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Ms Cia Connell
Clinical Policy Advisor
National Heart Foundation of Australia
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Dear Ms Connell,

Re: *Guidelines for the diagnosis and management of atrial fibrillation in Australia 2018*

Thank you for inviting The Royal Australian College of General Practitioners (RACGP) to provide feedback and comments on the above publication. The RACGP congratulates the National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand on producing this comprehensive and clear guideline on an important and often challenging topic. We are encouraged that the recommendations in your guideline are in line with the RACGP's *Guidelines for preventive activities in general practice* (Red Book), especially that screening for atrial fibrillation (AF) should be done opportunistically.

Some general comments on the guideline:

- A significant barrier to the publication's uptake by general practitioners (GPs) will be the length of the guideline. Creating a two-page summary of recommendations would be a challenge; however, we believe GPs would be more likely to read this summary. Included in this summary should be initial investigation and treatment algorithms to assist in clinical decision-making.
- We suggest that a 'What's new' section be included to identify new or changed evidence-based recommendations for experienced medical practitioners with an interest in this field.
- Several chapters of the guidelines would benefit from the inclusion of the number needed to treat (NNT) and number needed to harm (NNH), especially in patients with a CHA_2DS_2-VASc score of 2.

Some specific comments on the recommendations:

- **Recommendation 2 on Page 4 –** Thromboembolic risk can be hard to assess. Some have argued that a trans-oesophageal ultrasound should be done to ensure there is no clot present when determining thromboembolic risks.
- **Recommendation 1 on Page 7 –** The risk of bleeding scores are discussed in the body of the publication, but none are recommended. The RACGP's Red Book suggests HAS-BLED as a possible tool.
- **Recommendation 9 on Page 7 –** More information needs to be provided on this recommendation. It is not an uncommon scenario when a patient on NOAC needs surgery,

and surgeons tend to vary in their recommendations about altering NOACS, especially if the surgery is urgent.

- **Line 523 on Page 21 –** The issue of whether AF patients managed with a rate-control strategy should have regular echocardiogram to detect a decline in ejection fraction and other parameters needs to be answered.
- **Line 1270 on Page 37 –** The use of aspirin over OAC in older people will need to be further examined as it is a controversial area; GPs are often reluctant to use NOACS in very old patients. A clinical algorithm may help as an appendix.
- **Table 2 on Page 54 –** Based on the recommendations, all patients with hypertension who are aged >65 years should be put on a OAC – this will be a very large number of individuals. We suggest the guideline include figures for NNT and NNH for this group if they did start a OAC.

Additional information on how medical practitioners can manage young patients with persistent non-valvular atrial fibrillation should also be included in the guide. The CHA_2DS_2-VASc score was developed for patients aged >65 years, and the risk of stroke in young patients is very low.

Thank you once again for the opportunity to provide feedback and comments. We look forward to hearing about the progress and outcomes of this guideline.

Yours sincerely

Dr Bastian Seidel
President