West Yorkshire Atrial Fibrillation (AF) AF WAY Project

Frequently Asked Questions Primary Care

This document has been created as part of a project called AF way, delivered during 2024 across West Yorkshire.

The Consultant Pharmacists in Anticoagulation and Thrombosis working on the project have prepared a list of frequently asked questions (FAQs) specifically for health professionals. The list of FAQs is not conclusive. If you require have a patient query and would like some support, please complete the advice and guidance template by clicking on this link - AF WAY project web page and contact us via the Integrated Virtual AF Service. These can be found from page seven.

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Introduction

One in forty five people are known to be living with AF (BHF, 2023). It's estimated that if AF was adequately treated, around 7,000 strokes would be prevented and over 2,000 lives saved every year in England alone (Stroke Association, 2024) AF-related strokes are often more severe, with higher mortality and greater disability (Stroke Association, 2024). Billions of pounds are spent each year from health and social care budgets because of AF and AF-related strokes plus additional millions in informal care costs and productivity losses (i.e., income lost) due to care, disability and death.

What is the AF WAY Project?

Through a grant from Daiichi Sankyo the West Yorkshire Integrated Care Board (WY ICB) and Health Innovation Yorkshire and Humber (HYYH) partnered together in 2024 to deliver a West Yorkshire Atrial Fibrillation (AF) project – AF WAY.

Atrial Fibrillation affects approximately 59,000 people in West Yorkshire (WY) (PHE, 2021), and increases the risk of stroke by at least 5 times; AF related strokes are severe and disabling (NHSE, 2022). In 2020/21 there were ~600 admissions for AF-related stroke across West Yorkshire (OHID, 2022). The NHS England Long Term Plan has highlighted AF as a priority area to achieve improved detection and management (NHSE, 2022). The financial burden of AF-related strokes on the NHS is estimated to be up to £2538m in 2020 (Burdett and Lip, 2022).

Anticoagulation reduces the risk of stroke by 65% and where strokes still occur for patients on anticoagulation, they are significantly less disabling (Hindricks et al 2021). The national target by 2029 is for 95% of high-risk patients with AF to be optimised through anticoagulation. However, where people with AF are anticoagulated, international evidence suggests that 10-25% of patients prescribed a direct oral anticoagulant (DOAC) are on the wrong dose. This increases the risk of

strokes and bleeding in those who are on anticoagulation; a major problem yet to be tackled successfully.

The project aims to achieve the target of having 95% of the anticipated number of people with atrial fibrillation diagnosed by 2029. A full list of the project objectives and stakeholder engagement activities can be found on the AF WAY webpage using this link.

Top Five Facts - How and why this is needed

1. Case identification of AF by pulse checks in those aged 65 years and over is effective, it can be used to identify AF before it presents in the form of morbidity or mortality.
2. Most individuals with AF benefit from anticoagulation. The benefit/risk of treatment should be calculated using the CHA2DS2 -VASc and ORBIT tools and be discussed with those being considered for treatment.
3. Evidence is clear that aspirin is never adequate stroke prevention therapy alone, for those with AF and at significant risk of stroke.
4. People with AF should have optimal heart rate control and be symptom free. Those who remain symptomatic despite optimal heart rate control should be referred for specialist management.
5. People with AF should receive information on their condition, be actively involved in all care decisions and be supported in managing their long-term condition.

Where can I find patient resources?

The list below is not conclusive but does provide some useful information for patients that can be viewed online and/or printed.

- Stroke Association: Information and Resources
- Atrial Fibrillation: Reducing your risk of Stroke patient leaflet (Stroke Association)
- West Yorkshire Health and Care Partnership – CVD – AF WAY Project
- British Heart Foundation p- Atrial Fibrillation
- British Heart Foundation – How to check your pulse

NHS – Atrial Fibrillation - Treatment

FAQs

What are the symptoms of Atrial Fibrillation?

Symptoms can significantly impact a patient's quality of life and are the main reason patients seek medical advice.

Symptoms can vary and most often consist of:

- noticeably irregular, fast pulse and heart palpitations.
- tiredness, dizziness and/or shortness of breath, as the heart pumps slightly less efficiently than with a regular and easy rhythm. However, there are some people with no symptoms and some in which atrial fibrillation goes unnoticed.

Read more about the symptoms of atrial fibrillation (NHS, 2021).

Some people don't have symptoms and are not aware they have AF until they have a stroke, or it is picked up by testing or prior to surgery. This is why "knowing your pulse" is important.

What treatments are available for AF patients?

This decision support tool is to help with decisions about atrial fibrillation. It includes information about the condition and possible treatments (NHSE, 2023).

- Decision support tool: Making a decision about further treatment for atrial fibrillation

Treatment options for AF Management

- Medication to control the heart rate or rhythm
- Blood thinning medication - people with atrial fibrillation are more at risk of having a stroke

- Cardioversion – where the heart is given an electric shock to restore the normal rhythm
- Catheter ablation – where the area inside the heart that is causing the abnormal rhythm is destroyed using radiofrequency or cryo energy

How do I assess the stroke risk of my patients?

The risk of stroke is assessed by considering the presence or absence of various stroke risk factors, the most common of which are used to formulate a stroke risk assessment scoring $CHADS_2$ (Congestive heart failure, Hypertension, Age, Diabetes and Stroke). This has been superseded by the **CHA_2DS_2-VASc score** [CHA_2DS_2-VASc Score for Atrial Fibrillation Stroke Risk (mdcalc.com)] is an extension of the $CHADS_2$ scheme as it adds vascular risk (peripheral arterial disease, previous MI, aortic atheroma) and female gender is also included in this scoring system.

Current medication available

The following medications are all licensed for stroke prevention in non-valvular AF,

- Anti Xa inhibitors: apixaban; edoxaban; rivaroxaban
- Factor II inhibitor: dabigatran
- Vitamin K antagonists : warfarin, acenocoumarol (these are not within the scope of the project)

What should be assessed before starting a DOAC?

- What are the patient's risks?
- What does the patient want?
- What is the patient's weight?
- What other medicines are they taking?
- What are their baseline bloods?
  - ✓ Urea and Electrolytes (U and E)

- ✓ Liver Blood Test (LFT)
- ✓ Full Blood Count (FBC)
- ✓ Coagulation screen

- What is their BP?
- Do they have any history of bleeding or contra-indications to anticoagulation?
- What is their bleeding (ORBIT)/Thrombotic risk (CHA2Ds2VASC)

Which patients need extra care considerations to be taken?

- Those with a higher ORBIT score or previous bleeding
- Patients with weight <40kg or >120kg
- Cancer patients
- Concomitant use of drugs that have a high bleeding risk
- Poor renal function
- Liver disease

What are the Contra-Indications to DOAC's?

Poor renal function CrCl < 15ml/min	Mechanical heart valve	Extremes of weight	Moderate to severe mitral stenosis
Anti-phospholipid syndrome	Hepatic disease with cirrhosis and coagulopathy	Higher thrombotic risk (INR range > 2-3)	Active bleeding
	Interacting medicines	Pregnancy/ breast feeding	

What are the cautions to DOACs

Hepatic impairment – considerations

Apixaban

- Contraindicated in hepatic disease associated with coagulopathy disease associated with coagulopathy.
- Caution in patients with mild or moderate hepatic impairment (Child Pugh A or B) or patients with elevated liver enzymes >2 upper limit of normal.

Dabigatran

- Contraindicated in patients with hepatic impairment or liver disease expected to impact on survival
- Not recommended in patients with elevated liver enzymes >2 which is the upper limit of normal.

Edoxaban

- Contraindicated in hepatic disease associated with coagulopathy
- Not recommended in severe hepatic impairment. Caution with elevated liver enzymes >2 upper limit of normal.
- Caution in mild to moderate hepatic impairment.

Rivaroxaban

- Contraindicated in hepatic disease associated with coagulopathy including cirrhotic patients with Child Pugh B and C

What should be considered for patient follow up?

- Personalised care review

- Review bloods
- Adherence
- Side-effects
- Other medicines
- Weight

How frequently should checks be conducted?

- Within first month or after dose change
- Subsequent checks depend on changes
  - ✓ Illness
  - ✓ Renal function
  - ✓ Hepatic function
  - New medicines affecting renal/ hepatic function
  - Age/ Fragility

What is the guidance for routine monitoring and patient follow up

Timing of monitoring				
Time from Initiation	**Apixaban**	**Dabigatran**	**Edoxaban**	**Rivaroxaban**
1-6 weeks	**<u>All patients</u>** Telephone or face to face review by practice Or by hospital (will be clear on eDAN or clinic letter if this is the case)			
3 months	**<u>All patients</u>** AF - telephone review by practice			
6 months	If CrCl <60mLs/min complete routine monitoring including bloods **Repeat every 6 months if CrCl <60mLs/min**			
Annual	If CrCl >60mLs/min complete routine monitoring including bloods **Repeat annually if CrCl >60mLs/min**			

At the 1–6-week review and 3 month review (face to face or by telephone/video) monitor for:

- Adherence

- Side effects
- Signs of bleeding
- Drug interactions (including Over the Counter (OTC))
- Check all follow up and tests completed as per initial referral letter/discharge letter
- Blood tests only if clinically indicated (required test dependent on clinical concern)
- Contraception for woman of childbearing age
- Emergence of contraindications or complicating co-morbidities
- Reinforce safe alcohol limits

At the 6 month/annual review including everything from the three-month review plus:

- Bloods and monitoring
- U and E's then calculate Creatinine clearance. Renal function should ALWAYS be calculated using Cockroft and Gault CrCl, NEVER eGFR, LFT, FBC, Weight
- Check if been told they have mitral stenosis
- Check alcohol intake and reinforce safe alcohol limits if applicable (<14 units per week)
- Check if any thrombotic events have occurred which may require change in treatment
- Check that anticoagulation benefits still outweigh risks
- Check if the dose is clinically appropriate for the patient (e.g., based on renal function, age, weight, interactions)
- If renal function has deteriorated so the CrCl is < 60ml/min and is at least 10ml/min different from the last reading, use the following calculation to determine the frequency of recheck of renal function (full bloods not required):
- CrCl/10 e.g. if CrCl = 42mLs/min ÷ 10 = 4. Recheck after 4 months.
- If CrCl stabilises return to 6 monthly monitoring

I have a patient on an anti-platelet who now has been diagnosed with AF, should I stop the anti-platelet?

It depends what the antiplatelet is for? If after a stroke, for peripheral vascular disease or for primary prevention then it can usually be stopped. If the patient has cardiac (or other) stents, then discuss with cardiology/initiating team.

I have a patient who needs to continue an anti-platelet and start a DOAC, should they have a proton pump inhibitors (PPI)?

Yes, they should have some form of gastric protection. Consider apixaban as first line due to its similar rates of GI bleeding to warfarin and lower rates than other DOACs

I have a patient with AF and a Cha2ds2vasc score of 5 who had anticoagulation stopped due to falls. They haven't fallen for 6 months; can we restart anticoagulation?

If the patient wishes to and understands the risk if they fall again then it is reasonable to restart.

Is it safe to use DOACs in patients who weigh more than 120kg?

Yes. There is evidence to suggest DOACs can be safely used in patients up to 150kg.

I have a patient with AF who is 130kg and has a BMI of 50. What is the anticoagulant of choice?

Patients with BMI>40 have an increased thrombotic risk. Although there is more evidence for using DOACs for VTE treatment in patients with a higher weight/BMI we

should be cautious. Warfarin would be the first line choice, however, if this is unsuitable discuss with an anticoagulant specialist colleague.

What is the DOAC tool?

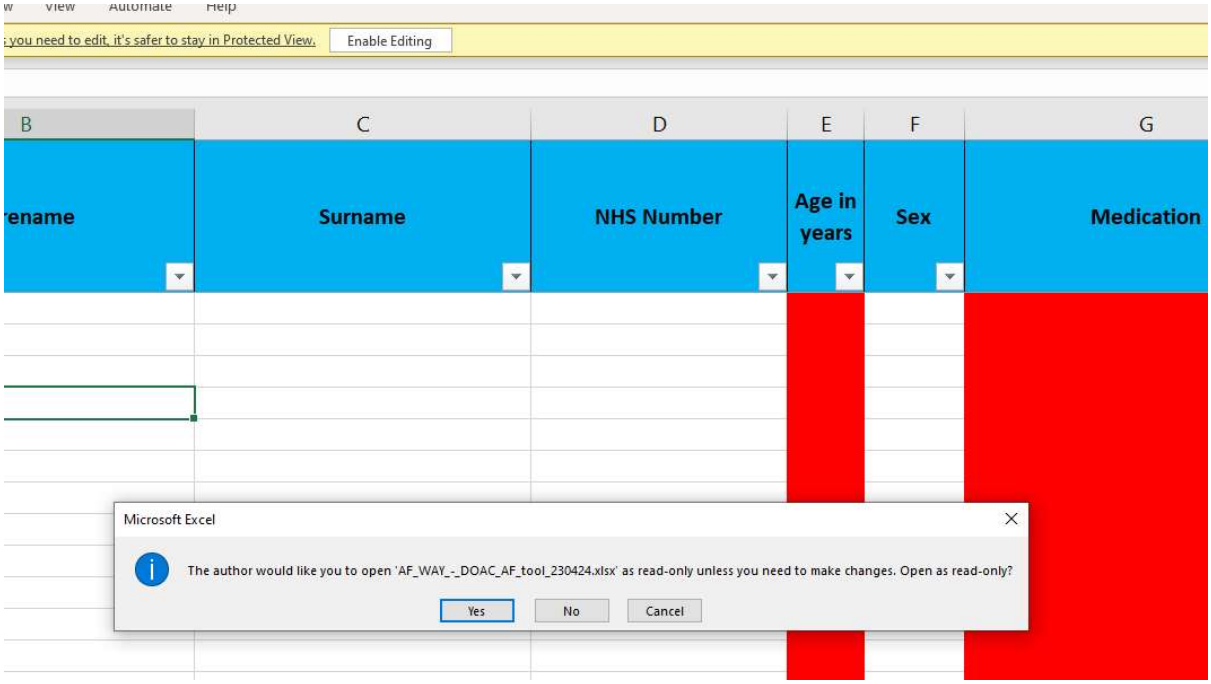
The tool was developed during an audit on DOAC dosing in AF by the Pharmacy Technician team. The following data is retrieved from the clinical system:

- Name and NHS number
- Age and sex
- Current dose of DOAC
- Weight and serum creatinine with dates
- Date of latest LFTs, FBCs and GFR
- The data is added to an excel based tool which calculates:
- The dose according to SPC
- Over or underdosing
- If monitoring is in date

The tool enables a quick audit of DOAC dosing in AF, identifies which patients need to be reviewed for dosing and any gaps in monitoring.

The tool can be downloaded from here- https://www.wypartnership.co.uk/our-priorities/long-term-conditions/cvd/atrial-fibrillation

When downloading the tool select “No” when these options pop up-



The tool contains full instructions for each clinical system on how to run the data, copy into the tool and use the tool. The AF WAY webpages accessed using this link also provides videos on each of these processes.

Who can I contact for information or support ?

Contact the AF WAY Project team at wyicb-wak.ltcpc.wy@nhs.net if you require more information.

What learning and or education can practices access to help improve detection and optimise the care of people at risk or identified to have AF?

The project whilst operational includes free support, education and learning, including:

- Integrated Virtual AF Service
- Virtual Webinars - available to book now

- Face to Face learning events
- Recorded Webinars
- DOAC Tool and user videos
- PrescQIPP Anticoagulation E-Learning
- PrescQIPP Lipid Modification E-Learning
- Resources
- Patient Resources

Full details, bookings, recording and resources available to download can be found on the West Yorkshire Health and Care Partnership, AF WAY project website page. This is only an offer available for the duration of the project implementation.