British Cardiovascular Society

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BCS Guidelines and Practice Committee Reviews

25 March 2014

BCS comment on: The UK National Screening Committee - Screening for Atrial Fibrillation in People aged 65 and over draft guideline

3. I think it is extraordinarily unlikely that asymptomatic AF behaves any differently to symptomatic and that any differences seen are the result of confounders (i.e. patients first symptoms of AF may be a stroke and they are labelled as having symptomatic AF even though their symptoms are the result of a complication of the AF not the AF itself . Therefore stroke rates will be higher in AF patients)

8. Much more common modifiable risk factors for AF are hypertension and alcohol ingestion.

32. I think this is overstated. The benefits of warfarin have been proven many times over and there are considerably more data demonstrating the benefits of warfarin than any other antithrombotic. The negative aspects of warfarin are often overstated as they are here. If patients are given the facts about their stroke risk and the benefits of anticoagulation in my experience it is extremely rare for patients to refuse the therapy. Granted, time has to be taken to explain the pros and cons which many GPs find difficult given the short consultation time slots available to them.

34. & 35. The new NICE guidelines for AF will clarify this point and recommend a single scoring system for AF stroke risk. Therefore this is largely redundant for UK practice

45. The statement that “It is questionable whether any screening programme that offers such a fine balance between benefit and harm could be justified.” Is unsupported by any evidence. It is true that there is much evidence demonstrating that time in therapeutic range is critical for the benefits of warfarin. However in many studies the majority of UK patients fulfill this requirement. This paper offers no evidence that significant numbers of patients in the UK are poorly controlled. It also ignores the impact of new anticoagulants which will be used in patients not well controlled on warfarin.

47. One of the reasons that “he use of oral anticoagulants (OACs) is inadequate. There is an urgent need to ... encourage better uptake and adherence to OACs” is that many patients with AF are not identified until they have a stroke or TIA. Furthermore these statements were made before the new anticoagulants were available in the UK. Given the huge burden of AF and the wide variety of presentation it is unrealistic to expect that the care of AF will be optimised any time in the next decade. The question that surely should be asked is, will a condition which has a very cheap screening tool available and a highly effective therapy to prevent an extremely expensive complication, be worth

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screening for? Given the cost benefit of anticoagulation and the recent improvements in these drugs it seems highly likely that this would be worth screening for.

57. Guidelines for anticoagulation have now changed and any patient who is screened for AF (<65 years and older) would benefit from anticoagulation. Therefore all patients identified with AF would be eligible for anticoagulation.

63. "Given the strongly age-related prevalence of AF, and the risks of treatment, it seems unlikely there would be public pressure to expand the programme beyond what is currently being considered". It is not clear to me why the age-related prevalence of AF would make it any less likely that there would be public pressure to improve care of AF. Furthermore the overwhelming evidence as to the benefits of stroke prevention and the increased convenience of the new stroke prevention drugs means that the risk of treatment is unlikely to be a factor preventing the public from demanding better care for this common condition.

Recommendations

I believe that it is a flawed argument to say that identified cases are not perfectly managed so we should not identify more. The management of AF has improved significantly over the last decade including anticoagulation rates. This has largely been due to education and publicity campaigns and the effect of the introduction of new drugs into practice has not yet been seen. Even if one ignored the improvement in clinical care, to reject a screening program because current cases are not well managed is flawed. Firstly the anticoagulation rates of patients at high risk of stroke, identified as part of a comprehensive screening program is likely to be much higher than the anticoagulation rates in historical patients with AF diagnosed via a number of different routes and with wildly varying risk for stroke. There is a large body of evidence that screening for AF is effective and satisfies all of the criteria for a screening program. There is absolutely no evidence that if one initiated such a screening program that patients would not be well managed and yet this is the argument put forward for not having a screening program. There have been huge efforts to improve the care of currently diagnosed patients with AF particularly with focus on anticoagulation. Much progress has been made. However because of the diverse characteristics of the patients and the source of their diagnosis, it is very difficult to set up a system to comprehensively review these patients and offer appropriate therapy, particularly when there is no funding source or national program to do so. Long overdue changes to QOF system will make this more viable but to ignore the large body of patients who have similar risk and may be identified by a simple screening process is short-sighted. That is not to say that the care of patients with a known diagnosis of AF should not be improved, but there is no evidence that this is cost effective, particularly as many patients will already be on appropriate therapy.

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On behalf of the British Cardiovascular Society

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Additional comments from BCS Guidelines and Practice Committee Chair, Dr David Wald:

Professor Schillings comments on the Draft UK National Screening Committee consultation on screening for Atrial Fibrillation were reviewed by the British Cardiovascular Society Guidelines and Practice Committee.

The committee share Professor Schillings serious reservations about the draft document and unanimously agree that the evidence supports screening for atrial fibrillation. The committee wanted to emphasize three corrections that were needed in respect of the draft consultation document.

1. *"It is likely, but not proven, that a national screening programme for atrial fibrillation in people aged 65 and over would produce more benefit than harm at population level, and be cost-effective"*

Response: Randomised trial evidence shows conclusively that warfarin reduces the risk of stroke in people with AF by about 2/3rds, that the strokes prevented exceed the bleeds caused and that treatment is cost effective. To suggest that this benefit would no longer apply to a population (rather than a trial) is scientifically incorrect.

Questions remain over where screening should be offered (primary care v pharmacies, v secondary care) but not whether.

2. *"However, current NHS management of AF that is detected through routine clinical practice is known to be frequently poor, both because patients who should receive anticoagulants do not receive anticoagulants, and because treatment with warfarin is often problematic".*

Response: The need to improve the application of a proven and effective treatment for a disorder is not a reason not to screen for the disorder. The rational solution is to screen AND improve the delivery of treatment.

3. *It is uncertain whether screen-detected AF carries the same risk of stroke as AF that is detected through routine clinical practice. The best available evidence (Flaker et al 2005) suggests that people with asymptomatic AF have similar risks of death and other major events to people with symptomatic AF, but the 95% confidence intervals around these estimates include the possibility that asymptomatic AF carries only two-thirds of the risk of symptomatic AF.*

This is incorrect. The study by Flaker et al in 2005, concluded that there was no material difference in stroke between asymptomatic and symptomatic AF. In fact stroke rates were directionally (though not statistically significantly) higher in asymptomatic AF

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patients. It is also misleading to focus on the lower confidence interval. The upper confidence interval would suggest that outcome was worse in asymptomatic AF. The clear conclusion is that patients with AF, whether symptomatic from their AF or not, have the same or perhaps a higher risk of stroke, and this high risk can be substantially reduced by anticoagulation.

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Chair BCS Guidelines and Practice Committee