National Institute for Health and Clinical Excellence

Atrial Fibrillation
Scope Consultation Table
2 May – 31 May 2012

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	AMORE Health Ltd	1	General	While we appreciate this guidance does not wish to discuss screening – it is widely felt that the prevalence of AF should be approaching 2% and this will not occur if there is not a mention – that AF screening in an opportunistic setting might be worthwhile – such as in the NHS Health Checks Program. This is a national heavily funded program in which AF screening has been neglected to date and might be picked up as it is clearly cost effective to screen in an existing program of 40-74 years olds.	Thank you for your comment. Screening is outside the remit of this guideline.
SH	AMORE Health Ltd	2	General	It would be worthwhile trying to promote a disease specific, symptom rating scale for AF patients to categorise the impact on patients of their AF	Thank you for your comment. We agree that this would be a worthwhile and interesting piece of work. However, it is outside the remit of our guideline to develop a tool.
SH	AMORE Health Ltd	3	4.3.1b	There is emerging evidence that stains may reduce AF and there should be a mention of the importance of fitness in reducing paroxysms of future AF and blood pressure management	Thank you for your comment. Statins are outside the remit of this guideline. A separate NICE guideline for lipid modification (update) is being developed. The scope is currently out for consultation from 13 June to 11 July 2012 and includes statins. Please follow this link to the consultation documents: http://guidance.nice.org.uk/CG/WaveR/123/Scoping/ScopeConsultation Thank you for your interesting point on the importance of fitness. Unfortunately, prevention and lifestyle are also outside the remit of this guideline. However, NICE is developing public health guidance on 'Physical activity advice in primary care'. Please follow this link for further information: http://guidance.nice.org.uk/index.jsp?action=byId&o=13443

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SH	AMORE Health Ltd	4	General	Thinking ahead to Patient Reported Outcome Measures from AF management and AF management satisfaction audit criteria :- Efforts should be made to appreciate the satisfaction of patients with AF management as there is considerable frustration in patients that communication is poor from many clinicians of what AF is and what treatment options in AF are. Communication as a means of engaging patients in their own disease management has not been mentioned and yet could in the future be a QOF audit outcome.	Thank you for your comment. We agree that patient communication is important. NICE has developed clinical guidance on patient experience in adult NHS services (http://www.nice.org.uk/CG138). This guideline will be cross referred to as appropriate during the development of this guideline.
SH	Arrhythmia Alliance	1	4.3.1	Arrhythmia Alliance is delighted to see that new key clinical issues are being considered.	Thank you for your comment.
SH	Arrhythmia Alliance	2	4.3.1	There is now a range of new rhythm control strategies that can be used to help effectively manage AF, whilst reducing the burden to patients and medical professionals for ongoing monitoring, and restoring the quality of life for those affected by the condition.	Thank you for your comment. Evidence on rhythm control strategies (section 4.3.1c of scope) will be included in the guideline. The guideline development group will prioritise the specific strategies that will be included in the guideline.
SH	Arrhythmia Alliance	3	4.3.1	Patient information and support for those affected by AF is crucial and we are very pleased to see that this is being noted specifically for inclusion in the revised guidance for AF.	Thank you for your comment. We are pleased you agree with this statement (4.3.1.f).
SH	Association of British Healthcare Industries	1	General	ABHI would like to thank NICE for the opportunity to contribute to this scope for developing Guidelines around Atrial Fibrillation. We look for to the positive effect the Guidelines will have on patients in this disease area.	Thank you for your comment.
SH	Association of British Healthcare Industries	2	4.3.1	We think that the key clinical areas have been covered however we wish to emphasise the fact that therapies used for the clinical management of AF should not be considered as standalone treatments but as a adjunctive therapies (eg: Treatment plus Prevention = AF ablation plus Left Atrial appendage occlusion) and we hope this will be reflected in the scope and subsequent guideline	Thank you for your comment. The guideline development group will prioritise the specific review questions that will be included in the guideline. This will include whether therapies are considered as standalone treatments or as an adjunctive therapy. The guideline development group will be made aware of this information during development.
SH	Association of British	3	4.3.1 e	The monitoring of AF (both pre and post ablation) should include use of an implantable loop recorders as a monitoring tool and gold standard.	Thank you for your comment. The guideline development group will take this information into account when

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	Healthcare Industries				prioritising the specific review question for monitoring.
SH	Bayer	1	5.1.2	Other related NICE guidance The technology appraisal for rivaroxaban in atrial fibrillation (stroke prevention) (TA256) was published in May 2012. As this STA relates to the same clinical area as the guideline it should therefore be referenced in accordance with section 8 of the guidelines manual: "The scoping stage of clinical guideline development should identify topics from other programmes that are relevant to the guideline being developed." As the topic for the guideline covers this STA, the technology appraisal guidance should be incorporated verbatim into the clinical guideline in accordance with section 8.1.1 of the guidelines manual.	Thank you for your comment. We agree and have added this to the scope.
SH	Bayer	2	4.1.1	b) Specific consideration should also be given to the needs of patients with concomitant coronary artery disease (CAD) and those with renal disease.	Thank you for your comment. We do not agree that these groups need inclusion within the scope. The guideline development group will consider all other subgroups for which differences are identified during development when setting the review questions and reviewing the evidence base.
SH	Bayer	3	4.3.1	b) Adherence with chronic-use prescription medications used by patients with cardiovascular disease has been shown to be greater with a once-daily dosing regimen versus a twice-daily dosing regimen.[1] 1. Bae JP, *et al.* Adherence and dosing frequency of common medications for cardiovascular patients. Am J Manag Care. 2012;18(3):139-46	Thank you for your comment. Adherence is outside the remit of this guideline. NICE has developed clinical guidance on medicines adherence that will be cross referred to as appropriate during the development of the guideline. http://guidance.nice.org.uk/CG76
SH	Bayer	4	4.3.2	Clinical issues that will not be covered Areas from the original guideline that will not be updated a) Identification and diagnosis of AF We believe that this area should be updated. The current guideline recommends opportunistic screening of	Thank you for your comment. The NICE review for update did not identify a need to update diagnosis but the diagnosis recommendations from the previous guideline will be included. Screening is outside the remit of this guideline.

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				symptomatic patients, but does not cover more general opportunistic screening in those over 65, which has been shown to improve on routine practice.[2] There is also now evidence from projects undertaken as part of the Heart and Stroke Improvement Programme to address the detection of atrial fibrillation, and its subsequent management which have shown that opportunistic screening can significantly increase detection rates of AF.[3] One practice based commissioning group has recorded that conducting manual pulse checks at flu clinics enabled an estimated annual cost saving of £220,000 which represented 322% return on investment in addition to improved quality outcomes for patients. This area of the clinical guideline should be updated. 2. Hobbs FD, *et al.* A randomised controlled trial and cost-effectiveness study of systematic screening (targeted and total population screening) versus routine practice for the detection of atrial fibrillation in people aged 65 and over. The SAFE study. *Health Technol Assess* 2005; 9(40):iii-x, 1. 3. NHS Improvement - Heart and Stroke Improvement. Atrial fibrillation in primary care: making an impact on stroke prevention National priority project final summaries. http://www.improvement.nhs.uk/LinkClick.aspx?fileticket=%2bLIKN1gSgOA%3d&tabid=62 2009 October. Accessed 18/05/2012.	
SH	Bayer	5	4.4	a) It has been suggested that the quality of life of AF patients treated with warfarin may diminish as they need to undergo frequent blood tests, limit their activities and alcohol intake and avoid other drugs.[4] 4. Robinson A, et al. How patients with atrial fibrillation value different health outcomes: a standard gamble study. J Health Serv Res Policy. 2001;6(2):94-98	Thank you for your comment. The guideline development group will prioritise the specific review questions and outcomes that will be included in the guideline.
SH	Bayer	6	5.2	Guidance under development	Thank you for your comment. We do not agree that this

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				The following NICE technology appraisal is also currently in development with the draft FAD due on 1st June 2012 and final publication in July 2012. Rivaroxaban for the treatment of deep vein thrombosis and prevention of recurrent deep vein thrombosis and pulmonary embolism.	guidance is relevant to this guideline.
SH	Boehringer Ingelheim	1	3.1 a)	We would suggest that AF epidemiology of 1.3%, likely based on 2006 figures is an underestimate, more recent March 2012 published RCPE UK consensus quotes 'at least 1.8% of population' are affected.	Thank you for your comment. The 1.3% figure was taken from the atrial fibrillation 2006 guideline for this scope. However, we agree that this figure may be an underestimate and the guideline group will aim to find an updated figure for the guideline.
SH	Boehringer Ingelheim	2	3.1 d)	With reference to '130,000 hospitalisations', this could be an underestimate and may only include episodes where AF is deemed to be the primary event, this number could be considerably higher if people with event such as heart failure or chest pain, secondary to AF are included.	Thank you for your comment. This figure is taken from the Hospital Episode Statistics (HES) and includes data on admissions primarily due to atrial fibrillation as stated.
SH	Boehringer Ingelheim	3	3.1 e)	In addition to this point, we would suggest that due to the well-known limitations of traditional anticoagulants, people are also being treated sub-optimally with aspirin.	Thank you for your comment and information. The guideline development group will consider evidence on antithrombotic therapy for the prevention of stroke (scope section 4.3.1.b). The guideline development group will prioritise the specific review questions that will be included in the guideline.
SH	Boehringer Ingelheim	4	3.1 g)	We would suggest that this guideline update is also needed importantly in order to establish good practice in management of people with AF	Thank you for your comment. We agree that good practice in management of people with atrial fibrillation is important. We believe that this will be reflected in the guideline.
SH	Boehringer Ingelheim	5	4.1.1 b)	We would suggest that additional groups of people are considered, in particular, those with renal impairment, or at risk of bleeding.	Thank you for your comment. We do not agree that these groups need inclusion within the scope. The guideline development group will consider all other subgroups for which differences are identified during development when setting the review questions and reviewing the evidence base. When formulating recommendations on drugs the guideline development group will discuss all special considerations relevant to that drug.

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SH	Boehringer Ingelheim	6	4.3.1 d); also 3.1 b)	This point could be extended to consider opportunistic screening for AF, for example within existing well-being clinics, where it would be easy to include a pulse-check	Thank you for your comment. The NICE review for update did not identify a need to update diagnosis but the recommendations from the previous guideline will be included. However, screening is outside the remit of the guideline.
SH	Boehringer Ingelheim	7	4.3.1 e)	Within the final bullet, we would suggest considering 'safety indicators'; for example INR >5 or >10, bleed events (which can also occur within therapeutic range), and thrombotic events	Thank you for your comment. The guideline group will prioritise the specific review questions to be included in the guideline.
SH	Boehringer Ingelheim	8	4.3.1 f)	Within this section, we would consider there is a need for justified exception from specific SPC guidance, for example, around cardioversion procedures,though the Pradaxa SPC states 'patients can stay on dabigatran etexilate while being cardioverted'. Dabigatran's role in cardioversion has clinical support and current AF guidelines (e.g. ACCP 2012) also endorse its use in this setting, including patients who may not necessarily already be on dabigatran etexilate.	Thank you for your comment. The guideline development group will formulate the recommendations after reviewing the evidence. If the guideline development group decides that there is an exceptional need to recommend use outside a licensed indication then this must be clearly supported by evidence.
SH	Boehringer Ingelheim	9	4.4 f)	We would suggest that although heart failure associated with AF is being captured, please also consider inclusion of patients developing chest pain or angina.	Thank you for your comment. The outcomes listed are examples suggested for questions that we expect the guideline to answer. The list is not exhaustive and will be tailored to each evidence review. The guideline development group will finalise the list that we will consider.
SH	Boston Scientific	1	4.3.1 b)	We welcome the inclusion of left atrial appendage occlusion in the list of interventions to prevent AF-related strokes. We would like to highlight that this procedure can be described as left atrial appendage occlusion OR left atrial appendage closure.this should be reflected in the Clinical Guidelines. Moreover it is also of note that the clinical evidence related to left atrial appendage closure is available mainly on one of the technologies available in the health service. This was highlighted in the Interventional Proceudre Guidance number 349. This should be considered by the GDG in their deliberations.	Thank you for your comment and for highlighting this to us. We will ensure that these terms are included in our search strategies and glossary of terms in the full guideline.
SH	British Cardiovasc	1	3g	Other data on new anti-arrhythmics should be considered e.g. dronaderone (which needs guidance on appropriate use). Also, needs	Thank you for your comment. Dronedarone will not be covered in this guideline as NICE has developed

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	ular Society			to update on role of ablation, especially to achieve cure in paroxysmal AF.	technology appraisal guidance on it. The guideline will incorporate this into the guideline (subject to the review proposal consultation with consultees) http://guidance.nice.org.uk/TA197 and any other relevant technology appraisals and guidelines will be referred to. We agree that ablation should be included and it is covered in section 4.3.1.c of the scope.
SH	British Cardiovascular Society	2	4.3.1	a. Should cover risk factors for stroke and bleeding too. EHRA/ESC Working Group on Thrombosis consensus document on bleeding risk assessment and management in AF patients should be considered (Lip et al. Europace 2011). Lots of real world data on stroke risk factors and bleeding have been published – reliance on non-warfarin arms of historical trial cohorts may be misleading, as these trials only randomized <10% of the patients screened. Benefits of a risk factor based approach to risk stratification – as recommended in ESC guidelines, and use of the CHA2DS2-VASc score. Patients with CHADS2 score 0-1 is NOT low risk (despite QOF recommending anticoagulation at CHADS2>1 as a 'quality standard'), as the untreated stroke/thromboembolism risk can range between 0.8%/year (if CHA2DS2-VASc=0) to 8%/year (CHA2DS2-VASc=5). Even CHADS2=0 is not low risk, with stroke/TE risk ranging between 0.8 to 3/2%/year! Bleeding risk assessment using HAS-BLED, as per European and Canadian guidelines. Also, net clinical benefit balancing stroke vs bleeding risk. Large analysis by Friberg et al Circulation 2012 (with a nice	Thank you for your comment. We agree that risk stratification for stroke and bleeding is important. They are covered in the scope key clinical issues (4.3.1.a) and will be included in the guideline.

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				Editorial by Valentin Fuster)	
SH	British Cardiovascular Society	3	4.3.1	b. A critical appraisal of the role of aspirin is needed, given how commonly it is used despite its ineffectiveness for stroke prevention and poor safety c. Need to consider specific drugs, to advise practitioners on how to use appropriately e.g. dronaderone d. Self-monitoring of warfarin should not be excluded – importance of achieving time in therapeutic range.	Thank you for your comments. -The guideline includes the prevention of stroke using antithrombotic therapy (section 4.3.1b). The guideline development group will prioritise the specific review question from this that will be included in the guideline. - NICE has developed guidance on dronaderone that will be incorporated into the guideline (subject to the review proposal consultation with consultees) http://guidance.nice.org.uk/TA197 - Self monitoring of warfarin has been excluded from this scope. NICE is developing guidance on the management of venous thromboembolic diseases and the role of thrombophilia testing (publication expected June 2012). This NICE clinical guideline includes guidance on self monitoring of anticoagulants, which can be cross referred to at following link: http://guidance.nice.org.uk/CG/Wave21/5
SH	British Cardiovascular Society	4		Patient values and preferences should be addressed – see EHRA consensus document mentioned above.	Thank you for your comment. The guideline development group will consider patient values and preferences when considering recommendations. NICE has developed guidance on patient experience in adult NHS services (clinical guideline 138) that we will cross refer to where appropriate.
SH	British Cardiovascular Society	5		Updated cost effectiveness and modeling needed, with respect to possibility of new oral anticoagulants and how these would impact in improving outcomes in those sub-optimally treated with warfarin, or those given aspirin if unable to attend for monitoring etc.	Thank you for your comment. The guideline development group will prioritise the key issues that will have economic modelling.

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SH	British Society for Haematology (BSH) and The Royal College of Pathologists (RCPath)			The British Society for Haematology (BSH) and The Royal College of Pathologists (RCPath) do not have any comments or suggestions at this stage of the consultation.	Thank you for your comment.
SH	Daiichi Sankyo	1	3.2 (e)	The scope states the following: "However, newer agents are now being used an alternatives to warfarin" It is important to specify that the "newer agents are being used as alternatives to warfarin in non-valvular atrial fibrillation" in line with their respective SPCs.	Thank you for your comment. We agree and have amended the scope accordingly.
SH	Daiichi Sankyo	2	3.2 (g)	The scope states "new evidence available for several clinical areas including stroke risk stratification, the role of new antithrombotic agents and ablation strategies". Please include "bleeding risk stratification" as well, for example the CHADSVASC/HASBLED scoring system.	Thank you for your comment. We agree and have amended the scope accordingly.
SH	Daiichi Sankyo	3	4.4	In Main Outcomes, please include "minor bleeding" as this often goes underreported, but is a significant complaint by patients?	Thank you for your comment. The outcomes listed are examples suggested for questions that we expect the guideline to answer. The list is not exhaustive and will be tailored to each evidence review. The guideline development group will finalise the list that we will consider.
SH	Department of Health	1	General	Thank you for the opportunity to comment on the draft scope for the above clinical guideline. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
SH	Heart Rhythm UK	1	general	It is the opinion of our professional body that the document is appropriately broad in its scope and ambition. We agree with the reasons provided in justification for an update of the current NICE guidelines for the management of atrial fibrillation ie (1) that new evidence exists for several clinical areas including stroke risk	Thank you for your comment. We are pleased that you agree with the reasons for updating the guideline.

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				stratification, the role of new pharmacological and non-pharmacological antithrombotic and ablation strategies and (2) variation in practice as to when it is appropriate to offer cardioversion, whether electrical or pharmacological cardioversion should be used and which first-line treatments should be used for rate control in AF.	
SH	Heart Rhythm UK	2	general	Heart Rhythm UK is very much in agreement with the necessity for robust outcome measures in the management of atrial fibrillation, whatever the treatment strategy that may be employed. In particular we endorse the need for clear guidance regarding quality control of anticoagulation, assessment of ventricular rate control and, in those patients in whom a rhythm control strategy has been employed, of heart rhythm	Thank you for your comments. The guideline development group will be prioritising the specific review questions to be covered in the guideline
SH	Heart Rhythm UK	3	general	Finally, we believe it important that the proposed document reflects the quality standard required for all aspects of management of the patient with atrial fibrillation. We strongly advocate early patient access to specialist advice in the form of consultants, GPs or nurses with a specialist interest in atrial fibrillation. We recognise that not all treatment modalities can nor should be provided by all healthcare providers and that clear guidance is needed as to what is expected of all elements in the healthcare chain to provide a "joined-up" approach to effective management of atrial fibrillation.	Thank you for your comment. This topic has been referred as a quality standard and development will follow publication of this guideline. Please follow this link for further information about NICE's quality standard programme http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp
SH	Johnson & Johnson	1	4.3.1 (c and d)	We would like to comment the importance of timing and pathways of referrals for successful management of AF patients	Thank you for your comment. We agree that referral of people with atrial fibrillation is an important clinical issue. It is covered in the scope of the guideline in section 4.3.1.d.
SH	Medtronic	1	General	Medtronic thanks NICE for the opportunity to comment on the draft scope. We believe that the scope and subsequent clinical guideline will improve patient care in the NHS. Particularly in reducing the inequity of access to Ablation therapy, by confirming its place in the treatment pathway	Thank you for your comment. We are pleased that you agree that ablation is a key issue that should be covered in the guideline.
SH	Medtronic	2	4.3.1	At the scoping working the chair and feedback groups referenced	Thank you for your comment and references provided.

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				cryptogenic stroke and the role that AF may play. This does not appear to be captured within the document. Evidence suggests that approximately 30% of ischaemic strokes occur without a well-defined aetiology and are thus labelled as cryptogenic[1] It is estimated that Paroxysmal AF (PAF) is often suspected as a causative factor in unexplained stroke.[2] While the identification of AF in patients with a prior stroke is dependent on the monitoring technology used; AF has been identified in up to 23% of patients with cryptogenic stroke[2,3,4,5,6]. Given the significant burden of cryptogenic stroke and role that AF contributes, we believe it is important that it is included in the scope, in order that the appropriate diagnosis and treatment options can be undertaken in this patient population. Refs: 1: Diener HC, Sacco R, et al. Rationale, design and baseline data of a randomized, double-blind, controlled trial comparing two antithrombotic regimens (a fixed-dose combination of extended-release dipyridamole plus ASA with clopidogrel) and telmisartan versus placebo in patients with strokes: the Prevention Regimen for Effectively Avoiding Second Strokes Trial (PRoFESS). Cerebrovasc Dis 2007;23(5-6): 368-80. 2: Liao J, Khalid Z, Scallan C, et al. Noninvasive Cardiac Monitoring for Detecting Paroxysmal Atrial Fibrillation or Flutter After Acute Ischemic Stroke. A Systematic Review. Stroke 2007;38:2935. 3: Barthélémy JC, Féasson-Gérard S, Garnier P, Gaspoz JM, et al. Automatic cardiac event recorders reveal paroxysmal atrial fibrillation after unexplained strokes or transient ischemic attacks. Ann Noninvasive Electrocardiol 2003 8(3):194-9. 4: Jabaudon D, Sztajzel J, Sievert K, et al. Usefulness of Ambulatory 7-Day ECG Monitoring for the Detection of Atrial Fibrillation and Flutter After Acute Stroke and Transient Ischemic Attack. Stroke 2004;35:1647. 5: Tayal AH, Tian M, Kelly KM, et al. Atrial fibrillation detected by mobile cardiac outpatient telemetry in cryptogenic TIA or stroke. Neurology	Diagnosis has not been prioritised for update due to limited new evidence.

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				2008;71:1696-1701. 6: Douen Ag, Pageau N, Medic S. Serial Electrocardiographic Assessments Significantly Improve Detection of Atrial Fibrillation 2.6-Fold in Patients With Acute Stroke. Stroke 2008; 39:480.	
SH	Medtronic	3	4.3.1e	The guideline should make reference to and assist in identifying where in the patient pathway longer term rate and rhythm monitoring should be placed either for diagnosis or as is the focus for this update the management of AF. For example, the role of implantable loop recorders post AF ablation to assess the long term effectiveness of the intervention. This monitoring should also be considered in section 4.5 under the Health Economics.	Thank you for your comment. The guideline group will prioritise the specific review questions to be included in the guideline. Economic evidence and considerations are reviewed for each key clinical issue that is covered by the scope. The guideline development group will prioritise which issues would benefit most from de novo economic modelling during development.
SH	Medtronic	4	5.1	Recently published NICE IPG omitted from document: *NICE interventional procedure guidance 427: Percutaneous balloon cryoablation for pulmonary vein isolation in atrial fibrillation*	Thank you for your comment. We agree and have added this to the scope.
SH	Merck Sharp & Dohme	1	General	Thank you for the opportunity to comment on the draft scope for the update to the Atrial Fibrillation clinical guideline. I can confirm that Merck Sharp & Dohme do not have any comments on this draft scope.	Thank you for your comment.
SH	NHS Direct	1	general	There is a possibility of monitoring AF using Tele health. This could be explored in the scope.	Thank you for your comment. Monitoring is included in the scope key issues to be covered (4.3.1.e). The guideline development group will prioritise the specific review questions that will be included in the guideline.
SH	Pfizer	1	4.3.1 a)	<u>Risk stratification for: Stroke or thromboembolic events</u> Pfizer welcomes the fact that a review of the evidence for stroke risk stratification is included within the scope for updating CG 36. It will be important to evaluate the evidence on the $CHADS_2$-$VASC_2$ risk score in addition to $CHADS_2$ to identify the optimal stroke risk algorithm for use in England and Wales. <u>Risk stratification for: Bleeding</u> There is a need to identify the key risk factors which contribute most to	Thank you for your comment. We are pleased that you agree that we should include risk stratification for stroke and bleeding (4.3.1a) in the guideline.

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				the risk of bleeding in AF patients receiving thromboprophylaxis, and in this context, the evidence on the HAS-BLED score to predict bleeding risk requires assessment.	
SH	Pfizer	2	4.3.1 b)	Prevention of stroke using: antithrombotic therapy In addition to cross-referral to the published new oral anti-coagulant NICE technology appraisal recommendations, it will be important for the guideline to provide a comparative overview of the risks and benefits of these treatments, along with warfarin, in terms of stroke prevention, bleeding risk, and the likelihood of other adverse events, as a guide to clinicians.	Thank you for your comment. The guideline will incorporate the NICE technology appraisal guidance (subject to the review proposal consultation with consultees) but can not conduct a comparative review.
SH	Pfizer	3	4.3.1 f)	Patient information and support specific to AF Review of patient information provision should include an update of the different anti-coagulation treatment options for stroke prevention, including risks and benefits to take into account the introduction of the new oral anti-coagulant treatments since the original development of CG36.	Thank you for your comment. The guideline development group will be made aware of this information during guideline development.
SH	Pfizer	4	4.4	Main outcomes Important outcomes missing from this list include gastro-intestinal bleeding, clinically relevant non-major bleeding, hospitalisation due to cardiovascular cause, myocardial infarction, stroke severity, and resource use (e.g. relating to having a stroke or a bleed)	Thank you for your comment. The outcomes listed are examples suggested for questions that we expect the guideline to answer. The list is not exhaustive and will be tailored to each evidence review. The guideline development group will finalise the list that we will consider.
SH	Pfizer	5	5.1.2	Other related NICE guidance Need to add 'Atrial fibrillation (stroke prevention) - rivaroxaban (TA256)' to this section.	Thank you for your comment. We agree and have added this to the scope.
SH	Pfizer	6	5.2	Guidance under development Need to add 'Stroke and systemic embolism (prevention, non-valvular atrial fibrillation) - apixaban [ID500]' to this section.	Thank you for your comment. We agree and have added this to the scope.
SH	Resuscitation Council (UK).	1	3.1 b	"The 'silent' nature of the arrhythmia…" This implies that it is always silent – although later wording clarifies to some extent. We suggest "The sometimes 'silent' behaviour of the arrhythmia…" The commonest but often unappreciated reason for silent behaviour is onset in people with	Thank you for your comment. We agree and have amended the scope accordingly.

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				hypertension who are already taking a beta blocker and therefore have some rate control. This is a group which should be specifically targeted for screening for AF.	
SH	Resuscitation Council (UK).	2	3.1 c	"The risk of stroke in people with AF is five times more than in a person with a regular heart rhythm." We suggest changing this to "…a person with a normal heart rhythm." AF with complete heart block produces a regular heart rhythm. Atrial flutter with a regular ratio of AV conduction produces a regular heart rhythm. Both have an increased stroke risk.	Thank you for your comment. We agree and have amended the scope accordingly.
SH	Resuscitation Council (UK).	3	3.1 f	We suggest that the list of risk factors should include obesity. This is an increasing and often unappreciated independent risk factor for AF and is (potentially) reversible!	Thank you for your comment. We do not agree that obesity should be added to this section (3.1.f). It is intended to be an introduction to the guideline scope and not an inclusive list of all risk factors.
SH	Resuscitation Council (UK).	4	3.2 c	For the sake of accuracy we suggest distinguishing between anti-arrhythmic drugs, which may restore normal rhythm or maintain it when it has been restored, and rate-controlling drugs. Digoxin is best regarded as entirely for rate control and not for rhythm control. Beta blockers, verapamil and diltiazem are also best regarded as primarily for rate control rather than rhythm control. If the wording of the scope and the guideline is not chosen carefully to emphasise this they will simply perpetuate the widespread failure to understand the precise purpose of drugs that are prescribed very commonly for people with AF. Healthcare professionals should understand their precise objective when they prescribe a drug and should know how to assess whether or not they have achieved it. If worded clearly, this guideline could help to promote such understanding.	Thank you for your comment. We agree and have amended the scope to clarify this.
SH	Resuscitation Council (UK).	5	3.2 d	"catheter and surgical ablation to create lesions to stop the abnormal electrical impulses that cause AF." This should be catheter or surgical ablation. There is also another opportunity to promote clear understanding here. AF requires triggers to initiate it and abnormal circuits to sustain it. The aim of ablation (specifically for AF) is usually firstly to isolate the source of the triggers so that they cannot initiate the arrhythmia, and secondly (to a variable degree depending on the individual circumstance) to interrupt the pathways that sustain the arrhythmia.	Thank you for your comment. We agree and have amended the scope accordingly.
SH	Resuscitati	6	3.2 e	"People with AF receive anticoagulation prophylaxis to thin the	Thank you for your comment. We agree and have

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	on Council (UK).			blood due to the increased risk of stroke." We recommend strongly that the wording is changed. This is simply perpetuating a common misunderstanding and common use (sadly by healthcare professionals as well as the public) of a largely meaningless phrase. The purpose of anticoagulation is not to "thin the blood", it is to reduce the risk of clot formation and of resulting disasters such as stroke.	amended the scope accordingly.
SH	Resuscitation Council (UK).	7	4.1.1 a	We suggest that you state clearly whether or not the scope will or will not include patients on ICUs who may have sepsis and/or multiple organ failure and/or acidosis and may be receiving vasopressor drugs and/or "inotropes". AF is quite common in that setting and many such patients receive amiodarone infusions.	Thank you for your comment. The scope covers all settings where NHS healthcare is provided or commissioned. This would include patients in intensive care units together with other specialist areas. We do not agree that all such areas should be specifically highlighted in the scope.
SH	Resuscitation Council (UK).	8	4.1.1 a	We suggest that you state whether or not the scope will include patients who develop AF following initial resuscitation from cardiac arrest.	Thank you for your comment. We do not agree that this group should be prioritised as a special group for this guideline.
SH	Resuscitation Council (UK).	9	4.3.2 a	The guidance on identification of AF and assessment of patients with AF in the 2006 guideline remains relevant. However you are missing an opportunity to highlight the potential dangers of misdiagnosis of AF which is very common, usually due poor quality ECG recordings and/or reliance on automated reports, with no attempt by the doctor to check that the recording actually shows what the report states. A statement emphasising the responsibility of the requester to ensure that the ECG is of adequate quality and that the report is accurate could help to reduce the numbers of people who are currently exposed to the risk of treatment for AF that they do not have.	Thank you for your comment. We will not be able to formulate new recommendations on diagnosis of atrial fibrillation as this topic is not being updated. The guideline will include the diagnosis chapter and recommendations from the original guideline. We will however pass your comment to the NICE implementation team for consideration when developing the implementation tools.
SH	Resuscitation Council (UK).	10	4.3.2	Areas not covered by the original guideline or the update a) Treatment of comorbidities associated with AF. Whilst we understand that coverage of this vast topic has to be outside the scope of this guideline there are some aspects that should not be ignored. For example, if a person has uncontrolled heart failure and is in AF, use of increasing doses of drugs to try to control heart rate is unlikely to succeed and is likely to do harm and place patients at increased risk. It is essential to treat the heart failure effectively in order to reduce excessive sympathetic drive that will otherwise prevent	Thank you for your comment. The scope includes people with left ventricular dysfunction as a group that will be given specific consideration within the guideline (4.1.1.b). NICE has developed guidance on chronic heart failure that will be cross referred to where appropriate: http://guidance.nice.org.uk/CG108. When formulating recommendations on drugs the guideline development group will discuss all special considerations relevant to that drug.

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				effective heart rate control.	
SH	Royal College of General Practitioners	1	General	Agree with the scope	Thank you for your comment.
SH	Royal College of Nursing	1	General	The Royal College of Nursing welcomes proposals to develop this guideline. It is timely. The draft scope seems comprehensive.	Thank you for your comment
SH	Royal College of Nursing	2	General	The draft scope clearly states what will and what will not be covered in the guideline. It also identifies clearly that it is the new risk stratification (CHADsVAS) and new age anticoagulants that have prompted the need for a review of the 2004 guideline.	Thank you for your comment. We are pleased that you agree the guideline should be updated.
SH	Royal College of Nursing	3	4.1.1	However, we have yet to see clear evidence on the question relating to the therapeutic levels of INR which we raised during the consultation on the review of the guideline - requesting clarity on the cost analysis of INR testing as there was disparity of the figures given which gave a positive weighting to new age anticoagulants. The therapeutic levels of INRs are still not achieved consistently enough in patients with AF but it is unclear how this gets factored into this guideline. The process is correct, but achieving this seems troublesome and may fall under the coagulation umbrella. It would be helpful if this guideline provides some clarity in this area.	Thank you for our comment. We agree that monitoring is important and have included it in the key clinical areas (4.3.1.e). The guideline development group will prioritise the specific review questions that will be included in the guideline. A review and assessment of the economic evidence will be undertaken for each question set.
SH	Royal College of Paediatrics and Child Health	1	general	Thank you for inviting the Royal College of Paediatrics and Child Health to review the Atrial Fibrillation (CG36). We have not received any responses to this review.	Thank you for your comment.
SH	Royal College of Physicians	1	General	Please take this email as confirmation that the Royal College of Physicians wishes to endorse the comments submitted by Prof Greg Lip on behalf of the British Cardiovascular Society.	Thank you, we have noted your comment.
SH	South	1	4.3.2	Although the scope specifically excludes the 'Identification and	Thank you for your comment. The NICE review for

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	Western Ambulance Service NHS Foundation Trust		(a)	diagnosis of AF', the document itself highlights the importance of this phase within section 3.1 (b), which states that the 'Early recognition of AF can be difficult. The 'silent' nature of the arrhythmia means that AF may remain undiagnosed for a long time, and about one third of people with AF are not aware of the rhythm disturbance. Many people with AF may never present to hospital, which may cause an underestimation in the prevalence of AF.' For this very reason, the provision of programs utilising opportunistic screening to detect AF have increased since the initial guideline was published. One of the largest programs is the Know Your Blood Pressure (KYBP) campaign run by the Stroke Association, which includes the screening of AF. The challenge faced by organisations providing AF screening outside of the traditional environment of primary care, is that with the exception of the KYBP Clinical Guideline, there is no nationally published guidance on the referral of patients where AF is detected. All published guidance assumes that AF has been identified within primary care, and can be risk assessed and managed accordingly. Where patients are detected within the community, guidance on the appropriate step wise referral methods and timeframes is urgently needed to minimise the risk of patients experiencing an adverse event whilst awaiting follow up. AF opportunistic screening is now being conducted by some ambulance services on every patient, community pharmacies and influenza vaccination clinics. These organisations have the potential to reach significant numbers of people within their existing patient contacts (500,000/year per ambulance service for example) and is therefore a real need to provide national guidance to address the current gap.	update did not identify a need to update diagnosis but the recommendations from the previous guideline will be included. However, screening is outside the remit of the guideline.
SH	St Jude Medical UK Ltd	1	3.2 g	SJM also would like to agree that 'An update of the guideline is needed because there is: new evidence available for several clinical areas including stroke risk stratification, the role of new antithrombotic agents and ablation strategies.' We would also like to add that left Atrial	Thank you for your comment. We agree that left atrial appendage closure should be included in the guideline and it is included under key issues (4.3.1.b) in the scope. It was not however identified in the review for update as

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				Appendage Closure is another reason for an update to the guidelines given the growing evidence supporting the use of this technology in reducing stroke risk.	a reason for this guideline being updated, and therefore it is not included as a reason for the update.
SH	St Jude Medical UK Ltd	2	4.3.1 c	We would like to recommend that NICE evaluates the benefits of the different treatment strategies for the management of AF as both standalone and concomitant therapies, for example AF ablation with or without Left Atrial Appendage occlusion. This would provide significant savings in procedure costs, a reduction in hospital bed stays and improved QOL and patient outcomes.	Thank you for your comment. The guideline development group will prioritise the specific review questions that will be included in the guideline and topic areas that would benefit from economic modelling. This will include whether therapies are considered as standalone treatments or as an adjunctive therapy. The guideline development group will be made aware of this information during development.
SH	St Jude Medical UK Ltd	3	4.3.1 e	For the review and monitoring of AF, particularly pre and post ablation, SJM would like to recommend the developers consider the use of an implantable cardiac monitors	Thank you for your comment. The guideline development group will take this information into account when prioritising the specific review question for monitoring.
SH	St Jude Medical UK Ltd	4	4.5	The STAR AF II study (Substrate and Trigger Ablation for Reduction of Atrial Fibrillation Trial) has recently closed for enrolment and the results, whilst not published yet may have an impact on AF ablation strategies. The study which is a multi-centre RCT was designed with the hypothesis that combined PV Antral Isolation and Ablation of Complex Fractionated Electrograms (PVI+CFE) approach will offer a higher success rate compared to the Wide Circumferential Pulmonary Vein Antrum Isolation (PVI) approach and to the Combined PV Antral Isolation and Empiric Linear Ablation (PVI+Lines) approach. The primary outcome measure for STAR AF II is the freedom from documented AF episodes > 30 seconds at 18 months after one or two ablation procedure with/without anti-arrhythmic medications. For more information please refer to the Clinical Trials.gov website: http://clinicaltrials.gov/ct2/show/NCT01203748	Thank you for informing us about this study. The review questions will be prioritised by the guideline group. Searches are carried out at the start of the development process and then an update search is completed close to draft guideline consultation.
SH	Stroke Association	1	4.3.2 (a)	Stroke Association would like to endorse the view taken by XXXX on this point: "Although the scope specifically excludes the 'Identification and	Thank you for your comment. The NICE review for update did not identify a need to update diagnosis but the recommendations from the previous guideline will be included. However, screening is outside the remit of the

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				diagnosis of AF', the document itself highlights the importance of this phase within section 3.1 (b), which states that the 'Early recognition of AF can be difficult. The 'silent' nature of the arrhythmia means that AF may remain undiagnosed for a long time, and about one third of people with AF are not aware of the rhythm disturbance. Many people with AF may never present to hospital, which may cause an underestimation in the prevalence of AF.' For this very reason, the provision of programs utilising opportunistic screening to detect AF have increased since the initial guideline was published. One of the largest programs is the Know Your Blood Pressure (KYBP) campaign run by the Stroke Association, which includes the screening of AF". To date, and since XXXX, Stroke Association has screened over XXXX people. With this experience in mind we would also echo Mr South's point that: "The challenge faced by organisations providing AF screening outside of the traditional environment of primary care, is that with the exception of the KYBP Clinical Guideline, there is no nationally published guidance on the referral of patients where AF is detected. All published guidance assumes that AF has been identified within primary care, and can be risk assessed and managed accordingly. Where patients are detected within the community, guidance on the appropriate step wise referral methods and timeframes is urgently needed to minimise the risk of patients experiencing an adverse event whilst awaiting follow up. AF opportunistic screening is now being conducted by some ambulance services on every patient, community pharmacies and influenza vaccination clinics….." Stroke Association believes that there is a real need to provide national guidance to address what happens when someone is diagnosed with AF outside the primary care setting.	guideline.

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These organisations were approached but did not respond:

Academic Cardiology
Action Heart
Airedale NHS Trust
Alder Hey Children's NHS Foundation Trust
Alere
Aneurin Bevan Health Board
Anglia Stroke and Heart Network
AntiCoagulation Europe
AOP Orphan Pharmaceuticals
Association of Anaesthetists of Great Britain and Ireland
Association of British Insurers
Association of Chartered Physiotherapists in Cardiac Rehabilitation
Astrazeneca UK Ltd
Atrial Fibrillation Association
Bard Limited
Barnsley Hospital NHS Foundation Trust
Barnsley Primary Care Trust
BBOLMC
Betsi Cadwaladr University Health Board
BIOTRONIK UK Ltd.
Birmingham & Brunel Consortium
Black Country Cancer and Cardiac Network

Blood Pressure Association
Bradford and Airedale Primary Care Trust
Bradford District Care Trust
Brighton and Sussex University Hospital NHS Trust
Bristol-Myers Squibb Pharmaceuticals Ltd
British Association for Nursing in Cardiovascular Care
British Association of Critical Care Nurses
British Association of Stroke Physicians
British Geriatrics Society
British Heart Foundation
British Hypertension Society
British Medical Association
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Nuclear Medicine Society
British Pacing and Electrophysiology Group
British Paramedic Association
British Society for Heart Failure
Buckinghamshire Primary Care Trust
BUPA Foundation
C. R. Bard, Inc.
Caledonian Medical LTD
Cambridge University Hospitals NHS Foundation Trust
Camden Link
Capsulation PPS
Capsulation PPS

Cardiac and Stroke Networks in Lancashire & Cumbria
Cardiff and Vale NHS Trust
CardioLogic Ltd
Cardiomyopathy Association, The
Care Quality Commission (CQC)
Central Lancashire Primary Care Trust
City and Hackney Teaching Primary Care Trust
Cochrane Heart Group
College of Emergency Medicine
Commission for Social Care Inspection
Countess of Chester Hospital NHS Foundation Trust
County Durham Primary Care Trust
Coventry and Warwickshire Cardiac Network
Covidien Ltd.
Cumberland Infirmary
Cumbria Partnership NHS Trust
David Lewis Centre, The
Department of Health, Social Services and Public Safety - Northern Ireland
Different Strokes
Dorset Primary Care Trust
East and North Hertfordshire NHS Trust
East Midlands Ambulance Service NHS
Education for Health
Epsom & St Helier University Hospitals NHS Trust
Faculty of Sport and Exercise Medicine
GE Healthcare
George Eliot Hospital NHS Trust

Great Western Hospitals NHS Foundation Trust
Greater Manchester and Cheshire Cardiac and Stroke Network
Guidant Corporation
Guy's and St Thomas' NHS Foundation Trust
Hammersmith and Fulham Primary Care Trust
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Healthcare Inspectorate Wales
HEART UK
Hindu Council UK
Humber NHS Foundation Trust
ICD Patient and Family Heart Support Group
Independent Healthcare Advisory Services
Inner North West London PCTs
Integrity Care Services Ltd.
Lancashire Care NHS Foundation Trust
Leeds Community Healthcare NHS Trust
Leeds Teaching Hospitals NHS Trust
Liverpool Primary Care Trust
London Clinic
Luton and Dunstable Hospital NHS Trust
MA Healthcare
Maidstone and Tunbridge Wells NHS Trust
Medicines and Healthcare products Regulatory Agency
Mid Staffordshire NHS Foundation Trust
Ministry of Defence
National CLAHRC stroke Group

National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Heart Forum
National Institute for Health Research Health Technology Assessment Programme
National Patient Safety Agency
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
Newcastle upon Tyne Hospitals NHS Foundation Trust
NHS Connecting for Health
NHS Health Check
NHS Improvement
NHS London
NHS Newcastle
NHS Nottinghamshire County
NHS Pathways
NHS Plus
NHS Trafford
NHS Warwickshire Primary Care Trust
Norfolk Suffolk & Cambridgeshire Strategic Health Authority
North East Lincolnshire Care Trust Plus
North Essex Partnership Foundation Trust
North of England Cardiovascular Network
North Staffs PCT
North Trent Network of Cardiac Care
North Yorkshire & York Primary Care Trust

Nottingham City Hospital
Oxford Radcliffe Hospitals NHS Trust
Oxfordshire Primary Care Trust
P.M.S
Papworth Hospital NHS Foundation Trust
Parkwood Healthcare
PERIGON Healthcare Ltd
Peterborough Primary Care Trust
Primary Care Cardiovascular Society
Progressive Supranuclear Palsy Association
Public Health Wales NHS Trust
Queen Elizabeth Hospital
Queen Elizabeth Hospital King's Lynn NHS Trust
Roche Diagnostics
Rotherham Primary Care Trust
Royal Berkshire NHS Foundation Trust
Royal Brompton Hospital & Harefield NHS Trust
Royal College of Anaesthetists
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society
Royal Society of Medicine
Royal United Hospital Bath NHS Trust

Sanofi
Scottish Intercollegiate Guidelines Network
SEE BETSI CADWALADR - North Wales NHS Trust
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence
Society and College of Radiographers
Society for Academic Primary Care
Society for Cardiothoracic Surgery of Great Britain and Ireland
Sorin Biomedica U K Ltd.
South Central Cardiovascular Network
South East Coast Ambulance Service
South London Cardiac and Stroke Network
South Staffordshire Primary Care Trust
South West London Elective Orthopaedic Centre
Spacelabs Healthcare
St Bartholomews Hospital
Stockport Primary Care Trust
Sue Ryder Care
Surrey Heart & Stroke Network
Tameside Hospital NHS Foundation Trust
The Ashley Jolly SADS Trust
The Association of the British Pharmaceutical Industry
The Princess Alexandra Hospital NHS Trust
The Rotherham NHS Foundation Trust
The University of Glamorgan
Translucency Ltd.

UK Clinical Pharmacy Association
UK Lung Cancer Coalition
UK National Screening Committee
UK Specialised Services Public Health Network
Unison
University Hospital Aintree
University Hospital Birmingham NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust
Welsh Government
Welsh Scientific Advisory Committee
West Midlands Ambulance Service NHS Trust
Western Cheshire Primary Care Trust
Westminster Local Involvement Network
Wirral University Teaching Hospital NHS Foundation Trust
Worcestershire Acute Hospitals Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
York Hospitals NHS Foundation Trust