

► See related Practice Guideline on page 332.

► See related article at <http://aafp.org/afp/2016/0915/p442.html>.

► See AAFP guideline at [http://www.aafp.org/dam/AAFP/documents/patient\\_care/clinical\\_recommendations/a-fib-guideline.pdf](http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/a-fib-guideline.pdf).

## Differences Between the AAFP Atrial Fibrillation Guideline and the AHA/ACC/HRS Guideline

MARGOT L. SAVOY, MD, MPH, FAAFP  
*Christiana Care Health System Department of Family and Community Medicine, Wilmington, Delaware*

Published online August 1, 2017.

The 2014 American Heart Association (AHA)/American College of Cardiology (ACC)/Heart Rhythm Society (HRS) guideline for the management of patients with atrial fibrillation provides comprehensive guidance applicable to primary care.<sup>1</sup> However, after reviewing it, the Commission on Health of the Public and Science at the American Academy of Family Physicians (AAFP) concluded that the guideline includes recommendations that did not have sufficient supporting evidence. To address this concern, the AAFP updated its guideline on pharmacologic management of newly detected atrial fibrillation,<sup>2</sup> which differs in part from the AHA/ACC/HRS guideline. It specifically highlights two questions commonly faced by family physicians, and is based on updated data from the Agency for Healthcare Research and Quality.<sup>3,4</sup>

### Strict vs. Lenient Rate Control

Both guidelines agree that rate control is preferred to rhythm control in most patients with atrial fibrillation. The AHA/ACC/HRS guideline recommends controlling ventricular rate using a beta blocker or nondihydropyridine calcium channel blocker in patients with paroxysmal, persistent, or permanent atrial fibrillation. It also advises that a strict rate control strategy (resting heart rate less than 80 beats per minute) is reasonable for management of atrial fibrillation.<sup>1</sup>

Many family physicians struggle with a recommendation for such strict control, especially in asymptomatic patients, and are concerned about the potential need for higher doses of medication and the increased risk of medication-related adverse

effects. No study definitively shows that strict control improves morbidity or mortality compared with more lenient control. There is some evidence that stroke may be reduced with lenient vs. strict control.<sup>5</sup>

Although both guidelines agree that data support preferentially using calcium channel blockers and beta blockers over digoxin, there is insufficient evidence to support the superiority of one calcium channel blocker or beta blocker over another.<sup>3</sup> The updated AAFP guideline recommends lenient rate control (resting heart rate less than 110 beats per minute) over strict rate control, but it does not recommend specific drug therapies.

### Usefulness of Stroke Risk Scores

Using a screening tool to determine a patient's risk of stroke and to inform the shared decision-making process about starting anticoagulation continues to be recommended as good clinical practice. In the AHA/ACC/HRS guideline, the CHA<sub>2</sub>DS<sub>2</sub>-VASc score is the recommended screening tool.<sup>1</sup> Another screening tool, the CHADS<sub>2</sub> score, uses fewer risk factors; therefore, this AHA/ACC/HRS recommendation for use of the CHA<sub>2</sub>DS<sub>2</sub>-VASc score implies that including additional risk factors makes it more likely to identify a patient at risk of stroke. In reality, although the CHA<sub>2</sub>DS<sub>2</sub>-VASc score increases the number of patients eligible for anticoagulation, both it and the CHADS<sub>2</sub> score are similar in assisting clinicians and patients in determining the risk of stroke.<sup>4</sup> In the AAFP guideline, there is no preference for the CHA<sub>2</sub>DS<sub>2</sub>-VASc score over the CHADS<sub>2</sub> score. The focus is on ensuring that persons with a high risk of stroke are identified, bleeding risk is evaluated, and the overall risks, benefits, and values are openly discussed to reach an optimal patient-centered decision.

### Limited but Beneficial Advice

The updated AAFP guideline is limited in scope and does not address all patients with

atrial fibrillation; atrial fibrillation due to a reversible cause (e.g., postoperative, post-myocardial infarction, hyperthyroidism) or valvular disease is excluded. The recommendations on rate control and stroke risk assessment are sound, and the guideline is transparent about the strength of the evidence used to reach those conclusions.

EDITOR'S NOTE: Dr. Savoy is a member of the AAFP Commission on Health of the Public and Science, which reviewed and approved the AAFP guideline on pharmacologic management of newly detected atrial fibrillation, although she was not an author of the guideline.

Address correspondence to Margot L. Savoy, MD, MPH, FAAFP, at [msavoy@christianacare.org](mailto:msavoy@christianacare.org). Reprints are not available from the author.

Author disclosure: No relevant financial affiliations.

#### REFERENCES

1. January CT, Wann LS, Alpert JS, et al. 2014 AHA/ACC/HRS guideline for the management of patients with atrial fibrillation: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society [published correction appears in *J Am Coll Cardiol*. 2014;64(21):2305-2307]. *J Am Coll Cardiol*. 2014; 64(21):e1-e76.
2. Frost JL, Campos-Outcalt D, Hoelting D, et al. Pharmacologic management of newly detected atrial fibrillation. April 2017. [http://www.aafp.org/dam/AAFP/documents/patient\\_care/clinical\\_recommendations/a-fib-guideline.pdf](http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/a-fib-guideline.pdf). Accessed July 11, 2017.
3. Agency for Healthcare Research and Quality. Treatment of atrial fibrillation. Comparative effectiveness review number 119. June 2013. <https://www.effectivehealthcare.ahrq.gov/ehc/products/358/1559/atrial-fibrillation-report-130628.pdf>. Accessed June 20, 2017.
4. Agency for Healthcare Research and Quality. Stroke prevention in atrial fibrillation. Comparative effectiveness review number 123. August 2013. <https://www.effectivehealthcare.ahrq.gov/ehc/products/352/1668/stroke-atrial-fibrillation-report-130821.pdf>. Accessed June 20, 2017.
5. Maan A, Mansour M, Ruskin JN, Heist EK. Current evidence and recommendations for rate control in atrial fibrillation. *Arrhythm Electrophysiol Rev*. 2013;2(1): 30-35. ■



## Earn CME for MACRA

You need to know MACRA. Now earn credits for learning about it.

### Making Sense of MACRA Conference

October 26 or October 27, 2017 | Phoenix, AZ

Get ready to:

- Master MACRA
- Hear from the AAFP's QPP experts
- Fast-track your understanding of MIPS

**Register now**  
[aafp.org/macra-az](http://aafp.org/macra-az)

**Register by September 27 and save \$70.**

*Approved for 3 AAFP Prescribed credits.*

