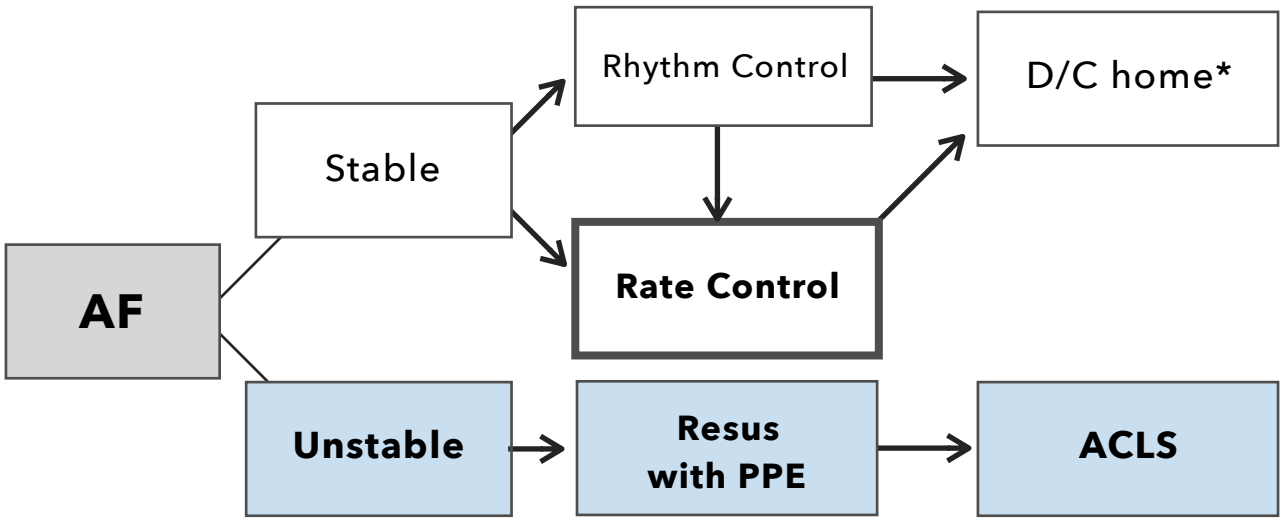
AF Pathways (during COVID-19)

NORTH YORK GENERAL



* Admission is rarely required for stable patients

1. Unstable AF Patients

Definition	Shock, cardiac ischemia, pulmonary edema
Destination	Resus
RN Recommendations	No change from current practice
MD Recommendations	**1. Electrical cardioversion IF the main etiology is thought to be rapid heart rate:** a. ED team prepare for protected Aerosol Generating Medical Procedure (AGMP) b. Enhanced PPE c. Sedation if patient alert d. Treatment as indicated by standard of care **2. Consider other etiologies driving rapid HR:** • In these patients, consider avoiding cardioversion or rate control and treating the underlying medical issue: - COVID-19 - Sepsis - Acute Coronary Syndrome - Pulmonary Embolism - Toxins

2. Stable AF Patients

Definition	Anyone else
Destination	Resus or Acute Care
RN Recommendations	**1. Medical directives** **2. Notify MD if:** 1. Chest pain or dyspnea 2. sBP <110 or symptomatic 3. HR >150
MD Recommendations	• **Canadian Cardiovascular Society (CCS) algorithm is recommended** *Key points:* 1. Most patients don't need cardioversion & will spontaneously convert 2. Rate control & anticoagulation are the most important interventions before discharge 3. Decision to proceed to electrical cardioversion is at MD discretion but should involve discussion with patient, charge RN, and help MD • **Consider:** a. Extended electrolytes & TSH b. Troponin only if patient has ischemic chest pain

Decision regarding Rhythm vs. Rate control

Rhythm control is an option if

i. Clear onset <12hrs *AND* no stroke or TIA in past 6 months
ii. Onset is between 12 to 48 hours *AND* CHADS <2

Rate Control Pathway *(Preferred)*	Rhythm Control Pathway

Set up:
• Baseline vitals
• Telemetry
• First dose: metoprolol 2.5 - 5mg IV, repeat q5 min to a max of 15mg
• Simultaneous PO dose
  • If HR >110 metoprolol 25mg po x1
  • If HR >120 metoprolol 50mg po x1
  • Can repeat dose 25mg to 50mg in 1 hour
Monitoring: BP q10 min
Targets:
• HR <120 - 130 is acceptable if patient is otherwise tolerating symptoms well
• If HR >130 → consult GIM
Tips:
• Safe and appropriate for almost all patients
• Most rate control patients do not need admission
	Contraindications to Rhythm control:
	• Patient already on anti-arrhythmic such as flecainide, sotalol, or amiodarone
	• K <3.5
	• Other electrolyte abnormality
	• Known Valvular AF
	Setup:
	• ECG before
	• Telemetry
	• Procainamide 1g IV over 1 hour
	Monitoring:
	a. BP q10 min
	  • If sBP <100mmHg, stop infusion
	b. Telemetry strip q20 min
	  • If QRS duration increases by >50% stop infusion and get ECG
	Post Infusion:
	• If successful → go to discharge
	• If unsuccessful → go to rate control

Rate & Rhythm Controlled Discharge Planning & Follow-up

(during pandemic)

1. **Medications:**

   1) Metoprolol PO 25 - 50 mg BID or TID (*if HR is high at time of discharge*)

   2) DOAC – See appendix at nyghemerg.ca for dosing instructions

      - If patient cardioverted *(spontaneous or by treatment)* → DOAC x 4 weeks
      - Otherwise, suggest CCS or Thrombosis Canada algorithm, plus clinical judgement
      - Cardio will discuss long-term DOAC needs

2. **Please send all patients to rapid cardio clinic for follow up**
   - Will have virtual consult within 3 - 4 business days
   - After first consult, cardio will follow as indicated or at their discretion
   - *To ensure good follow-up during the pandemic*, please refer patients even if they have an existing cardiologist

3. **Ask all patients to follow up with GP in one week**

4. **Provide education + information sheet for patient *and* for GP:**
   - Context of Pandemic
   - How to self-monitor: need to get BP machine, pulse monitor or pulse app
   - Information sheets found at AC desk or at nyghemerg.com

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