significantly different

from warfarin [13,14]. Thus, the panel made a call for AF patients who are taking aspirin solely for stroke prevention in AF to be reviewed.

The combination of aspirin plus clopidogrel was recognized to reduce ischemic stroke risk in AF, but this is offset by a risk of serious bleeding, and thus, the panel advised such combination therapy was not recommended for thromboprophylaxis in AF.

Before starting an OAC, bleeding risk is a major consideration by clinicians, as reflected by a recent overview on this topic from the European Heart Rhythm Association and the European Society of Cardiology Working Group on Thrombosis [15]. Indeed, the risks and benefits of treatment, including an assessment of cognition and comorbidities, was recommended. A bleeding risk assessment score, the HAS-BLED score, can help identify modifiable bleeding risks [16] that need to be addressed, but it was emphasized that a HAS-BLED score *per se* should not on its own be used to exclude patients from OAC therapy.

All patients with AF should have the risks and benefits of OAC assessed annually. Where warfarin was in use, the consensus panel recommended that anticoagulation services should provide annual data of time within therapeutic range as a means of quality improvement, as warfarin was effective only if well controlled (with therapeutic ranges >70%) [17,18]. Anticoagulant control may be improved by near patient testing, education and engaging patients in their own care, especially since OAC use remains suboptimal [17]. New interventional technologies, such as a left atrial appendage occlusion device, could be considered in high-risk patients in whom all OACs are contraindicated.

What are the differences between physician & patient expectations with regard to the management of AF?

A session dealing with physician and patient expectations dealt with differences between these groups in relation to management. Indeed, doctors underprescribe OACs, often assuming patients are not willing or able to take these drugs safely, to the detriment of the patients who would be at risk of stroke. Also, patients presenting with AF should have their beliefs and expectations about

the condition and treatments fully explored, and patients allowed time to consider treatment options [6].

The need for education and compliance was emphasized, as part of a shared decision-making. The development of decision support aids involving professionals, patients and patient organizations was recommended, which should facilitate the discussion of the risks and benefits of, for example, OACs with patients and their families/carers.

Conclusion

After 2 days of presentations and lively debate, the multidisciplinary consensus panel chaired by David Stott (Glasgow, UK) produced an important Consensus Statement that clearly highlights important issues in the contemporary management of AF. There was adequate representation and perceptions of management from primary care, cardiologists, geriatricians, neurologists and pharmacists. The Consensus Statement and its background papers are recommended reading for the development of local guidelines for management, and for the management of individual patients.

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References

- Banerjee A, Marín F, Lip GY. A new landscape for stroke prevention in atrial fibrillation: focus on new anticoagulants, antiarrhythmic drugs, and devices. *Stroke* 42(11), 3316–3322 (2011).
- Kirchhof P, Lip GY, Van Gelder IC *et al.* Comprehensive risk reduction in patients with atrial fibrillation: emerging diagnostic and therapeutic options. Executive summary of the report from the 3rd AFNET/EHRA consensus conference. *Thromb. Haemost.* 106(6), 1012–1019 (2011).
- Harris K, Edwards D, Mant J. How can we best detect atrial fibrillation? *J. R. Coll. Physicians Edinb.* 42(Suppl. 18), 5–22 (2012).
- Camm AJ, Savelieva I. Atrial fibrillation: the rate versus rhythm management controversy. *J. R. Coll. Physicians Edinb.* 42(Suppl. 18), 23–34 (2012).
- Lip GYH. What is the most effective and safest delivery of thromboprophylaxis in atrial fibrillation? *J. R. Coll. Physicians Edinb.* 42(Suppl. 18), 35–44 (2012).
- Fay M, Montana C. What are the differences between physician and patient expectation with regard to the management of atrial fibrillation? *J. R. Coll. Physicians Edinb.* 42(Suppl. 18), 45–54 (2012).
- Liao J, Khalid Z, Scallan C, Morillo C, O'Donnell M. Noninvasive cardiac monitoring for detecting paroxysmal atrial fibrillation or flutter after acute ischemic stroke: a systematic review. *Stroke* 38(11), 2935–2940 (2007).
- Lip GY, Tse HF, Lane DA. Atrial fibrillation. *Lancet* 379(9816), 648–661 (2012).
- Camm AJ, Kirchhof P, Lip GY *et al.*; European Heart Rhythm Association/European Association for Cardio-Thoracic Surgery. Guidelines for the management of atrial fibrillation: the Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC). *Eur. Heart J.* 31(19), 2369–2429 (2010).

- 10 Calkins H, Kuck KH, Cappato R *et al.* 2012 HRS/EHRA/ECAS Expert Consensus Statement on Catheter and Surgical Ablation of Atrial Fibrillation: recommendations for patient selection, procedural techniques, patient management and follow-up, definitions, endpoints, and research trial design. *Europace* 14(4), 528–606 (2012).
- 11 Lip GY, Nieuwlaat R, Pisters R, Lane DA, Crijns HJ. Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. *Chest* 137(2), 263–272 (2010).
- 12 Lip GY. Anticoagulation therapy and the risk of stroke in patients with atrial fibrillation at 'moderate risk' [CHADS₂ score=1]: simplifying stroke risk assessment and thromboprophylaxis in real-life clinical practice. *Thromb. Haemost.* 103(4), 683–685 (2010).
- 13 Lip GY. The role of aspirin for stroke prevention in atrial fibrillation. *Nat. Rev. Cardiol.* 8(10), 602–606 (2011).
- 14 Olesen JB, Lip GY, Lindhardsen J *et al.* Risks of thromboembolism and bleeding with thromboprophylaxis in patients with atrial fibrillation: a net clinical benefit analysis using a 'real world' nationwide cohort study. *Thromb. Haemost.* 106(4), 739–749 (2011).
- 15 Lip GY, Andreotti F, Fauchier L *et al.*; European Heart Rhythm Association. Bleeding risk assessment and management in atrial fibrillation patients. Executive Summary of a Position Document from the European Heart Rhythm Association [EHRA], endorsed by the European Society of Cardiology [ESC] Working Group on Thrombosis. *Thromb. Haemost.* 106(6), 997–1011 (2011).
- 16 Pisters R, Lane DA, Nieuwlaat R, de Vos CB, Crijns HJ, Lip GY. A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the Euro Heart Survey. *Chest* 138(5), 1093–1100 (2010).
- 17 Gallagher AM, Setakis E, Plumb JM, Clemens A, van Staa TP. Risks of stroke and mortality associated with suboptimal anticoagulation in atrial fibrillation patients. *Thromb. Haemost.* 106(5), 968–977 (2011).
- 18 Mazzaglia G, Filippi A, Alacqua M *et al.* A national survey of the management of atrial fibrillation with antithrombotic drugs in Italian primary care. *Thromb. Haemost.* 103(5), 968–975 (2010).

Websites

- 101 Cobbe S (Ed.). Atrial fibrillation in hospital and general practice: the Sir James Mackenzie Consensus Conference. *Pro. Royal College Physicians Edinburgh* 39(3) (1999).
www.rcpe.ac.uk/journal/supplements/supplement-6.pdf
- 102 Stott DJ (Chair); Dewar RI, Garratt CJ, Griffith KE, *et al.* RCPE UK Consensus Conference on "Approaching the comprehensive management of atrial fibrillation: evolution or revolution?" 1–2 March 2012.
www.rcpe.ac.uk/clinical-standards/standards/rcpe-af-consensus-statement-2012.pdf
- 103 Royal College of Physicians of Edinburgh. Methodology for convening RCPE Consensus Conferences.
www.rcpe.ac.uk/clinical-standards/methodology.php