



Atrial fibrillation decision-making guide for family physicians

The American Academy of Family Physicians developed this guide to provide practical, evidence-based guidance for family physicians caring for patients with atrial fibrillation (AF). It highlights key decision points, medication recommendations and referral considerations.

What is the best approach for managing AF diagnosed by exam and confirmed with office ECG in an asymptomatic patient?

Estimate the patient's risk using the CHA₂DS₂-VASc* tool.

- **CHA₂DS₂-VASc score of 2 or greater in men or 3 or greater in women:** Anticoagulation is recommended (Class I, Level of Evidence [LOE]: A).¹
- **CHA₂DS₂-VASc score of 1 in men or 2 in women:** Anticoagulation is reasonable to prevent stroke and systemic thromboembolism (Class IIa, LOE: A).¹

Aspirin and clopidogrel are no longer recommended as treatment options for patients with CHA₂DS₂-VASc scores of 0-1.^{2,3}

What is the recommended anticoagulation strategy for patients with nonvalvular AF who are candidates for anticoagulation?

Direct-acting oral anticoagulants (DOACs) are generally preferred over vitamin K antagonists (e.g., warfarin) for these patients.¹

Consider using SPARCtool (www.sparctool.com; not available as an app) to choose the best DOAC for a patient with nonvalvular AF.

Are some patients ineligible for DOACs based on their HAS-BLED[†] bleeding risk score?

No, HAS-BLED should not be used to exclude patients from anticoagulation.⁴ However, it may indicate the need to modify a patient's risk factors for bleeding. Evidence suggests that patients with a HAS-BLED score of 3 or greater still do better with anticoagulation.⁴

Which patients with AF should receive warfarin rather than a DOAC?

Warfarin is recommended over DOACs for patients who have valvular AF (i.e., moderate-to-severe mitral stenosis or a mechanical heart valve).^{1,5} It might also be reasonable to prescribe warfarin for patients with AF who are at increased risk for stroke and have end-stage chronic kidney disease.¹

What is the target heart rate for patients with AF?

For symptomatic management of AF, a strict rate control strategy (resting heart rate less than 80 beats per minute) is reasonable (Class IIa, LOE: B).⁶ A lenient rate control strategy (resting heart rate less than 110 beats per minute) may be reasonable as long as patients remain asymptomatic and left ventricular systolic function is preserved (Class IIb, LOE: B).

Beta blockers (e.g., metoprolol) and centrally acting calcium channel blockers (e.g., verapamil, diltiazem) are the preferred agents to help patients with AF achieve target heart rate goals.¹

*CHA₂DS₂-VASc = Congestive heart failure, Hypertension, Age 75 or older [doubled], Diabetes mellitus, Stroke [doubled], Vascular disease, Age 65 to 74, Sex category [female]
†HAS-BLED = Hypertension, Abnormal renal/liver function, Stroke, Bleeding history or predisposition, Labile international normalized ratio, Elderly [age 65 or older], Drugs/alcohol concomitantly

Which patients need prolonged monitoring with an external ambulatory ECG monitor or implantable loop recorder (ILR)?

Initial cardiac monitoring and, if needed, prolonged monitoring with an ILR are reasonable to improve detection of AF in patients following a cryptogenic stroke or transient ischemic attack (TIA) (Class IIa, LOE: B).¹ The recommended course of action is extended external ambulatory ECG monitoring for 30 days.⁷ If AF is not detected with external ambulatory monitoring, implantation of an ILR is reasonable (Class IIa, LOE: B).⁵

Which patients with AF should be referred to cardiology/electrophysiology for antiarrhythmic drugs (AAD) or ablation?

Referral to cardiology/electrophysiology will depend on local cardiology expertise.

Ablation may be considered for:

- Younger patients
- Patients for whom AADs have been ineffective or not well tolerated
- Asymptomatic patients at increased risk of stroke (CHA₂DS₂-VASc score of 2 or greater)

How long should oral anticoagulation be continued after a successful ablation?

All patients should continue taking oral anticoagulants for at least three months following the procedure (Class I, LOE: B).¹ Current evidence indicates that oral anticoagulation should be continued long term following catheter ablation in patients with a CHA₂DS₂-VASc score of 2 or greater (Class I, LOE: B).

What are the treatment options for patients with AF who are not candidates for anticoagulation?

Percutaneous left atrial appendage occlusion (LAAO) may be considered in patients with AF who are at increased risk of stroke and have contraindications to long-term oral anticoagulation.¹ As of 2025, the Watchman and Amulet devices for percutaneous LAAO had been approved by the FDA.^{8,9}

Recommendations for secondary prevention of AF (Class I, LOE: B)¹

- Engage in moderate-to-vigorous exercise (goal of 210 minutes per week)
- Lose weight if body mass index is greater than 27 kg/m²
- Minimize or eliminate alcohol consumption
- Achieve optimal blood pressure control (goal of less than 130/80 mm Hg¹⁰)
- Quit smoking

References

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