

Brandon Walker:

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Hi, everyone. I'm Brandon Walker, learning and development trainer at the American Heart Association. Joining me for today's discussion on atrial fibrillation are AHA volunteers Pamela McCabe, Assistant Professor of Nursing at the Mayo Clinic College of Medicine and Science. Robert Page, Professor of Clinical Pharmacy and Physical Medicine, Rehabilitation at the University of Colorado and Annabelle Volgman, Professor of Medicine and senior attending physician at Rush Medical College and Rush University Medical Center. Today we will be resulting the results of a recent a-fib provider survey conducted by the American Heart Association. This podcast has been made possible through a grant from the BMS Pfizer Alliance.

So what exactly is atrial fibrillation or a-fib? A-fib is a quivering or irregular heartbeat, also known as arrhythmia that can lead to blood clots, strokes, heart failure and other heart related complications. At least 2.7 million Americans are living with a-fib. This clot risk is why patients with this condition are put on blood thinners. Even though untreated atrial fibrillation doubles the risk of heart related deaths and is associated with a five fold increase risk for stroke, many patients are unaware that a-fib is a serious condition. Primary HCP's attempt to diagnose a majority of possible a-fib patients themselves rather than immediately referring to a specialist.

Our survey showed that less than one in 10 make an immediate referral before conducting tests. Once a-fib was suspected 54% of PCP's and 71% of nurses would refer the patient to a specialist for further evaluation and diagnosis. Dr. McCabe, can you comment on the these findings?

Pamela McCabe:

[01:42](#)

Yes Brandon, I don't think those numbers are too surprising. I think that primary care providers will want to assure that they do have some positive findings before they actually do refer to a cardiologist. It is sometimes very difficult to make the diagnosis of atrial fibrillation. But the primary care guidelines don't necessarily require providers to refer to a cardiologist. So, they may go ahead and get the electrocardiogram and if they can't find the atrial fibrillation on electrocardiogram they may use some sort of a continuous monitoring process such as a Holter monitor. Now, once they find that the patient does have atrial fibrillation diagnosed by an electrocardiogram, they may or may not choose to refer the patient. There's really no place in the guidelines that says primary care providers can't manage a patient with atrial fibrillation.

I think that primary care may feel comfortable depending upon the particular provider managing the patient if they can be

managed with very first line kinds of therapies like rate control for example. Especially if they're not symptomatic. Then also providing that anticoagulation. Now, if the patient should develop more symptoms and not be managed on that first line therapy, then I can see that primary care providers may choose to refer them to a cardiologist. But again, I think it depends upon the particular culture of the institution. The culture maybe of the community. In the UK, many, many patients, a great portion of them are managed actually by primary care providers. So, I think this is a real variance in practice even perhaps within institutions depending upon the comfort level that the primary care provider has.

I don't know Dr. Volgman what are your thoughts?

- Volgman: [03:54](#) Thank you Dr. McCabe, I completely agree with you, I think that a lot of physicians feel that they can take care of atrial fibrillation. Especially if the patient is not that symptomatic. There are a lot of patients who are not that symptomatic that don't really need to be seen by a cardiologist. As long as the primary care physicians are adhering to the guidelines where they should be anticoagulating patients who need to be anti coagulated, whether they are controlling their heart rates, if they're going to stay in atrial fibrillation. Most physicians who are not electrophysiologists or cardiologists would refer if the patient needed to be cardioverted, of course or stay in sinus rhythm with an anti-arrhythmic drug. I think that would be when they would refer to a cardiologist of electrophysiologist. But I think that a lot of physicians feel comfortable taking care of those patients themselves. Thank you.
- Brandon Walker: [04:54](#) Excellent, well thank you so much for your input, Dr. McCabe and Dr. Volgman. Is Dr. Page available? Please [inaudible 00:05:02] answer.
- Robert Page: [05:02](#) I definitely completely agree. It sometimes is very difficult for patients to get that referral. Therefore, primary care is one of the largest avenues via which in order to evaluate for atrial fibrillation, have shared decision making with regards to anticoagulation, as well as considering rate versus rhythm control.
- Brandon Walker: [05:24](#) Excellent, thank you sir. Since you're already on mic, let's go to another question about surveys. So in a recent survey we conducted among primary health care providers, it seems that many are unaware or use the CHADS VASc score to evaluate their patients whom they feel have a-fib. So Doctor Page how

can we help them learn what they should be doing in these cases?

Robert Page:

[05:48](#)

Well first let's take a step back and just talk a little bit about the CHADS2 score the CHADS VASc score. First and foremost, also, I would say that these data aren't surprising to me. Older published data back from 2014 has suggested that about 50% of those practicing within primary care don't really use one of the clinical prediction scoring tools. So the question is, is why is that the case? Well, when evaluated, when they were questioned, sometimes there are some things in terms of the provider. Many providers felt that their clinical judgment really superseded the use of one of these prediction risk scores. Secondly, was with regards to the age of the patient. A lot of individuals felt like well, you know they're old, they're a bleeding risk. Then third, some individuals are just not familiar with some of the bleeding risk score that exist such as that of the HAS-BLED.

So, when we think about these scoring systems, both the CHADS2 score and the CHADS VASc score, are clinical prediction tools that are used to assist with estimating the risk of stroke in patients who have non-valvular or non-rheumatic atrial fibrillation. The CHADS2 score is the one that is the most commonly used, I think because it's also the easiest to remember. C stands for congestive heart failure, H is for hypertension, a blood pressure that's above 140 over 90 or a patient who's currently being treated. Age greater than 75, D for diabetes and then the S is prior stroke or TIA or thromboembolism. Each one of these points is assigned one point. If a patient has prior stroke or TIA or thromboembolism it's two. Again, based upon this scoring system, providers can assist or work with patients in order to estimate their overall stroke risk and determine whether or not that they warrant anticoagulation.

Now its the CHADS VASc score is a refinement of the CHADS score. What it does is it actually now extends the latter by including common other risk factors. That is risk and age 65 to 74, female gender and vascular disease. So, the difference however is again congestive heart failure is given a point, hypertension, H again, greater than 140 over 90 or being treated is one point. Age greater than or equal to 75 is now two points, diabetes one point. Prior stroke or TIA is two. Vascular disease such as peripheral artery disease, an MI, one. Then age 65 to 74 is one and then if they are female they get a one. So, this newer stroke risk calculator really tries to capture those who are lower, maybe even intermediate risk.

What makes I think this so important within the primary care setting is that it allows for shared decision making. Providers they may say, well it may be difficult in order to calculate out that score but I would say what we've done within our outpatient clinics is I actually have an app on my phone and it calculates actually out the stroke risk and the patient can visualize it and they can also then work with their primary care provider in order to decide what are my thoughts with regards to anticoagulation. The same things goes with the HAS-BLED. Again, these are all tools that providers can utilize in order to assist with a patient in determining their overall anticoagulation.

But again, I think some of the barriers that exist is number one, sometimes there may be not knowledge of the CHADS2 VASc score. Or there may be some difficulty in potentially calculating it or as it mentioned already, three some providers may feel well my clinical judgment may supersede this. But I will say that the data do support that we're able to capture and reduce the risk of stroke when utilizing either of these scores. Doctor McCabe or Volgman any comments with regards to these data?

Pamela McCabe:

[10:17](#)

I wonder if there are some documentation issues that may be barriers to them calculating it depending upon if they're using in an electronic medical health record that actually helps them. Maybe has a bit of a reminder there to do it. I know there's all kinds of algorithms that are available. Perhaps if providers don't have access to these kinds of cues to making these assessments, that may be a factor in them just not thinking about doing it and they may have thought about it but then maybe they don't document it. If there's the appropriate mechanisms for them to document it and as you say make that calculation very easily that may be a barrier.

Volgman:

[11:10](#)

I just wanted to comment, this is Doctor Volgman. There's an easy way to calculate the ASCVD score in the electronic medical record. I wonder if we could incorporate the CHADS VASc score in the electronic medical record so that you just have to type in a few letters and it will pop up what the CHADS VASc score is and the recommendations for those particular risk scores. I think that might help also. I think the primary care physicians are so incredibly busy that a lot of things can slip through their care because there's just so much going on with certain patients. So I think that might help them. If you could have an easy phrase that they could just plug in if a patient has atrial fibrillation, it's an automatic calculate your CHADS VASc score, that might help them. Thank you.

Brandon Walker:

[12:07](#)

All right, well I'd like to again give a special thanks to our volunteers for your time today. We absolutely appreciate the fact that you have taken time away from your busy schedule to join us and provide us with this great information. Your participation and insights have been invaluable. So thanks for listening everyone. This podcast has been made possible through a grant from the BMS Pfizer Alliance. The views expressed in this podcast do not necessarily reflect the official policy or position of the American Heart Association and American Stroke Association. For transcripts of this podcast and more information about a-fib please visit [heart.org/afib](http://heart.org/afib). Thank you very much, once again.