



Managing Atrial Fibrillation in Primary Care: A Practical Approach for GPs

This webinar will start shortly.





Cardiology at the interface of primary and secondary care session two

Managing Atrial Fibrillation in Primary Care: A Practical Approach for GPs

Zoom webinar – Wednesday 7 May, 6.30-8pm

Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.

Learning outcomes

After this session, I will be able to:

- Identify key clinical features of atrial fibrillation and initiate appropriate diagnostic workup.
- Understand first-line management strategies for rate and rhythm control.
- Assess stroke risk using CHA₂DS₂-VASc and bleeding risk using HAS-BLED to guide anticoagulation decisions.
- Recognise red flags and indications for referral to cardiology.
- Apply current guideline-based approaches to the long-term management of AF in the primary care setting.

Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
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Presenter



Dr Jonathan Lipton

Panel





Dr Paul MacIntyre

Dr Graeme Bleach

malimetration

Managing Atrial Fibrillation in Primary Care: A Practical Approach for GPs

Primary Care Interactive webinar 7 May 2025

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Disclosures

• No conflicts of interest to report

Learning objectives

- Identify key clinical features of atrial fibrillation and initiate appropriate diagnostic workup.
- Understand first-line management strategies for rate and rhythm control.
- Assess stroke risk using CHA₂DS₂-VA and bleeding risk using HAS-BLED to guide anticoagulation decisions.
- Recognize red flags and indications for referral to cardiology.
- Apply current guideline-based approaches to the long-term management of AF in the primary care setting.

Key references

- 2024 ESC Guidelines for the management of atrial fibrillation. Van Gelder et al. European Heart Journal, Volume 45, Issue 36, 21 September 2024, Pages 3314–3414
- 2018 Australian Clinical Guidelines for the Diagnosis and Management of Atrial Fibrillation. Brieger, David et al. Heart, Lung and Circulation, Volume 27, Issue 10, 1209 – 1266.
- 2019 Atrial fibrillation. Verma et al. AJGP VOL. 48, NO. 10, Oct 2019.
- Tasmanian Health Pathways https://tasmania.communityhealthpathways.org/
- Credit to Dr Melanie Gunawardene (selected slides used and modified for this presentation)

Clinical Features and workup

Atrial fibrillation



- Rapid and disorganised atrial activation
- Initiated by ectopic activity, usually from the pulmonary veins
- Resulting in irregular and often rapid ventricular activation
- Diagnosis by ECG

Presentation

- Asymptomatic (subclinical)
 - Detected by screening / pacemaker check / smartwatch
- Symptomatic (clinical)
 - Palpitations
 - Shortness of breath
 - Lack of energy
- 20-25% of patients with asymptomatic AF will become symptomatic within the next 2.5 years

Healey J et al, N Engl J Med 2012; 366:120-129

AF progression



Age

Predictors for Progression of Atrial Fibrillation in Patients Awaiting Atrial Fibrillation Ablation

Simon Kochhäuser, MD • Dirk G. Dechering, MD • Kathleen Trought, BSc • ... Bernice Tsang, MD • Lars Eckardt, MD • Atul Verma, MD A 🖾 • Show all authors

Published: April 22, 2016 • DOI: https://doi.org/10.1016/j.cjca.2016.02.031 • 🔘 Check for updates



During a median waiting time of 9.7 (6.1, 14.2) months, 60 (11%) of 564 patients progressed to persistent AF.

Incidence and impact of AF





| Heart Lung and Circulation | | Submit | Log in | Register | | Subscrib | e Clain |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------|----------|------------|--------------|---------|
| | REVIEW I VOLUME 26, ISSUE 9, P870-879, SEPTEMBER 2017 소 Download Full Issue | Purchase | D Subscribe | Save | D Share | Reprints | Request |
| | Epidemiology of Atrial Fibrillation: The Austr Asia-Pacific Perspective | alian ar | nd | | | | |
| 1 | Christopher X. Wong, MBBS, MSc, PhD • Alex Brown, BMed, MPH, PhD • Hung-Fat Ts Thomas H. Marwick, MBBS, PhD, MPH • Dennis H. Lau, MBBS, PhD • Prashanthan Sanders, MBBS, PhD □ □ • Show all authors | e, MD, PhD • | | | | | |
| | Published: May 24, 2017 • DOI: https://doi.org/10.1016/j.hlc.2017.05.120 • Epidemi Perspec | ology of Atrial | Fibrillation: [*] | The Aust | ralian a | nd Asia-Paci | fic |

In Tasmania:

- 7000 patients with atrial fibrillation,
- 15 admissions with AF per day
- 4300 bed days per year
- Annual cost of AUD 35.000.000

Workup

- Medical history for AF pattern, risk factors and co-morbidities
- 12 lead ECG
- Assess symptoms and functional impairment
- Pathology tests: FBC, U&E, LFT, glucose/HbA1c, thyroid function
- Transthoracic echo
- In selected patients:
 - 24 hour ambulatory ECG recording
 - sleep study
 - ischaemia testing.







Systematic approach to the ECG

- 1. Rate
- 2. Regularity
- 3. QRS width
- 4. P waves

- Choose and use your system of choice, but be consistent!
- Relationship P wave to QRS (atrio-ventricular relationship)
- 5. ST segment
 - Elevation/Depression
 - QT
- 6. Other
 - QRS axis/P wave morphology/specific patterns









Regularity





Regularity



P waves present/absent





AF diagnosis







 A 74-year-old woman presents with fatigue and intermittent palpitations for 2 weeks. She has a history of hypertension and type 2 diabetes. On examination, pulse is irregular at 110 bpm.







What is the most appropriate next step in her diagnostic workup?

- A. Exercise stress testing
- B. 24-hour Holter monitoring
- C. Serum troponin & NT pro BNP
- D. Transthoracic echocardiogram
- E. FBC, TSH, U&E, LFT



What is the most appropriate next step in her diagnostic workup?

- Correct answer is E:
 - Reversible causes need to be excluded including hyperthyroidism, anaemia and electrolyte dysfunction.
 - Ischemia is also present and likely secondary to her AF, but does also require further investigation.





Management strategies for rate and rhythm control.



EAST-AFNET 4 Trial (2020)

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Rhythm-Control Therapy in Patients with Atrial Fibrillation

P. Kirchhof, A.J. Camm, A. Goette, A. Brandes, L. Eckardt, A. Elvan, T. Fetsch, I.C. van Gelder, D. Haase, L.M. Haegeli, F. Hamann, H. Heidbüchel,
G. Hindricks, J. Kautzner, K.-H. Kuck, L. Mont, G.A. Ng, J. Rekosz, N. Schoen,
U. Schotten, A. Suling, J. Taggeselle, S. Themistoclakis, E. Vettorazzi, P. Vardas, K. Wegscheider, S. Willems, H.J.G.M. Crijns, and G. Breithardt, for the EAST-AFNET 4 Trial Investigators*

- RCT (135 Centers, 2789 Patients)
- <u>Inclusion:</u> "Early AF" (<12 months since first AF diagnosis) and CV risk factors
- <u>Combined Endpoint</u>: death from CV causes, stroke, or hospitalization with worsening of heart failure or ACS



Early rhythm control is the new goal !

Atrial fibrillation and heart failure



Verma, et al. Circulation. 2017.



CASTLE-AF

Catheter Ablation Versus Standard Conventional Therapy in Patients with Left Ventricular Dysfunction and Atrial Fibrillation

- 33 centres, 363 patients
- AF, LVEF <35%, and ICD/CRT
- catheter ablation vs. medical therapy (rate/rhythm control)
- median follow-up of 37.8 months

| Table 2. Primary and Secondary Clinical End Points.* | | | | | | | | | | | |
|------------------------------------------------------|---------------------|----------------------------|--------------------------|-------------------|------------------|--|--|--|--|--|--|
| End Point | Ablation (N=179) | Medical Therapy (N=184) | Hazard Ratio (95% Cl) | P Value | | | | | | | |
| | | | | Cox Regression | Log-Rank Test | | | | | | |
| number (percent) | | | | | | | | | | | |
| Primary† | 51 (28.5) | 82 (44.6) | 0.62 (0.43-0.87) | 0.007 | 0.006 | | | | | | |
| Secondary | | | | | | | | | | | |
| Death from any cause | 24 (13.4) | 46 (25.0) | 0.53 (0.32-0.86) | 0.01 | 0.009 | | | | | | |
| Heart-failure hospitalization | 37 (20.7) | 66 (35.9) | 0.56 (0.37-0.83) | 0.004 | 0.004 | | | | | | |
| Cardiovascular death | 20 (11.2) | 41 (22.3) | 0.49 (0.29-0.84) | 0.009 | 0.008 | | | | | | |
| Cardiovascular hospitalization | 64 (35.8) | 89 (48.4) | 0.72 (0.52–0.99) | 0.04 | 0.04 | | | | | | |
| Hospitalization for any cause | 114 (63.7) | 122 (66.3) | 0.99 (0.77-1.28) | 0.96 | 0.96 | | | | | | |
| Cerebrovascular accident | 5 (2.8) | 11 (6.0) | 0.46 (0.16–1.33) | 0.15 | 0.14 | | | | | | |



- Reduced AF burden (63% vs. 22%)
- AF burden below 50% was associated with decrease in primary composite outcome and allcause mortality

Rhythm control

- In patients with symptomatic AF
 - Catheter ablation is recommended as first-line option
 - To reduce symptoms, recurrence and progression of AF
 - To reverse AF associated left ventricular dysfunction
 - To improve survival and reduce hospital admissions in patients with heart failure with left ventricular dysfunction
 - Shared decision making is recommended taking into account procedural risks & benefits.
 - Electrocardioversion
 - In case of persistent AF if unclear if symptomatic
 - In acute setting if hemodynamically unstable



Rate control

- For patients with AF, no symptoms and preserved ventricular function
- Factors favouring rate control:
 - Longstanding (>1 year) atrial fibrillation
 - Older age (>80 years)
 - Frailty and comorbidities
 - Severe atrial dilatation
- With safer ablation technology increasingly favouring rhythm control.
- Aim for resting rate of <110/min



Medical management

- Rhythm control:
 - Amiodarone
 - Sotalol
 - if ventricular function is normal
 - Flecainide
 - In combination with betablocker/calcium channel blocker
 - If ventricular function is normal
 - If no significant coronary disease
- Rate control:
 - Beta-blocker
 - Digoxin
 - Calcium channel blockers (verapamil/diltiazem)
 - If ventricular function is known and normal
Catheter ablation

- More effective than medication for rhythm control.
- Less adverse events than long term medication for rhythm control.
- Mortality benefit in patients with reduced LVEF compared to medical therapy.
- Class 1 indication for symptomatic AF



Ablation target: pulmonary veins



Ablation technology





Electroporation / pulse field ablation:

Transmembrane induced electrical field results in destabilisation of cell membrane





Pulsed Field Ablation - Benefits

- Shorter procedure time
- Ability for same day discharge
- Improved safety
- Same efficacy



Steiger, Romero et al, JCE 2022

Energy source: Pulsed Field Ablation vs. thermal Ablation – ADVENT trial



Catheter ablation for AF

- Success rate 70-80% freedom from clinically significant AF at 5 years
 - 50-60% in persistent AF
- Patients may require redo procedure.
 - Reconnection of pulmonary veins
 - Additional substrate ablation (posterior wall, flutter)
- Procedure duration 40-90 minutes
 - Same day discharge for most patients
 - <1% serious complication rate
- Continuation of medication post ablation
 - At least 60 days for anticoagulation
 - 1-3 months for anti-arrhythmic medication



Ablation vs anti-arrhythmic drugs

ESC European Society doi:10.1093/europace/euab185 of Cardiology

CLINICAL RESEARCH Ablation for atrial fibrillation

Catheter ablation vs. antiarrhythmic drugs as 'first-line' initial therapy for atrial fibrillation: a pooled analysis of randomized data

Shaojie Chen ^{© 1,2}^a, Helmut Pürerfellner³, Feifan Ouyang⁴, Márcio Galindo Kiuchi⁵, Christian Meyer^{6,7,8,9}, Martin Martinek³, Piotr Futyma¹⁰, Lin Zhu¹¹, Alexandra Schratter¹², Jiazhi Wang¹³, Willem-Jan Acou¹⁴, Zhiyu Ling¹⁵, Yuehui Yin¹⁵, Shaowen Liu¹⁶, Philipp Sommer¹⁷, Boris Schmidt¹, and Julian K.R. Chun^{1,2}

Efficacy

Catheter ablation vs. AADs as First-line treatment for AF: overall pooled effect A Study name Statistics for each study Odds ratio and 95% CI Odds Lower Upper limit Z-Value p-Value limit ratio 1.STOP AF First (2020) 0.278 0.153 0.503 -4.2230.000 2. EARLY-AF (2020) 0.356 0.223 0.570 -4.311 0.000 0.972 3. RAAFT-2 (2014) 0.464 0.221 -2.035 0.042 4. MANTRA (2012) 0.771 -2.847 0.433 0.244 0.004 5. RAAFT-1 (2005) 0.255 0.073 0.884 -2.155 0.031 -7.172 Overall effect 0.361 0.273 0.476 0.000 (I²: 0%, P=0.76) 0.01 0.1 10 100 **Favours Ablation Favours AADs** Regarding AF/AT/AFL recurrence

| | Ablati | on | AAD | S | | Odds Ratio | Odds Ratio |
|------------------------|--------|-------|--------|-------|--------|---------------------|---------------------|
| Study or Subgroup | Events | Total | Events | Total | Weight | M-H, Random, 95% Cl | M-H, Random, 95% Cl |
| 1.STOP AF First (2020) | 5 | 104 | 4 | 99 | 18.5% | 1.20 [0.31, 4.60] | |
| 2. EARLY-AF (2020) | 5 | 154 | 6 | 149 | 22.8% | 0.80 [0.24, 2.68] | |
| 3. RAAFT-2 (2014) | 6 | 66 | 2 | 61 | 12.4% | 2.95 [0.57, 15.21] | |
| 4. MANTRA (2012) | 11 | 146 | 9 | 148 | 40.1% | 1.26 [0.51, 3.13] | |
| 5. RAAFT-1 (2005) | 1 | 33 | 3 | 37 | 6.2% | 0.35 [0.04, 3.58] | |
| Total (95% CI) | | 503 | | 494 | 100.0% | 1.16 [0.65, 2.06] | + |
| Total events | 28 | | 24 | | | | |

Safety

"Pace and ablate"

- Considered "last resort" for rate control in AF
 - Performed in combination with pacemaker implantation
 - If not deemed suitable for rhythm control strategy
 - If medical rate control is ineffective or medication is not tolerated
- Usually pacemaker with conduction system pacing or cardiac resynchronization therapy implanted
 - AV node ablation 3-4 weeks later





- 75 year old female with known hypertension and paroxysmal AF for the past 3 years has had ongoing palpitations for 6 months associated with lack of energy.
- The 12 lead ECG shows AF with ventricular rate 140/min.
- Medications: amlodipine 5mg, simvastatin 10mg, escitalopram.



What is the most appropriate next step in treatment for this patient?

- A. Amiodarone
- B. Electrical cardioversion
- C. Catheter ablation
- D. Metoprolol
- E. Flecainide



What is the most appropriate next step in treatment for this patient?

- Correct answer is D. Metoprolol
 - Beta-blockers are first-line for rate control in patients with sufficient BP and without HF signs.
 - She will likely benefit from a rhythm control strategy as she is symptomatic.
 - With a CHA2DS2VA score of 3 she will ideally have least 3 weeks of anticoagulation prior to cardioversion.



Assessing stroke and bleeding risk





Oral Anticoagulation in clinical AF

Chadsvasc risk factors [click on present risk factors]

| RISK FACTORS | SCORE |
|-----------------------------|-------|
| Congestive heart failure | 1 |
| Hypertension | 1 |
| Age ≥ 75 | 2 |
| Age 65-74 | 1 |
| Diabetes mellitus | 1 |
| Stroke/TIA/thrombo-embolism | 2 |
| Vascular disease | 1 |
| Sex Female | 1 |

HASBLED clinical characteristic [click on present risk factors]

| CLINICAL CHARACTERISTIC | POINTS AWARDED |
|-------------------------|-------------------|
| Hypertension | 1 |
| Abnormal liver function | 1 |
| Abnormal renal function | 1 |
| Stroke | 1 |
| Bleeding | 1 |
| Labile INRs | 1 |
| Elderly (Age >65) | 1 |
| Drugs | 1 |
| Alcohol | 1 |

CHADSVASC clinical risk estimation. Adapted from Lip et al. See Van den Ham et al. below for actual risks in a larger population.

| CHA ₂ DS ₂ VASc SCORE | PATIENTS (n=7329) | ADJUSTED STROKE RATE (% year) |
|------------------------------------------------|----------------------|----------------------------------|
| 0 | 1 | 0% |
| 1 | 422 | 1,3% |
| 2 | 1230 | 2,2% |
| 3 | 1730 | 3,2% |
| 4 | 1718 | 4,0% |
| 5 | 1159 | 6,7% |
| 6 | 679 | 9,8% |
| 7 | 294 | 9,6% |
| 8 | 82 | 6,7% |
| 9 | 14 | 15,2% |



2/3 of all strokes avoidable by VKA $^{\rm 1}$

Subclinical AF and Anticoagulation



2020 ESC guidelines

AF detection and stroke prevention

- Clinical AF:
 - Clear benefit for DOACs for patients with symptomatic AF and increased stroke risk
- Subclinical AF
 - The more you monitor, the more you find.
 - May be marker of stroke risk rather than the cause.
 - In patients with cryptogenic stroke treatment with DOAC may reduce stroke risk but not improve patient outcomes.
 - Implantable loop recorders may be of benefit in highly selected patients with cryptogenic stroke.
 - In cardiac implantable device detected AF >24 hours and high stroke risk (CHA2DS2VA <u>></u>2) shared decision for DOAC

DOAC dosing

Up to 20-25% patients are on incorrect dose of DOAC!

| DOAC | Standard full dose | Criteria for dose reduction | Reduced dose only if criteria met |
|-------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| Apixaban | 5 mg twice daily | Two out of three needed for dose reduction: (i) age ≥80 years (ii) body weight ≤60 kg (iii) serum creatinine ≥133 mmol/L. | 2.5 mg twice daily |
| Dabigatran | 150 mg twice daily | Dose reduction recommended if any apply: (i) age ≥80 years (ii) receiving concomitant verapamil. Dose reduction considered on an individual basis if any apply: (i) age 75–80 (ii) moderate renal impairment (creatinine clearance 30–50 mL/min) (iii) patients with gastritis, oesophagitis, or gastro-oesophageal reflux (iv) others at increased risk of bleeding. | 110 mg twice daily |
| Rivaroxaban | 20 mg once daily | Creatinine clearance 15–49 mL/min. | 15 mg once daily |

Percutaneous left atrial appendage occlusion





• May be considered in patients with AF and contraindications for long-term anticoagulation to prevent ischaemic stroke and thromboembolism.

Case 3

- A 76-year-old male with hypertension and previous TIA presents with newly diagnosed AF. She has no history of bleeding. The CHA₂DS₂-VA score is 5 and HAS-BLED score is 2.
- What is the most appropriate management strategy regarding anticoagulation?
 - A. No anticoagulation needed
 - B. Prescribe aspirin
 - C. Prescribe apixaban
 - D. Refer for left atrial appendage closure
 - E. Delay anticoagulation until rhythm is controlled



What is the most appropriate management strategy regarding anticoagulation?

- Correct answer is C.
 - The stroke risk is 7% per year, with a low bleeding risk: anticoagulation is warranted.
 - In the absence of moderate/severe mitral stenosis or mechanical heart valves DOACs are preferred over Warfarin.



Referral and red flags

Referral for initial assessment

- AF nurse specialist clinic and AF GP specialist clinic

 - F nurse specialist clinic and AF GP specialist clinic
 Most patients with newly diagnosed AF
 Provide rapid access for w Funding may be withdrawn by THS for •
 - Capacity of 10-12 patients 000-600/year
- Arrhythmia clinic
 - For complex patients with other arrhythmia or recurrence post ablation. •
 - Electrophysiologist led clinic.
- Ideally perform workup for all patients:
 - 12 lead ECG
 - Echo (please request bulk billing via private provider due to staffing shortages at ulletRHH)
 - Bloods including thyroid function \bullet



GP management

- Patients with longstanding AF
 - Asymptomatic
 - Adequate rate control
 - Normal LVEF
- Patients seen through cardiology clinic
 - With management plan for AF
 - Clinically stable
 - Generally no need for routine cardiology follow-up



Red flag

- Syncope
- Chest discomfort



- Signs and symptoms of decompensated heart failure
- Uncontrolled ventricular rate >150/min
- Hemodynamically unstable
- Refer to emergency department
- > If unsure: discuss with cardiology team for advice





- A 50-year-old man with no significant past history presents with new-onset AF and associated syncope. His ECG reveals AF with ventricular rate of 85/min, BP 120/70mmHg.
- What is the most appropriate next step?
 - A. Initiation of apixaban
 - B. 24 hour holter monitor and echo
 - C. Referral to emergency department
 - D. Sitting and standing BP measurement
 - E. Blood tests including U&E, FBC, thyroid function, LFT





- Correct answer is C.
 - Syncope is a red flag and can indicate AF with hemodynamic instability or other pathology with sinus node disease or structural cardiac abnormalities.
 - Inpatient assessment is indicated to investigate the etiology and rule out significant pathology.



long-term management of AF in the primary care setting.







Ongoing assessment

- 6 months after initial presentation, 12 months thereafter if stable
- Re-assess treatment aims:
 - Stroke prevention
 - Maintain sinus rhythm (rhythm control strategy)
 - Prevent high ventricular rates (rate control strategy)
- Re-assess and address triggers/risk factors
 - ETOH, caffeine
 - Weight loss, exercise
 - Hypertension
 - Diabetes
 - Sleep apnoea
 - Ischaemia
 - Structural abnormalities
 - Pulmonary disease
 - Thyroid dysfunction



Weight loss >10% reduces progression of AF







Case 5

- A 78-year-old woman with longatnding AF and CHA₂DS₂-VA score of 3 presents for review. Blood tests are normal, HR is 75/min. Medications: rivaroxaban 20 mg and bisoprolol 5mg.
- Which of the following best reflects guideline-based long-term management?
 - A. Refer for electrical cardioversion
 - B. Reduce rivaroxaban to 15mg daily due to age >75.
 - C. Continue current rate control and anticoagulation
 - D. Switch from DOAC to aspirin
 - E. Refer to cardiologist to assess for ablation



Which of the following best reflects guideline-based longterm management?

- Correct answer is C: continue current management
 - She is appropriately managed with anticoagulation. Reduced dose of 15mg daily is recommended if eGFR is <50ml/min.
 - She has adequate rate control.
 - She has longstanding AF without symptoms. A rhythm control strategy will not result in improved clinical outcomes or symptoms.



Case 6

- A 64-year-old man with paroxysmal AF and hypertension asks how he can reduce his AF episodes without taking more medication. BMI 32, drinks 3–5 beers 2-3x/week, wife notes he snores and naps during the day.
- Which of the following lifestyle interventions is most strongly associated with reducing AF burden?
 - A. Reducing caffeine intake
 - B. Quitting alcohol and treating sleep apnea
 - C. Starting aspirin daily
 - D. Avoiding exercise
 - E. Diet including intermittent fasting, low carbohydrate intake and avoiding seed oils.



Case 6

- Correct answer: B.
 - Alcohol and untreated obstructive sleep apnea are significant, modifiable risk factors for AF recurrence.
 - Weight loss and exercise (moderate intensity 30min/day) are additional modifiable risk factors for AF.
 - Moderate caffeine intake is **not** associated with increased incidence of AF.










Counter-clockwise, "typical" Atrial flutter







Atrial flutter

- Management similar to AF with regards to:
 - Anticoagulation
 - Initial rate and rhythm control
 - Risk factors
- Ablation for atrial flutter is a simpler and shorter procedure
 - The cavo-tricuspid isthmus is ablated
 - Procedure time 30-40 minutes
 - Success rate >90%
 - If atypical flutter, success rate is lower.
- Many patients (>50%) will develop AF during follow-up!
 - Lifestyle intervention important to reduce chance of AF

Questions and comments

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Tasmanian HealthPathways is a web-based information portal developed by Primary Health Tasmania. It is designed to help primary care clinicians plan local patient care through primary, community and secondary healthcare systems.



tasmania.communityhealthpathways.org



Update- New personalised accounts

Registering for the first time

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Cardiology Series

Cardiology at the interface of primary and secondary care – A vision for contemporary cardiac rehabilitation with Dr Paul MacIntyre

Resource List

Cardiology at the interface of primary and secondary care – A vision for contemporary cardiac rehabilitation with Dr Paul MacInt



Primary Health Tasmania's Learning Hub

learning.primaryhealthtas.com.au

Password: phtlearning

Session three:

Shortness of breath, leading to heart failure Wednesday 11 June

6.30 – 8pm

Some final words

- After this webinar end, your browser will open a link to an evaluation survey.
- Statements of attendance will be emailed to participants.
- For event queries, please contact <u>events@primaryhealthtas.com.au</u>

Thank you

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