SHV Recommendations for ED management of Afib/flutter

Acceptable Risk (Treat in ER, then discharge with rapid follow up)
• Atrial Fibrillation (with or without RVR) primary diagnosis
• Conversion to sinus rhythm • Resting HR <110 AFTER intervention
• Mild to moderate atrial fibrillation symptoms
• Normal cardiac enzymes

High Risk (Requires Admission)
• Hemodynamically unstable/Cardiogenic shock
• Atrial Fibrillation is secondary diagnosis (hospitalization indicated for primary problem, such as Sepsis, ACS, HF, recent surgery, acute substance overdose/withdrawal, etc.)
• Decompensated heart failure and/or volume overload ** Consider paging Cherry Hill Heart Failure Team (Advanced Cardiac Support)
• Severe/Concerning Symptoms • Unstable or difficult to control Heart Rate (>110 bpm)

For 'Acceptable Risk' patients: the ③ main pillars of ED care should include:

① Restore Rhythm or Control Rate

DCCV (200-360J Synchronized)

- If uninterrupted DOAC (or therapeutic warfarin) ≥ 3 weeks, proceed with DCCV, continue OAC.
- If Onset AF < 48h – Proceed with DCCV + initiate DOAC.
- If Onset AF ≥ 48h or unsure – initiate DOAC + rate control + discharge for outpatient DCCV

Rate Control

- Initiate Rate control for HR >110bpm @ rest or >130bpm with ambulation
- Known LVEF >40% (Diltiazem ER PO, OR Metoprolol ER PO)
- Known LVEF <40% (Metoprolol ER 50mg)

Recommend hallway ambulation to ensure rate control (<130 bpm) prior to discharge

② Stroke Risk Reduction

- For ALL patients with CHA_2DS_2Vasc – if ≥2, initiate anticoagulation (**DOAC preferred**)
- For ALL Patients undergoing (or anticipating undergoing) chemical or electrical cardioversion – initiate DOAC, to be continued for a minimum of 4 weeks after electrical CV.
- If CHA2DS2Vasc <2, initiate ASA 81 mg daily (EXCEPT CHA_2DS_2Vasc = 1 = CHF, initiate DOAC)
- *If discharging on DOAC, please ensure at least 30 day continuous supply*

③ Rapid access to outpatient care

Swedish Comprehensive Afib Network

Epic – SMG Referral to Swedish Comprehensive Afib Network (AMBR1167)
Questions? Message SCAN Inbox pool at "SHV Swedish Afib" [603609]
Telephone – (206) 215-AFIB (2342)

Medical Therapy Discharge Options

Known LVEF ≥40%	Known LVEF <40% or Unknown LVEF
• Diltiazem CD 120-240 mg daily • Metoprolol ER 25-50 mg daily	• Metoprolol ER 25-50mg daily • Carvedilol 6.25 mg twice daily • Digoxin 0.125mg daily

➢ If currently on BB or CCB with inadequate rate control, consider dual rate therapy with other agent or the addition of Digoxin 125 mcg (if adequate renal clearance)

Oral Anticoagulation

All patients who are CHA2DS2Vasc: 2 or higher should be started on OAC

DOAC preferred agent for OAC	Warfarin only if DOAC contraindicated (*refer to ACC for management)
Apixaban (Eliquis) 5mg* BID (*Dosing reduced to 2.5 mg BID if patient has at least 2 factors: age≥80, weight ≤60 kg, serum Cr ≥ 1.5mg/dL) **Dabigatran (Pradaxa) 150 mg* BID** (Do not prescribed for CrCl<30 mL\min) **Edoxaban (Savaysa) 60 mg* QD for CrCl >50 and ≤ 95 mL\min** (*Dosing reduced to 30mg QD for CrCl > 15 and ≤50 mL\min) **Rivaroxiban (Xarelto) 20 mg* QD** (*Dosing reduced to 15mg QD for CrCl > 15 and ≤50 mL\min) Discount cards for FREE 30-day supply available on manufacturer websites for all patients, regardless of insurance. Epic tools: .eliquisdiscountcard - Eliquis discount card smart phrase (link to free 30 day card - regardless of insurance)	▪ Mechanical valve replacement, mitral stenosis ▪ CKD/Renal Failure (relative contraindication, drug dependent 15-30 CrCl) ▪ Non-compliance with daily medication.

***~ALL OAC* contraindicated**

Recommend referral to SCAN/cardiology for specialist evaluation