Atrial Fibrillation - SDU - Summary Clinical Guideline

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Adverse features?
- Shock
- Syncope
- Myocardial ischaemia
- Heart failure

YES
Manage according to Resus policy guidance

Synchronised D.C. Cardioversion - up to 3 shocks

I.V. Amiodarone 300mg over 10-20 minutes

Further synchronised D.C. shock

I.V. Amiodarone 900mg over 24 hours

NO

Consider & treat hypovolaemia, pain, sepsis & electrolyte imbalance. Check and commence correction of hypokalaemia (> 4.0mmol/L) & hypomagnesaemia (consider 10mmol magnesium bolus for **RATE** control)

Known Atrial Fibrillation?

New Atrial Fibrillation

HR > 110/min or symptomatic?

YES

If duration of AF >12 hours request echo & consider anticoagulation

NO

Treatment not indicated

Chemical Cardioversion
IV Amiodarone 300mg over 1 hour, then 900mg over 23 hours.

Patient remains in **rate controlled** AF (**HR < 110**)

Convert to IV/ oral digoxin/ β blocker

Patient remains in **fast** AF (**HR > 130**)

Contact cardiology re. 2nd line management

When appropriate, request:
- ECG
- ECHO (non urgent)
- TFTs
- CXR if ?HAP/ LVF

Paroxysmal Atrial Fibrillation

HR ≥ 130/min

Metoprolol IV up to 5mg in 1mg boluses until HR < 130/min

If remains uncontrolled Treat as new AF – use chemical cardioversion

HR < 130/min

Treatment can be delayed for 24 hours

Manage fluids & analgesia

Chronic Atrial Fibrillation

Patient's usual treatment

Digoxin

IV digoxin 250mcg two hourly until HR < 130/min or 1mg total

Check digoxin level

β blocker

Metoprolol IV up to 5mg in 1mg boluses until HR < 130/min

If first line doesn't achieve rate control <130/min, use other alternative if not contraindicated

If usually only on warfarin, treat with metoprolol unless contraindicated (COPD, allergy), in which case, use digoxin

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