Introduction:
New Onset Atrial Fibrillation (NOAF) during critical illness frequently resolves prior to discharge. However long-term risks of NOAF (i.e. heart failure, ischaemic stroke and death) remains high [1]. Previous studies noted that nearly half of NOAF cases did not have diagnosis recorded [2]. Addressing this may reduce post critical illness mortality by increasing AF surveillance post intensive care (ICU) discharge.

Methods:
Retrospective data was collected from an electronic health record for ICU admissions over a 10 month period from 1st of January to 31st of October 2019 at Medway Maritime Hospital. Data collected included; demographics, onset, rate, possible precipitants, attempted electrical or chemical cardioversion, rate control, anticoagulation, rhythm on discharge from ICU and hospital discharge medication. It was recorded if NOAF was documented in ICU and Hospital discharge summaries.

Results:
Over 10 months 429 patients were admitted to ICU. 37 patients developed new onset AF with an average age of 69.2 (±10.3) and 59.4% male. Patients with NOAF had an in-hospital mortality of 43.2% compared to 29.8% . Beta blockers were used in 38% and amiodarone in 59%. 23 patient’s with NOAF survived ICU admission (62%). 13.5% remained in AF on discharge of which 1 patient was discharged from ICU on therapeutic anticoagulation (2 total, 11%). Of those not anticoagulated 19 had a Cha2ds2-VASc of >= 2. On ICU discharge, 23 patients had NOAF. 35% episodes documented on ICU discharge summaries. Thirty three per cent patient had documentation about the reason for choosing rate control approach. On hospital discharge only 28% had documentation of NOAF episode on their hospital discharge summaries.

Conclusion:
Need to implement an automated referral to cardiology to assess long term anticoagulation for patients with NOAF with CHA2DS2-VASc score >=2. For clear documentation of NOAF episode in ICU discharge summaries.

References: