

# NEWLY DETECTED ATRIAL FIBRILLATION

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# NEWLY DETECTED ATRIAL FIBRILLATION

68 y/o woman complains of

- generalized fatigue
- mild DOE
- “never eats” but keeps gaining weight
- symptoms going on for “some time”

Last seen 2 years ago (BP 152/68)

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- Exam:
- slightly overweight
  - HR 90, irregular
  - BP 164/80
  - RR 22
  - heart sounds distant
  - mild pretibial edema

ECG: Afib rate 90-100, LVH

WHAT TO DO ?

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## QUESTIONS

Outpatient Management or Admit?

What Tests are Indicated?

Rate Control?

Anticoagulate?

Rhythm Control?

Referral?

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## Reasons to Admit:

- severe sx. (resp. distress, angina)
- severe volume overload (IV diuretics)
- marked tachycardia (HR >130)
- recent neurological symptoms
- Acute Afib (?)

This patient can be evaluated as an outpatient.

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## Goals for today's visit:

1. Initiate appropriate work-up
  - risk-stratify
2. Control Heart Rate
3. Initiate appropriate anti-coagulation
4. Relieve symptoms
  - relieve volume overload
  - control heart rate
  - ? Control rhythm?

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## Minimum Evaluation of Newly Detected AFIB:

- ECG
- History (reversible factors, risk-factors for stroke)
- CXR if dyspnea or abnormal lung exam
- ECHO
- Thyroid function, metabolic panel

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## Additional Investigations of *Selected* Patients:

- Exercise stress test – CAD, HR control
- Holter or Event Recorder
- TEE – to identify LA thrombus
- EP study

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## What to do about Heart Rate?

### Adequate Rate Control:

- resting HR  $\leq$  80
- moderate exercise (6 min walk)  $\leq$  110
- 24 Hr. Holter – Avg. HR  $\leq$  100

This patient's resting HR is inadequately controlled

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## Heart Rate Control

Beta-Blockers: best for controlling exercise HR

- excellent for patients w/ LV dysfctn

Verapamil / Diltiazem: very good for HR control

- not good if LV dysfctn

Digoxin: helps resting HR, however little benefit for controlling exercise HR

- helpful in some CHF patients
- 2<sup>nd</sup> line agent

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Should this patient be anticoagulated?

## Risk-Factors for Cardioembolic Stroke:

- previous TIA/Stroke
- Hypertension (current or remote)
- DM
- CHF / LV Dysfunction
- Age >75

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Should this patient be anticoagulated?

	<u>Annual Stroke Risk</u>
Lone Afib, age <65	<1%
Afib + risk factor(s)	5%
Afib + prior stroke*	12%

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Should this patient be anticoagulated?

- ❖ Low-risk patients ( $\leq 2\%/year$ ): ASA
- ❖ Intermediate/High-risk patients: Coumadin

Coumadin: 1000 pts. 30 CVA prevented (6 major bleeds)  
Risk Reduction 69%

ASA: 1000 pts. 12.5 CVA prevented  
Risk Reduction 22%

Ximelagatran very likely to replace coumadin by the end of the year

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Should this patient be anticoagulated?

Age < 65, no risk factors – ASA

65-75, no risk – ASA or coumadin

Any Age, (+) risk factors - coumadin

Age > 75 – coumadin

\*Ximelagatran very likely to replace coumadin by the end of the year

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## Should You Restore Sinus Rhythm?

- Rate of stroke & death are no better with rhythm control than with rate control and anticoagulation
- Exercise capacity slightly better in rhythm control group, although “sense of well-being” equivalent
- Current anti-arrhythmics relatively ineffective, have significant toxicity
- Silent paroxysms of Afib common, may present as stroke


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## Consider Restoring Sinus Rhythm:

- Reversible precipitant identified / treated.
- Symptomatic despite rate control.
- Difficulty controlling HR when in Afib.
- Contraindication to anticoagulation.
- *Possibly* younger patients, those with first episode that is easily converted.

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## When to Refer:

- When you are uncomfortable with management.
  - Restoring sinus rhythm important (symptomatic, anticoagulation contraindicated).
  - Difficulty controlling HR.
  - Significant underlying heart disease
  - Wolfe-Parkinson-White
  - As new therapies develop.
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## How I would treat this Patient in the Office:

- Begin low-dose beta-blocker.
- Begin Coumadin 4-6 mg daily (INR 2-3).  
-close f/u, keep INR > 2
- Begin Diuretic (+/- potassium)
- TFT, BMP, CBC
- ECHO / CXR
- Stress ECHO or Cardiolite
- Return 7-10 days