PREVENTION OF ATRIAL FIBRILLATION RELATED STROKE
Position Statement 2016/17

This position statement is intended to support the implementation of NICE guidance[1] for the prevention of atrial fibrillation (AF)-related stroke across London:

DETECT!

Across London AF is under-detected, with an estimated 68,000 patients with AF currently undiagnosed[2]

1. **People with AF should be identified through opportunistic pulse checks**, targeted particularly at those aged over 65 years and those on chronic disease registers. New technologies, such as AliveCor and Watch BP Home A, should be considered to improve the identification of AF.

PROTECT!

Across London, of those diagnosed with AF and identified as at risk of stroke, 29% are not receiving anticoagulant therapy.[3]

2. Stroke risk assessment should be undertaken **in all people with AF (including paroxysmal AF, or those post cardioversion or ablation)** using the CHA_2DS_2VASc risk assessment tool at least annually.[4]

3. All people with AF with CHA_2DS_2VASc score ≥ 2 should be offered anticoagulant therapy. Anticoagulation should also be considered for men with a CHA_2DS_2VASc score = 1.

4. People requiring anticoagulation for the prevention of AF-related stroke should be offered all NICE approved options, including warfarin and the direct oral anticoagulants (DOACs).[5,6] The patient and clinician should have a full discussion regarding the benefits and risks of all the agents available in order to make an informed decision about the most suitable option. This decision should take into account the licensed indications, patient characteristics and patient preferences.

5. The HASBLED score should be used to identify modifiable risk factors for bleeding which can be addressed to minimise bleeding risk during anticoagulant therapy.[4]

PERFECT!

In 2014, of 1,290 patients admitted to London hospitals with stroke and with known AF prior to admission – 812 (63%) were not prescribed anticoagulant therapy.[7]

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[1] NICE 2014 CG180: Atrial Fibrillation: Management
[2] QOF 2015; NCVIN 2015; UCLP 2015 Position statement: Opportunistic Screening for Atrial Fibrillation
[3] QOF 2015
[4] CHA_2DS_2VASc is a scoring system used to assess stroke risk in AF and HASBLED is used to assess bleeding risk to inform decisions regarding anticoagulation. Details of CHA_2DS_2VASc and HASBLED can be found at http://www.chadsvasc.org/
[5] Previously known as non-vitamin K oral anticoagulants [NOACs]
[6] DOACs are only licensed for the prevention of AF-related stroke in patients with **non-valvular AF**. Patients with a prosthetic mechanical valve or those with known moderate to severe mitral stenosis are therefore exclude from treatment with a DOAC
[7] SNNAP 2014

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6. **Aspirin (with or without clopidogrel) is not a suitable alternative to warfarin or DOACs for prevention of atrial fibrillation-related stroke,** as it offers significantly less protection against stroke. People currently treated with aspirin for stroke prevention in AF should be reviewed with a view to initiating anticoagulant therapy.

7. **All people with AF at risk of stroke should be reviewed annually to ensure optimal anticoagulant therapy. Priority groups for review are:**
   - People with AF currently treated with aspirin or an alternative antiplatelet agent
   - People with a warfarin allergy, warfarin specific-contraindication or are unable to tolerate warfarin therapy due to severe adverse effects
   - People who are unable to comply with the specific monitoring requirements of warfarin
   - People who are unable to achieve a satisfactory international normalised ratio (INR) after an adequate trial of warfarin (usually at least 3 months) despite compliance with drug therapy and INR monitoring appointments.
     Anticoagulant therapy should be reviewed in people with
     - 1 or more INR result > 8 within the last 6 months
     - 2 or more INR results > 5 in the past 6 months
     - 2 or more INRs < 1.5 in the past 6 months
     - INR <65% time in therapeutic range (TTR) over the past 6 months

     Reasons for poor control should be identified and addressed, including non-adherence, cognitive ability, drug, food or alcohol interactions or concurrent illness.
   - People who have had an ischaemic stroke whilst stable on warfarin therapy

   There are a number of potential options for consideration following a review, these include but are not limited to: alternative INR monitoring arrangements (e.g. self-testing), patient education / adherence counselling, switching to an appropriate alternative oral anticoagulant agent, referral for consideration of left atrial appendage occlusion device.
   The rationale behind treatment decisions and the outcome of any change in therapy should be fully documented in the patients' notes.

8. **Initiation of oral anticoagulant therapies should be undertaken by clinicians in primary or secondary care who are competent in managing anticoagulation**. This clinician is responsible for the safe prescribing of anticoagulation, including ensuring the most appropriate drug and dose is initiated after consideration of patient preferences.

9. **When initiated outside the GP practice**, the GP should receive adequate communication regarding the indication, drug, dose and frequency prescribed, initial supply given, creatinine clearance and monitoring requirements before the transfer of prescribing responsibility.

10. **Efforts should be made to identify patients requiring additional support to ensure long-term adherence to therapy.** Appropriate support should be offered, including referral to a community pharmacist for the New Medicines Service (NMS) / Medicine Use Review (MUR).