AF Aware Week

AF Aware Week helps raise awareness of atrial fibrillation and this year highlights the importance of detecting via a simple pulse check, protecting against AF-related stroke through the use of appropriate anticoagulation and ultimately correcting the heart rhythm.

Key Messages

1. One in four people will develop AF; it affects an estimated 1.5 million across the UK and in excess of 16 million worldwide.
2. Every 15 seconds someone suffers an AF-related stroke. AF is the most powerful single risk factor for suffering a deadly or debilitating stroke.
3. AF can be detected cheaply and easily with simple manual pulse checks.
4. Treatment with an anticoagulant is vital to reducing the risk of stroke.
5. For AF Aware Week, make the detection and protection of AF a priority.

The aims of AF Aware Week are simple:

Detect:
A simple pulse check is the easiest way to detect the irregular heart rhythm. The importance of pulse checks should be widely publicised and undertaken both inside and outside of medical practices.

Protect:
AF is the single most relevant risk factor for stroke, increasing an individual’s risk five-fold and being responsible for at least 20% of all ischaemic strokes. AF-related strokes have the worst prognosis for severe disabling and mortality rates.

Identifying and treating AF at an early stage will deliver significant health and cost benefits.

Correct:
Early detection, diagnosis and appropriate medical management leads to fewer appointments and admissions, saving individuals from long term ill-health. Information regarding AF risks, symptoms and therapy options should be routinely made available to all suspected and diagnosed patients and their carers.

Patients should be monitored and reviewed within four weeks of initiation of therapy and referred for specialist consideration if first line therapy has not sufficiently improved symptoms.

INSIDE THIS ISSUE:

• AF Related stroke
Learn the signs and symptoms

• Fundraising champions!
Huge congratulations to all of you who have donated!

• Ask the Experts
Dr Dhiraj Gupta answers your questions

• Understanding your blood pressure
Recognising when you should seek further care
What can I do to help?
There are many ways to get involved with AF Aware Week:

1. Give information to your friends and family such as our Know Your Pulse information sheet and Know Your Pulse poster to educate on how to monitor your heart rhythm. AF Aware Week resources can be downloaded from www.afa.org.uk or contact t.murphy@afa.org.uk.

2. Display and share information about AF and the risk of AF-related stroke, importance of being anticoagulated and treatment to reduce symptoms of AF in your local centres which provide support and information. Our Know Your Pulse poster can also be found on the back page.

3. Share your story - AF Aware Week generates interest nationally, regionally as well as locally; share your story to help many others affected by atrial fibrillation - you can make a difference. Our Patient Services team are here to help by email: info@afa.org.uk or call: 01789 867502. Please contact us if you would be willing to share your story, it helps others going through similar experiences and reassures those who are just beginning their AF journey.

4. Volunteer your time and hold an AF Pulse Awareness event in collaboration with your local leisure centre, health centre or workplace. We have a large number of resources for such events; these can be downloaded from our website or contact t.murphy@afa.org.uk. Please contact us now and we can help you to help us spread the word.

5. Fundraise for us, for example by baking some goodies to sell, holding a coffee morning, quiz night or create your own event. You may also wish to become a Friend of AF Association.

6. Make a donation to enable us to continue to raise awareness and offer support by giving us a call on 01789 867502 or send a cheque to: AF Association, PO Box 6219, Shipston on Stour, CV37 INL.

Refer a Friend to AF Association!

Does AF also affect a friend, colleague or loved one? Newly diagnosed patients may not always be directed to us by their clinicians. You can help to extend our reach to those in need by referring a friend.

If you have found our advice and information helpful, and someone within your circle also has AF, please ask them to visit our website: www.afa.org.uk, call us for advice: 01789 867502 or email: info@afa.org.uk for more information.
The Future of Anticoagulation

NICE recently approved a new anticoagulant therapy called edoxaban (Lixiana) for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation. Edoxaban is an oral, once daily, direct factor Xa inhibitor. In trials, edoxaban was found to be non-inferior for stroke prevention and superior for the principal safety endpoint of major bleeding in comparison to warfarin.

With the launch of edoxaban the choice for people with AF to be protected against stroke has increased further. The national guideline puts the choice of anticoagulant firmly with the patient, this is re-enforced with the quality standard and the release of edoxaban that choice is widened and patients should choose which agent fits their personal situation the best, guided by their supervising clinician.

- Dr Matthew Fay, GPwSI

When choosing an anticoagulant there are many factors which need to be considered and it is best to discuss these with your clinicians. However, the table below gives a simple comparison between all of the recommended anticoagulants for AF.

A comparison of anticoagulants for atrial fibrillation

<table>
<thead>
<tr>
<th></th>
<th>Warfarin (Coumadin)</th>
<th>Dabigatran (Pradaxa)</th>
<th>Rivaroxaban (Xarelto)</th>
<th>Apixaban (Eliquis)</th>
<th>Edoxaban (Lixiana)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mechanism of action</strong></td>
<td>Inhibits Vitamin K's affects on coagulation</td>
<td>Direct thrombin inhibitor</td>
<td>Factor Xa inhibitor</td>
<td>Factor Xa inhibitor</td>
<td>Factor Xa inhibitor</td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
<td>Initial: 2 mg to 5 mg daily based on INR goal</td>
<td>150 mg twice daily</td>
<td>20 mg once daily with food</td>
<td>5 mg twice daily</td>
<td>60 mg once daily</td>
</tr>
<tr>
<td><strong>Onset</strong></td>
<td>36-72 hours</td>
<td>30 minutes - 2 hours</td>
<td>2.5 - 4 hours</td>
<td>1 - 3 hours</td>
<td>1 - 2 hours</td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
<td>Long term healthcare experience. Reversible with Vitamin K</td>
<td>Routine monitoring is not required</td>
<td>Routine monitoring is not required</td>
<td>Routine monitoring is not required</td>
<td>Routine monitoring is not required</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td>Regular INR monitoring required. Dose adjustment may be needed. Numerous drug food interactions</td>
<td>Not reversible - At least annual review Can not be used in valvular AF or with mechanical heart valves</td>
<td>Not reversible - At least annual review Can not be used in valvular AF or with mechanical heart valves</td>
<td>Not reversible - At least annual review Can not be used in valvular AF or with mechanical heart valves</td>
<td>Not reversible - At least annual review Can not be used in valvular AF or with mechanical heart valves</td>
</tr>
<tr>
<td><strong>Adverse effects</strong></td>
<td>Bleeding, haemorrhage, necrosis, purple toes syndrome</td>
<td>Necrosis, purple toes syndrome, Dyspepsia, bleeding, possible increased risk of MI</td>
<td>Bleeding, haemorrhage, haematoma</td>
<td>Bleeding, haemorrhage, nausea, vomiting, constipation</td>
<td>Bleeding, nausea, vomiting, confusion</td>
</tr>
<tr>
<td><strong>Management prior to surgery (always mention that you are on an anticoagulant prior to any procedure)</strong></td>
<td>Discontinue warfarin 5 days before surgery</td>
<td>Discontinue dabigatran 1 to 5 days before procedure or longer depending on procedure</td>
<td>Discontinue rivaroxaban at least 24 hours before surgery</td>
<td>Discontinue apixaban at least 24 hours before surgery</td>
<td>Discontinue edoxaban at least 24 hours before invasive or surgical procedures</td>
</tr>
</tbody>
</table>

AF Association has produced booklets and fact sheets which provide more information regarding anticoagulation. Available titles are:

Blood Thinning in AF
Apixaban
Dabigatran
Edoxaban
Rivaroxaban
Coming in 2016: Updated Drug Information for AF booklet

To order your copies please email info@afa.org.uk or call 01789 867502.
Signs and symptoms of AF-related stroke

Every minute counts during a stroke. By knowing the signs and symptoms of stroke you can take action quickly. Signs and symptoms include:

• Sudden weakness or numbness of the face, arm or leg, particularly on one side of the body
• Difficulty walking, lack of coordination of balance, dizziness
• Slurred speech or difficulty speaking, confusion
• Sudden loss or blurring of vision
• A sudden and severe headache
• Loss of consciousness

The consequences of stroke due to AF

- 30% Don’t survive the stroke
- 30% Don’t survive 12 months post stroke
- 16% Will not return home
- 24% Survive, able to return home

Call 999 and ask for an ambulance immediately if you or someone else has these symptoms. Even if the symptoms pass, you should still go to hospital for assessment by a medical professional.

Become a Friend of AF Association

For just £15 per year or £2 per month, you can become a Friend of AF Association and not only help us continue to help others, but also receive:

- Free copies of our patient information resources
- Monthly e-news
- A dedicated telephone help line and email service
- Opportunities to attend local and national meetings
- Help in locating arrhythmia healthcare specialists
- Printed copies of our bi-annual newsletter

For more information please contact us on:
☎️ +44 (0) 1789 867502
✉️ info@afa.org.uk
🌐 www.afa.org.uk

Post to:
AF Association
PO Box 6219
Shipston on Stour
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Go online: www.afa.org.uk • info@afa.org.uk
Anticoagulation reports

In June 2015, a report called ‘The future of anticoagulation management in atrial fibrillation in Europe’ was launched as an assessment of today’s challenges, with recommendations for the future. Last November AF Association and Anticoagulation Europe launched a landmark report to raise awareness amongst policy makers of the growing burden posed by strokes due to atrial fibrillation.

To read these reports please visit www.afa.org.uk or email info@afa.org.uk. AF Association has created fact sheets for all of the anticoagulants. To order a copy please email info@afa.org.uk or call 01789 867502.
Treatment for AF has come a long way over the last 20 years. How do you see treatment for AF evolving over the next 10 years?

Although stroke-risk stratification has improved immensely over the past 10-20 years with the use of CHADS2 and CHA2DS2VASc scoring systems, these tools remain rather imprecise. For instance, many physicians have treated unfortunate AF patients who have suffered from stroke in spite of low CHA2DS2VASc scores. As such, we need to do better in individualizing oral anticoagulation prescription for AF patients by assessing their stroke risk more accurately. This assessment may involve gene tests, and or blood tests for markers of inflammation and clotting. I see this individualised risk assessment and anticoagulation prescription becoming more refined over the next 10 years.

The anti-arrhythmic medication sotalol has fallen out of favour for atrial fibrillation since the new NICE guidelines. European, American and even some doctors in the UK still prescribe it. Can you explain why it is no longer recommended and how one should react when asking the doctor about the prescription?

Some physicians consider sotalol as just another beta-blocker, whereas in actual fact, it is a potent antiarrhythmic drug that shares the potential of causing pro-arrhythmia through prolonging the QT interval with other similar drugs such as flecainide and amiodarone. The NICE AF guideline has made this distinction between a standard beta blocker and sotalol very clear. In particular, it has stressed that sotalol should not be used solely for rate control. Even for rhythm control, a standard beta blocker should be the drug of first choice because of better safety profile. Should AF not be adequately controlled with a standard beta blocker, then a more potent antiarrhythmic drug can be used, which includes sotalol. This recommendation is in line with the European and American scientific guidelines too. It is recommended that patients who are started on sotalol get an ECG performed within a week to ensure that they have not developed significant QT interval prolongation as a result. Furthermore, patients on sotalol (and other antiarrhythmic drugs) should avoid taking other medications that can increase the QT interval.

What are the criteria which might prompt a shift in focus from ablation with an EP cardiologist to a modified maze procedure with a cardiothoracic surgeon?

There have been encouraging advances in both catheter ablation and surgical ablation techniques for AF over the past few years. In experienced hands, the two approaches should be comparable in terms of efficacy. Given that surgical ablation remains more invasive than catheter ablation with greater morbidity and a longer hospital stay, at present it is usually reserved for more complex AF patients. These include those who have long standing persistent AF, particularly if catheter ablation has been unsuccessful, or in those patients in whom pulmonary veins are not accessible to the cardiologist, for instance if there is a septal occluder device in place. One possible advantage of a surgical modified maze procedure over catheter ablation is that it should be possible to ligate the left atrial appendage in the former; this intervention may reduce the subsequent risk of stroke and possibly of AF recurrence, although this remains to be proven.

I am 73 with paroxysmal AF. I live a normal life thanks to my medications and warfarin. I travel regularly to Europe by plane or train but am considering travelling to the US. Will I be able to travel long distance or should this be avoided?

You mention that you lead a normal life on medication, which suggests that your AF is well controlled. As such there should be no issues in you travelling long distance. You will obviously need to declare your condition on your travel insurance. Also, if you have identified any clear triggers for your AF episodes, for example, heavy alcohol intake, you may wish to avoid these triggers while you are overseas.

Dr Dhiraj Gupta is a Consultant Cardiologist and Electrophysiologist at The Liverpool Heart & Chest Hospital. He has special clinical interests in curative catheter ablation for all heart rhythm disorders, especially atrial fibrillation.
When arrhythmias are successfully controlled by drugs such as flecainide, for many people the condition still progresses in spite of the antiarrhythmic drugs. During such treatment, do the rogue electrical signals continue to fire but the heart’s cells do not react because of the drug treatment? If so, what causes the signals to get to the point where they may overwhelm the drug’s effects - do they just become stronger or better established?

Antiarrhythmic drugs decrease the rate and frequency of firing of the ‘rogue signals’ that are mostly found in the pulmonary veins. If the underlying risk factors are not controlled, for example through inadequate control of blood pressure or body weight, the firing of these triggers continues to progress till such time that they overwhelm the drug’s effects.

I am a 56 year old male, I have a severely enlarged left atrium, and PVC’s under load. I am taking 1.25 mg bisoprolol, and have been training for triathlons - about 15 hours a week. Now I have been told to go easy. What would be considered easy and would a maximum heart rate number help me?

Given the various issues involved, it would be impossible to give individualised clinical advice via this forum. Under circumstances where you have concurrent conditions, it is always advisable to discuss these with your own specialist. If you have not yet seen a specialist, then please ask your GP for a referral. You may also wish to join the AF Association online forum: www.healthunlocked.com/afassociation.

I am 67 years old and I was diagnosed over 10 years ago with paroxysmal AF. I take a low dose of aspirin every day and when I get an attack I take flecainide. I have spoken to my GP on a few occasions and have been told to carry on with the aspirin. I had 5 AF attacks last year, the longest lasting 29 hours but this year so far I have had only 1 attack lasting 28 hours. Do I continue with the aspirin or should I take something else?

If you do not suffer from high blood pressure or diabetes, and provided you have not suffered from previous heart attack or stroke, then your risk of AF-related stroke should be only low to moderate (less than 1% per year). This has to be counterbalanced against the increased risk of serious bleeding with warfarin or one of the NOACS of around 2% per year. According to the latest NICE AF guidance, while patients such as you could be considered for stronger blood thinning drugs than aspirin, the recommendation is not a strong one, and dependent upon patient preference.

I’m currently taking dronedarone following a complicated ablation 18 months ago. All is well, apart from short bursts of ectopic beats from time to time. It seems to be a fantastic drug, and has fewer side effects than amiodarone, which I will not take. I have been experiencing sudden, very deep, spontaneous gasps which occur singly and completely randomly. It is very worrying to people around me, since it looks and sounds very startling. Is this something to be concerned about?

I am sorry that I am not in a position to comment about these symptoms based on the description alone. What I would advocate is that you undergo mobile ECG monitoring so that symptom-ECG correlation can be obtained. Please speak to your GP regarding your concerns to arrange this.

After suffering two TIAs I was given a 24hr heart monitor. I was told it showed an episode of AF and I was eventually put on dabigatran and bisoprolol. I later saw a cardiologist who doubted that I had AF. He arranged an echocardiogram and stress test which did not show much so I was taken off bisoprolol. I’m still unsure if I have AF and have never seen an EP. My stroke doctor was convinced my TIA’s were caused by paroxysmal AF. Is it possible I do have AF?

I would recommend that you get your 24 hour monitor traces reviewed by an electrophysiologist. If there is uncertainty about the diagnosis, you could even consider having an implantable loop recorder fitted. Given the fact that you have suffered 2 TIAs and have had AF diagnosed, I would be inclined to continue dabigatran till such time that this diagnosis is confidently excluded.

To read more questions and answers please visit the ‘Ask The Experts’ area of the website: www.afa.org.uk
My name is Graham, and although born and raised in Warwickshire, I have lived on the Orkney Islands with my wife and family for the past 40 years. A retired surveyor, soon to celebrate my 67th birthday, I own a small 70 acre farm where I keep beef cattle. I was first diagnosed with atrial fibrillation almost four years ago after contracting a flu virus which affected my lungs and heart. The symptoms indicated a condition called pericarditis which causes the heart lining to become inflamed.

Exercise and sport have always formed an important part of my life and my main activities have included quite intense cardio exercises, rugby, running and hill walking among others. I was still working as a part-time fitness instructor at the local gym, and training quite strenuously for a 110 mile cycling sportif at the time of the virus.

Ironically my wife would sometimes say after a day’s physical work on the farm or a training session “there’s nothing wrong with your heart”. Still a fit man with a regular resting heart rate below 60bpm, I suddenly found myself in an episode of AF. I had always felt fit and healthy prior to this, despite borderline high blood pressure and moderate sleep apnoea (the latter condition having been dismissed by a specialist as I was never sleepy during the day). It is only since that I have learned that these conditions could be factors of AF.

The biggest surprise however, was to be told by a cardiologist that intense exercise could also cause this heart rhythm disorder, and that ageing athletes were often candidates for fibrillation. Having been so fit, I found it difficult to accept, and although I felt unwell physically, the mental effect was worse.

After a few months, my heart remained in permanent AF, and although I tried cardioversion, this proved unsuccessful. My cardiologist thought I might be a person who could live satisfactorily with “Still a fit man with a regular resting heart rate below 60bpm, I suddenly found myself in an episode of AF” AF, providing the rate was controlled, and I was prescribed beta blockers, a blood pressure tablet, and warfarin. I reassure myself that my condition is now fairly consistent. I do not have the constant worry of my heart periodically going out of sinus rhythm, along with the disappointment and health changes that would bring.

After taking two holter monitor tests, on both occasions my heart rate maximum recorded 260bpm while I was exercising which is far too high. The strange thing is I did not feel ill or faint at these levels. I was however requested to stop intense exercise which I have done. My lowest reading over twenty four hours was only 27bpm recorded whilst sleeping. Although I am still interested in finding an alternative drug to beta blockers if there is a medication that could control my rate better during periods of physical exertion, I feel so normal at present that it may be better to leave well alone.

“My lowest reading over twenty four hours was only 27bpm recorded whilst sleeping.”

Initially the beta blockers caused tiredness, I now seem to have no side effects from my medication and my local practice does an efficient job in checking my INR levels regularly. My life is now very much back on track and I have begun to realise how fortunate I am to feel normal and capable of carrying out all the necessary physical tasks on the farm such as calving cows, erecting fences etc.

My message to other AF sufferers is do not get too despondent. Investigate and discuss the different options available. Persevere if on medication, and remember, if you are prepared to make minor adjustments, there is no reason in most situations you cannot enjoy a normal life.

Graham, Orkney (2015)
Christine’s Story - Early Palpitations

Christine first experienced palpitations in her 30s but was only diagnosed by chance in her late 50s. Here she tells her story of how seeing the appropriate expert can make all the difference.

I was in my early 30s when I had my first palpitations. I was fit, active and sporty. I found it very frightening. I went to my GP who assured me that ‘it happens to everyone’ and not to worry about it. So I didn’t!

By the time I was in my early 50s it was happening more and more frequently and lasting longer. I had learned the triggers; all the usual culprits – caffeine, alcohol, stress, tiredness, dehydration and I tried to avoid them. I even went back to my GP and had a couple of 24 hour ECGs but nothing ever showed up when I was wearing the monitor. Once again I was told not to worry about it.

One afternoon, just before I was 60, I started having more palpitations which lasted all night. My heart was still racing and irregular the next morning. In desperation I went to the surgery (without an appointment) saying “Look it’s happening right now”. Luckily I knew the receptionist who fitted me in with the practice nurse. She immediately gave me an ECG. Suddenly everyone started to worry! I saw my GP straight away; he prescribed sotalol and discussed anticoagulant treatment. I was referred to a specialist who diagnosed paroxysmal AF.

For 2 years I took Sotalol which worked well, but as time went on I had more and more unpleasant side effects. I dislike taking any medication and I knew I couldn’t continue like that. I was tired all the time, very bad tempered, putting on weight (which made me even more bad tempered!) and pretty depressed.

At that point I read about catheter ablation thanks to the AFA Today magazine. A little research sent me to an Electrophysiologist at a centre of excellence. This wonderful Electrophysiologist and his superb team have really changed my life.

After 3 ablations (2 for AF and 1 for SVT) I appear to be cured. I have stopped taking Sotalol and I have also chosen to stop Warfarin (as in my case the stroke risk is low).

I would encourage anyone to go for catheter ablation where suitable. Be prepared that more than one procedure may be required to completely clear the problem. It is nothing to worry about and the recovery time was very quick for me.

“I feel 20 years younger, have lost all the excess weight and once again can enjoy the outdoor life I love.”

For my 67th birthday last year, I was given a two-seater inflatable canoe. My husband and I went for a maiden voyage along the Dorset coast for 6 hours. What an adventure, something I could only have dreamt about a few years ago. There really is life after atrial fibrillation.

Christine, Somerset (2015)
Fundraising Champions!

A huge thank you to everyone who participated in the AF Association 2015 Raffle, which raised over £1000 for AF Association.

Why would 5 otherwise sane Daichi Sankyo staff attempt to run half a marathon across Oxfordshire hills through knee-high, thick mud, swim through ice-filled skips, attempt to climb obstacles higher than the average house, and worse? To raise as much money as possible for people with atrial fibrillation. Thank you all so much for your amazing efforts which with employee matched giving made the total raised a fantastic £3230.

Andrew & Liz took to the hills to raise over £200 for the charity close to their heart. The pair completed the Trek Fest Challenge in the top 20%, a great achievement, thank you for choosing AF Association.

We were delighted to be chosen as charity of the month by Royal Bank of Scotland in Edinburgh in April. After holding various events throughout the month, the bank raised over £1000 for AF Association. Thank you for your tremendous support.

Wow and thank you to David & Louise who took on the infamous 100km London to Brighton Challenge to raise £1100 for AF Association.

Do something amazing and jump for AF Association! Combine the most exciting and exhilarating moment of your life with raising funds for a worthy cause and be a part of a Guinness World Record in 2016, by completing a tandem skydive from nearly 3 miles above the earth! Please visit our website or call 01789 867502 for more info.
Your easy guide to understanding your blood pressure

Changes in blood pressure can be a contributing factor to atrial fibrillation and with an increase in the use of home blood pressure monitors, patients frequently ask if their blood pressure results are normal, or if they should contact their GP for follow up. This easy-to-follow guide is designed to give an indication on if and when you should seek further care.

Blood pressure readings have two numbers. The higher number is your **systolic pressure** – when your heart beats and pushes blood around the body. The lower number is your **diastolic pressure** – when your heart rests between beats. It can be very difficult to get an accurate blood pressure reading when in atrial fibrillation. For this reason, it is advisable to take three readings and take an average from all three.

NICE guidelines support the use of the ‘WatchBP Home A’ device which can also detect atrial fibrillation whilst blood pressure is being measured. The chart below shows the various categories blood pressure can fall into. If only one of the two numbers is either lower or higher than it should be, then your blood pressure may need attention. A high reading may be perfectly normal during stress or exertion but if you suspect that you may have either low or high blood pressure, please seek further advice from your clinician. NICE recommends a 24 hour blood pressure monitor to identify if further treatment is required.

<table>
<thead>
<tr>
<th>Blood Pressure Category</th>
<th>Systolic (Higher number)</th>
<th>Diastolic (Lower number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Blood Pressure</td>
<td>&lt;90</td>
<td>&lt;60</td>
</tr>
<tr>
<td>Normal</td>
<td>&lt;120 and</td>
<td>&lt;80</td>
</tr>
<tr>
<td>Pre-hypertension</td>
<td>120-139 or</td>
<td>80-89</td>
</tr>
<tr>
<td>High Blood Pressure (Stage 1)</td>
<td>140-159 or</td>
<td>90-99</td>
</tr>
<tr>
<td>High Blood Pressure (Stage 2)</td>
<td>160&gt; or</td>
<td>100&gt;</td>
</tr>
<tr>
<td>Hypertensive (Urgent care required)</td>
<td>180&gt;</td>
<td>110&gt;</td>
</tr>
</tbody>
</table>

**Treating low blood pressure (Hypotension)**
If your GP feels that there is a treatable underlying cause for your low blood pressure, they will be able to offer the appropriate treatment option for you. The treatment will vary from person to person depending on symptoms and the reasons why the individual may be experiencing hypotension.

**Treating high blood pressure (Hypertension)**
Changes to your diet and increasing physical activity can help to improve your blood pressure but you may still require medications to lower it further. There are a wide range of blood pressure medications available. Your GP will be able to advise you which medication may be right for you.

**Further information**
For further information and advice please contact AF Association:

*Email: info@afa.org.uk Phone: 01789 867502*
The Route Map for the prevention of AF-related stroke

Last November, the Arrhythmia Alliance and AntiCoagulation Europe launched a landmark report that aims to raise awareness amongst policy makers of the growing burden posed by strokes due to atrial fibrillation (AF).

Trudie Lobban, from the Arrhythmia Alliance, Professor John Camm from St Georges University of London, and Eve Knight, from AntiCoagulation Europe, formed the steering committee which oversaw the development of the report.

The first-ever atlas on AF-related stroke across Europe

The report contains a first-ever atlas on how each country is addressing the challenges posed by AF-related stroke, in the form of 27 individual country profiles.

A wake up call for policy makers

The report is a powerful reminder that efforts are still needed to better understand the increased risk of stroke in people with AF, and to ensure that AF patients in all countries have equitable access to appropriate anticoagulation treatment and care to help reduce their risk of stroke.

The urgent need for action

Much could be done to reduce the burden posed by AF-related strokes

At least 1 in 5 strokes is due to AF, more in some countries

360,000 strokes per year are due to AF in the EU

#2 risk

AF is the 2nd most important risk factor for stroke after blood pressure

€38 billion is spent per year treating strokes in the EU

x2 by 2050

The prevalence of AF to double

10-45% of AF cases may be undetected

40% Up to 40% of AF patients do not receive OAC therapy

2 / 27 Only 2 out of 27 EU countries have dedicated national strategies

3 / 27 Only 3 countries have dedicated AF registries

Simple screening tools are underused

2 / 27 Only 2 out of 27 EU countries have dedicated national strategies

3 / 27 Only 3 countries have dedicated AF registries

If you have not seen it already...
Key findings: how do different countries compare?

We still don’t know the full size of the problem

One of the key findings from the 27 country profiles is that reliable data are generally lacking to estimate the true burden of AF-related stroke – and that this burden may well be even greater than suggested in existing studies.

“The more you look, the more you find.”
Professor John Camm

The proportion of strokes due by AF higher than expected

The international literature suggests that 1 in 5 strokes is due to AF. However, data from several countries suggest that this proportion may be far higher – although data are only available in a few countries, and estimates vary by country.

Cost of AF-related strokes is high, but data are rare

AF-related strokes are more expensive, fatal and disabling than strokes not due to AF. However, there are very limited estimates of the costs associated with AF-related stroke across Europe – although what data do exist confirm that AF-related strokes are more debilitating and costly than strokes not due to AF.

Too many patients still do not receive guideline-recommended therapy to help prevent stroke

- In 13 out of 20 countries where data were available, up to 40% of patients do not receive oral anticoagulation therapy
- In almost all countries, there is over-reliance on aspirin – even if it is no longer recommended by ESC guidelines as effective at reducing the risk of stroke in people with AF.
What can policymakers do?

On the basis of the findings of the Atlas, the authors propose 7 priorities for action for governments to help improve the prevention of AF-related strokes across Europe:

1. **Targeted policies and resources** to enable the effective prevention of AF-related stroke

2. **Greater public awareness** of AF and the increased risk of stroke with AF

3. **Improved detection of AF** and integration of pulse checks into clinical practice

4. **Appropriate anti-coagulation therapy** for every AF patient at increased risk of stroke

5. **Patient-centred care** and clear information to patients

6. **A whole-system approach** to the prevention of AF-related stroke

7. **Better data** to guide policy and inform clinical management

To find out more and access the full report:

The full interactive PDF of the report can be accessed here:
Self-Monitoring

Talk to your Health Care Professional about INR Self-Monitoring:

If you would like to become more involved in self-monitoring your INR whilst taking warfarin, having a conversation with the GP/health care professional managing your anticoagulation is the first step. Your GP/health care professional is in the best position to help you achieve and maintain good health.

Consider and write down the information you would need to make an informed decision including:

<table>
<thead>
<tr>
<th>The reasons why you would prefer to self-monitor your INR</th>
<th>Any concerns you may have about your current testing frequency</th>
<th>Any other questions you may have</th>
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Be prepared to discuss your lifestyle, diet, additional medications and if you are taking any herbal supplements. If you find visiting the clinic inconvenient, you could also discuss this. The more information you can make available, the better informed your GP or health care professional will be to help support your decision. You may want to consider bringing along a friend, relative or carer to the discussion, if they will be supporting your self-monitoring.

Is self-monitoring your INR right for you?

1. Are you able to follow your doctor’s recommendations and prescription guidance easily?
2. Do you live or work far from the clinic or your doctor’s surgery?
3. Do you have a busy schedule that makes it difficult to attend appointments?
4. Are you physically capable of performing a test by taking a finger prick blood sample, or do you have a carer that could assist you?
5. Do you dislike or have difficulty providing a blood sample from a vein?
6. Would you like to spend less time at the doctor’s surgery, clinic or hospital?

It is essential to be interested and motivated to monitor your own INR. If you can answer YES to most of these questions, it is likely that you will benefit from self-monitoring.

Points to Remember:

- Self-monitoring your INR is easy to undertake and may enable you to test more frequently. This can improve your time in range and ultimately improve the quality of your treatment control¹.
- NICE (National Institute for Health and Care Excellence) has recommended INR self-monitoring for children and adults who have atrial fibrillation or heart valve disease and are on long-term vitamin K antagonist therapy (anti-coagulants, like Warfarin), as long as the individual prefers this form of testing and they are able to self-monitor effectively (or have a carer/ relation that is able to)².

2. NICE Diagnostics Guidance: Self-monitoring coagulation status in people on long-term vitamin K antagonist therapy who have atrial fibrillation or heart valve disease: point-of-care coagulometers (the CoaguChek XS system and the INRatio2 PT/INR monitor) (August 2014)
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