NICE guideline (NG196) —
Diagnosis and management of atrial fibrillation:
Key recommendations for patients

In April 2021, in collaboration with the Royal College of Physicians (RCP), the National Institute for Health and Care Excellence (NICE) published a new guideline on the diagnosis and management of atrial fibrillation (AF) — updating and revising the guideline published in 2014. The aim of the guideline is to provide both healthcare professionals and patients with an overview of the optimal management of AF. This report summarises the key recommendations for patients.

Detection and diagnosis
- If a healthcare professional thinks you may have AF, because you have symptoms and/or you have had a stroke, they should manually check your pulse to identify if it is irregular. For more information on how you can check your own pulse, visit www.KnowYourPulse.org
- If they do identify an irregular pulse, they should use a 12-lead ECG to confirm the diagnosis (they should do this whether you have symptoms or not). This may mean being referred to another centre for the test.
- If a 12-lead ECG does not detect AF and a healthcare professional thinks you may have paroxysmal AF (i.e., AF comes and goes), they should arrange for a 24-hour ambulatory ECG monitor for further investigations. If your symptoms are more than 24 hours apart, they should give you an ambulatory ECG monitor, event recorder, or other ECG technology for an appropriate period.

Prevention of AF-related stroke
- After diagnosing you with AF (or atrial flutter) a healthcare professional should assess both your risk of an AF-related stroke and your risk of bleeding (specifically, your risk of bleeding if you are given anticoagulation medication to protect against AF-related stroke). They should discuss these risks with you and what they might mean for the management of AF.
- Your risk of an AF-related stroke is likely to be higher than your risk of bleeding, which means you are more likely to have an AF-related stroke without anticoagulation than you are to have a bleed while taking anticoagulation. However, if you do have a risk of bleeding, your healthcare professional should carefully assess this risk.
- If you are at risk of an AF-related stroke, and your risk of bleeding is considered acceptable (after discussion between you and your healthcare professional) you should be offered a direct-acting oral anticoagulant (DOAC). Four DOACs are currently available, and you and your healthcare professional should review and discuss which one best suits your needs (they are equally effective but have different dosing regimens).
- If you are already taking warfarin (an anticoagulant that requires regular blood checks), your healthcare professional should review with you (at your next routine appointment) the risks and benefits of switching to a DOAC.
• If your healthcare professional thinks you will have too many side-effects with a DOAC or a DOAC will interfere with other medications you may be taking (known as “contraindications”), you should be offered warfarin).

• If AF is no longer detectable, you should probably still receive anticoagulation. Any decision to stop anticoagulation should be based on your risk of an AF-related stroke/risk of bleeding rather than the current status of the AF.

• If you have contraindications to any anticoagulation medication (e.g., either warfarin or a DOACs), your healthcare professional should discuss with you the risks and benefits of a procedure called left atrial appendage occlusion (LAAO) as an option for protecting against AF-related stroke. According to NICE, you should not be offered LAAO unless you have clear contraindications to, or cannot tolerate, anticoagulation.

**Rate and rhythm control**

• Your healthcare professional should give you treatments to control your heart rate (known as “rate control”). They should discuss the risks and benefits of these treatments with you to help you understand the importance of taking them (and how and when to take them). However, in certain circumstances (such as they think the AF is reversible), you may be given treatments to restore your rhythm to normal (known as rhythm control) instead.

• If rate control does not work (i.e., you still have a high heart rate and/or you are still having symptoms because of the AF), your healthcare professional should explore with you the options for restoring your heart rhythm to normal.

• If drug treatment is unsuccessful at rhythm control, or is not tolerated, your healthcare professional should consider radiofrequency ablation. If they think this may be unsuitable, they should consider cryoballoon ablation or laser balloon ablation.

**Referral for specialised management**

• If treatment does not control your symptoms, your healthcare professional should refer you to a specialist (for example, an electrophysiologist — a cardiologist who specialises in heart rhythm disorders such as AF). NICE say this should be within four weeks after a “failed treatment” or the recurrence of AF after cardioversion treatment.

**Personalised package of care**

• Your healthcare professional, or medical team, should provide you with a package of care that is tailored to your individual needs and wants. This should include giving you information about the treatments and therapies you may be receiving and providing you with details of who to contact should you need further advice/psychological support if needed.

• At every step of the process of managing the AF, you should be involved in any decision about therapies and treatment. Your healthcare professional should explain the risks and benefits of any medication or procedure that they recommend. They should also be clear about the goal of the therapies/treatments that they are providing. For example, even if an ablation procedure is successful, you may need further procedures.
References

- NICE. Atrial fibrillation: diagnosis and management. NG196 2021: https://www.nice.org.uk/guidance/ng196 [Date accessed 18 June 2021].