

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 these findings?

Pamela McCabe:

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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:

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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

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

Robert Page:

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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? (SyHa(S))



Brandon Walker:

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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 A Woo