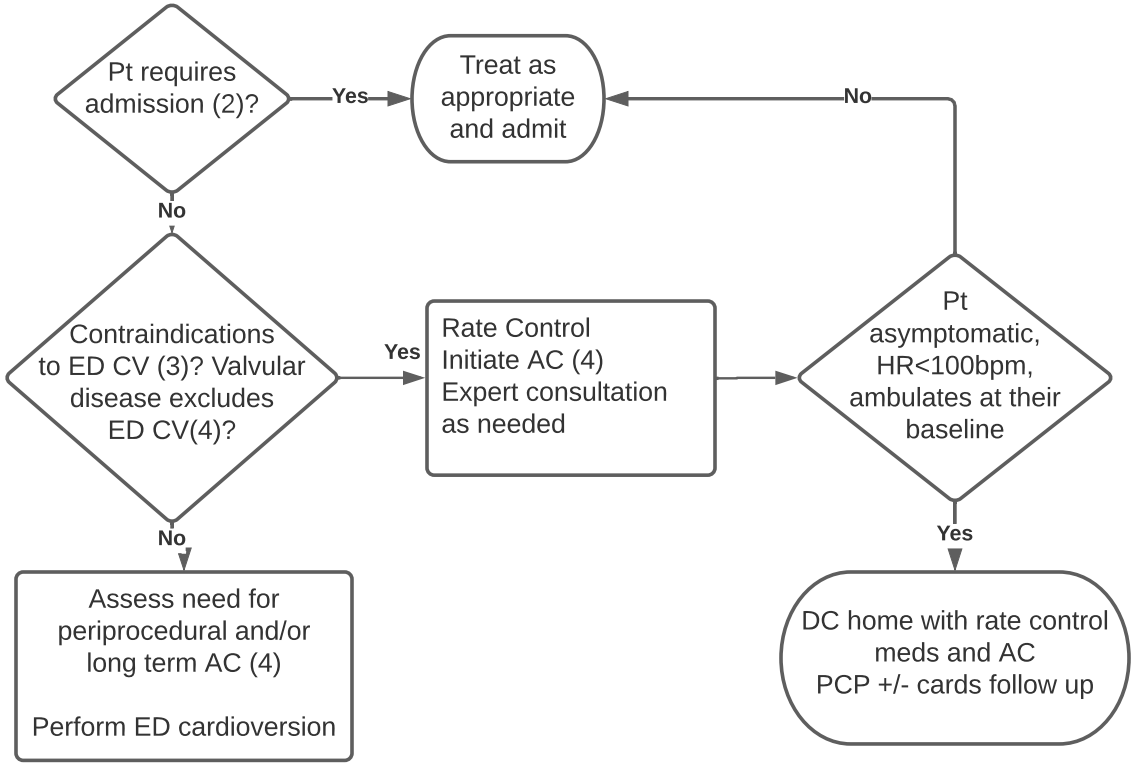
Hemodynamically stable patient with atrial fibrillation (AF) presents to the ED
Consider underlying cause (PE, hyperthyroidism, intoxication or withdrawal, valvular disease, infection). Evaluate and treat underlying causes as appropriate.
Consider CBC, BMP, TSH
INR if appropriate
Calculate CHA_2DS_2-VASc score (1)
Consider bedside echo, formal echo, or arranging outpatient echo



1. CHA_2DS_2-VASc Score
CHF = 1
Htn = 1
Age 65-74 = 1
Age >/= 75 = 2
DM = 1
H/o stroke or TIA = 2
Vascular disease (MI, PAD, aortic plaque) = 1
Female gender = 1

2. Patients likely to require admission
- Signs of decompensated heart failure
- Known intracardiac thrombus
- Ongoing angina thought to not be rate-related
- Other comorbid conditions or social factors that require admission
- Emergency physician judgment
- Failure to rate control if not a CV candidate

3. Contraindications to ED cardioversion (CV)
- Emergency physician judgment, patient preference
- EF<30%
- Acute MI within 4 weeks
- Stroke/TIA or thromboembolism within 6 months
- Creatinine clearance <30 mL/min
- CHA_2DS_2-VASc>/=5
- AF duration >48 hours in a non-anticoagulated patient
- Some sources (ESC, CCS) recommend caution in AF duration >12-24 hours in a non-anticoagulated patient with CHA_2DS_2-VASc >/=2
- Patient on AC but missed doses or subtherapeutic INR if duration of AF > 12-48h (may still be eligible for ED CV if AF onset <12-48h)
- Inappropriate for ED sedation

4. Special considerations: valvular disease
- Mechanical valve: should be on vitamin K antagonist already. OK to cardiovert if INR>2 and AF<24-48h, or if AF duration>48h and INR>2 for >21 days
- Rheumatic valve disease + AF: consult cardiology
- Recent bioprosthetic valve < 3 months + AF: consult cardiology

4. Periprocedural and long-term anticoagulation (for patients not already on AC)
Use shared decision making; assess bleeding risk (ie HASBLED score)

CHA_2DS_2-VASc score	Male = 0-1, Female = 1-2	Male >/= 2, Female >/= 3
Periprocedural AC	Administer single dose DOAC as soon as possible prior to cardioversion (apixaban preferred due to better absorption while npo, 10mg suggested)	Administer DOAC as soon as possible prior to cardioversion (apixaban preferred due to better absorption while npo)
Long-term AC	No need for post-procedural anticoagulation Some sources recommend 4 weeks AC for all (CCS) or if AF >24h (ESC)	Long-term anticoagulation

This guideline was ratified by the Emergency Department faculty at Maine Medical Center in March 2022. It reflects our expert opinion and is not necessarily applicable to all institutions. It is intended to be a reference for clinicians caring for patients and is not intended to replace providers' clinical judgment.
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Guideline Evidence

Guideline Topic: Atrtial Fibrillation
Author: Samantha L. Wood, MD
Date of Creation: 3/1/2022 Sugg Update: 2024
Search Criteria:

Databases:

Key Guidelines (Dates) AHA/ACC afib guideline 2019, ESC guideline 2020,

#	Recommendation	Source	Classification	Level of Evidence
1	For patients with AF or flutter of <48 hours duration with a CHA2DS2Vasc score of 2 or greater in men or 3 or greater in women, administration of heparin, a factor Xa inhibitor, or a direct thrombin inhibitor is reasonable as soon as possible before cardioversion, followed by long-term anticoagulant therapy	AHA/ACC guideline 2019	Iia B-NR	Moderate
2	For patients with AF or flutter of <48 hours duration with a CHA2DS2Vasc score of 0 in men or 1 in women, administration of heparin, a factor Xa inhibitor, or a direct thrombin inhibitor may be considered before cardioversion, without the need for postcardioversion anticoagulation	AHA/ACC guideline 2019	IIB, B-NR	Weak
3	Cardioversion of symptomatic Afib/flutter without at least 3 weeks of therapeutic anticoagulation (or TEE) reserved for patients with non-valvular afib/flutter who present with clear onset within 12 hours in the absence of recent stroke/TIA (6 months), or patients with a CHADS2 score <2 who present within 12-48 hours	CCS		Weak
	Anticoagulation for 4 weeks post cardioversion in all patients in the absence of any contraindication	CCS		Weak
4	For cardioversion within 48 hours of onset: ideal candidates have AF<12 hours and no previous thromboembolism, or AF 12-48 hours and CHA2DS2Vasc <= 1 for men or </=2 for women	ESC guideline		
5	4 weeks post-cardioversion anticoagulation if CHA2DS2-VASc = 0 in men or 1 in women, optional if afib onset was definitely less than 24 hours	ESC guideline	Iib	
6	Long term anticoagulation for all patients with CHA2DS2-VASc >/= 1 in med or >/= 2 in women	ESC guideline		
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CPQE Guideline Evidence, cont.

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