**Atrial Fibrillation: medicines: indications for stoppage of a stroke – what are the option**

**Personalised package of care and information**

Offer people with atrial fibrillation a personalised package of care. Ensure that the package of care is documented and delivered, and that it covers:

- stroke awareness and measures to prevent stroke
- rate control
- assessment of symptoms for rhythm control
- who to contact for advice if needed
- psychological support if needed
- up-to-date and comprehensive education and information on:
  - cause, effects and possible complications of atrial fibrillation
  - management of rate and rhythm control
- practical advice on anticoagulation in line with recommended NICE guidance and to work with patients using the Patient Decision Aid.

**Patient-centred care**

This guideline offers best practice advice on the care of adults (aged 18 and over) with suspected or diagnosed atrial fibrillation.

Patients and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these.

The NHS Constitution can be read or downloaded at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england

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**Updated Guidance on Atrial Fibrillation**

This article is intended to briefly summarise the most important changes from a patient’s perspective.

The full guidance can be read or downloaded at: https://www.nice.org.uk/guidance/CG180

NICE also developed a patient decision aid that may help you to decide whether to take anticoagulant to reduce your risk of stroke, and which treatment to take an anticoagulant to reduce the risk for you personally.

**This information is intended to help you reach a decision about which treatment to take an anticoagulant to reduce the risk for you personally.**

**Stoke risk**

1.1 Use the CHA2DS2-VASC stroke risk score to assess stoke risk in people with one of the following:

- symptomatic or asymptomatic paroxysmal persistent or permanent atrial fibrillation
- atrial flutter
- a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm.

**Bleeding risk**

1.2 Use the HAS-BLED score to assess the risk of bleeding in people who are starting or have started anticoagulation. Offer modification and monitoring of the following risk factors:

- uncontrolled hypertension
- poor control of international normalised ratio (INR) (table INRs)
- concurrent medication, for example concomitant use of aspirin or a non-steroidal anti-inflammatory drug (NSAID)
- harmful alcohol consumption.

1.3 When discussing the benefits and risks of anticoagulation, explain to the person that:

- for most people the benefit of anticoagulation outweighs the bleeding risk
- for people with an increased risk of bleeding the benefit of anticoagulation may not always outweigh the bleeding risk
- careful monitoring of bleeding risk is important.

1.4 Do not withhold anticoagulation solely because the person is at risk of having a fall.

**Assessment of stroke and bleeding risks**

**Interventions to prevent stroke**

**Anticoagulation**

1.5 Anticoagulation may be with apixaban, dabigatran etexilate, rivaroxaban or a vitamin K antagonist (warfarin).

1.6 The decision about whether to start treatment with apixaban should be made after an informed discussion between the clinician and the person about the risks and benefits of apixaban compared with warfarin, dabigatran etexilate and rivaroxaban. For people who are taking warfarin, the potential risks and benefits of switching to apixaban should be considered in light of their level of international normalised ratio (INR) control. (This recommendation is from Apixaban for preventing stroke and systemic embolism in people with nonvalvular atrial fibrillation (NICE technology appraisal guidance 275).) [2013]

**Dabigatran etexilate**

1.5 Dabigatran etexilate is recommended as an option for the prevention of stroke and systemic embolism within its licensed indication, that is, in people with nonvalvular atrial fibrillation with one or more of the following risk factors:

- previous stroke, transient ischaemic attack or systemic embolism
- left ventricular ejection fraction below 40%
- symptomatic heart failure of New York Heart Association (NYHA) class 2 or above
- age 75 years or older
- age 65 years or older with one of the following: diabetes mellitus, coronary artery disease or hypertension [This recommendation is from Dabigatran etexilate for the prevention of stroke and systemic embolism, in atrial fibrillation (NICE technology appraisal guidance 291).] [2012]

1.6 The decision about whether to start treatment with dabigatran etexilate should be made after an informed discussion between the clinician and the person about the risks and benefits of dabigatran compared with warfarin, apixaban and rivaroxaban. For people who are taking warfarin, the potential risks and benefits of switching to dabigatran should be considered in light of their level of international normalised ratio (INR) control. (This recommendation is from Dabigatran etexilate for the prevention of stroke and systemic embolism in people with nonvalvular atrial fibrillation (NICE technology appraisal guidance 275).) [2013]
INReview

1.5.10 The decision about whether to start treatment with Rivaroxaban should be made after an informed discussion between the clinician and the person about the risks and benefits of rivaroxaban compared with warfarin. For people who are taking warfarin, the potential risks and benefits of switching to rivaroxaban should be considered in light of their level of international normalised ratio (INR) control. [This recommendation is from Dabigatran etexilate for the prevention of stroke and systemic embolism in atrial fibrillation (NICE technology appraisal guidance 256)] [2012]

RIVAROXABAN

1.5.9 Rivaroxaban is recommended as an option for the prevention of stroke and systemic embolism within its licensed indication, that is, in people with nonvalvular atrial fibrillation. [new 2014]

Assessing anticoagulation with vitamin K antagonists (warfarin).

1.5.11 Calculate the person’s time in therapeutic range (TTR) at each visit. When calculating TTR:

- use a validated method of measurement such as the Rosendaal method for computer-assisted dosing or proportion of tests in range for manual dosing
- exclude measurements taken during the first 6 weeks of treatment
- calculate TTR over a maintenance period of at least 6 months. [new 2014]

1.5.12 Reassess anticoagulation for a person with poor anticoagulation control shown by any of the following:

- 2 INR values higher than 5 or 1 INR value higher than 8 within the past 6 months
- 2 INR values less than 1.5 within the past 6 months
- TTR less than 65%. [new 2014]

1.5.13 When reassessing anticoagulation, take into account and if possible address the following factors that may contribute to poor anticoagulation control:

- cognitive function
- adherence to prescribed therapy
- illness
- interacting drug therapy
- lifestyle factors including diet and alcohol consumption. [new 2014]

1.5.14 If poor anticoagulation control cannot be improved, evaluate the risks and benefits of alternative stroke prevention strategies and discuss these with the person. [new 2014]

1.5.15 Review of people with atrial fibrillation.

1.5.16 For people who are not taking an anticoagulant, review stroke risk when they reach age 65 or if they develop any of the following at any age:

- diabetes
- heart failure
- peripheral arterial disease
- coronary heart disease
- stroke, transient ischaemic attack or systemic thromboembolism. [new 2014]

1.5.17 For people who are not taking an anticoagulant because of bleeding risk or other factors, review stroke and bleeding risks annually and ensure that all reviews and decisions are documented [new 2014]

1.5.18 For people who are taking an anticoagulant, review the need for anticoagulation and the quality of anticoagulation at least annually, or more frequently if clinically relevant events occur affecting anticoagulation or bleeding risk. [new 2014]

*HAS-BLED is a scoring system to assess risk of stroke.

*CHA2DS2-VASc is a clinical scoring system to estimate bleeding risk in patients with atrial fibrillation.

1.5.19 Anticoagulation.

1.5.20 Antithrombotic therapy.

1.5.21 Reassessing anticoagulation.

1.5.22 Anticoagulation and bleeding risks annually, and other factors, review stroke risk when they reach age 65 or if they develop any of the following at any age:

- diabetes
- heart failure
- peripheral arterial disease
- coronary heart disease
- stroke, transient ischaemic attack or systemic thromboembolism. [new 2014]

1.5.23 For people who are not taking an anticoagulant because of bleeding risk or other factors, review stroke and bleeding risks annually and ensure that all reviews and decisions are documented [new 2014]

1.5.24 For people who are taking an anticoagulant, review the need for anticoagulation and the quality of anticoagulation at least annually, or more frequently if clinically relevant events occur affecting anticoagulation or bleeding risk. [new 2014]

AF REVALIDATION TOOL

The AF Revalidation tool, which was developed by the AF Association and AntiCoagulation Europe, is an online learning tool for GPs on AF to help drive the switch of AF patients from aspirin to OAC therapy. It has been designed to fulfill specific educational and audit requirements for GP revalidation. The tool logs all activity for the automatic creation of relevant revalidation portfolio content.

The tool can be found at: http://www.af-revalidation.org/

CALLING ALL TRAVELLERS – WE NEED YOUR HELP

We are updating our useful list of clinics and hospitals around the world where you can get your INR checked. We need that a change in diet and temperature can sometimes affect your INR. We rely on people telling us their experience so that we can list the information and help others.

We hope that the information will help you enjoy your travels whether they are business or pleasure.

If you have been abroad and had your INR tested please e-mail any information you may have to: inrtestabroad@gmail.com or phone 0208 289 6875

THANK YOU FOR YOUR HELP

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