Atrial Fibrillation is the most common type of atrial fibrillation managed in clinical practice. This condition predisposes patients to a multitude of potential complications that can be managed or prevented by medical or surgical means. Such complications include stroke, hemorrhage, or heart failure, among others. Although surgical intervention may be a viable option in some cases, pharmacological rate-control is a less invasive and more robust method in preventing the genesis of these sequelae. However, current guidelines regarding pharmacologic control of atrial fibrillation sequelae may be difficult to interpret. Based upon clinical prediction rules derived from large-scale clinical trials, we provide a simple three-step sequential algorithm that clinicians may use as guidelines when managing patients with rate controlled atrial fibrillation. These protocols can help clinicians decide if anticoagulation medication is indicated (CHA$_2$DS$_2$-VASC score), select the appropriate agent for anticoagulation (SAMe-TT$_2$R$_2$ score), and anticipate a high risk of hemorrhage (HAS-BLED score).

### Key Words
- Anticoagulation, Atrial fibrillation, CHA$_2$DS$_2$-VASC score, SAMe-TT$_2$R$_2$ score, HAS-BLED score, Stroke

### Abbreviations
- AF: Atrial Fibrillation; VKA: Vitamin K Antagonist; TTR: Time in Therapeutic Range; INR: International Normalized Ratio; DOAC: Direct Acting Oral Anticoagulant

---

**Figure 1** Flow-chart depicting a three-step algorithm to manage atrial fibrillation. Patients with AF can be managed with rhythm control or rate control. Those managed with rate control may require anticoagulation, which can be determined with the CHA$_2$DS$_2$-VASC score. This is the first major step in the management of rate controlled AF. If the score is found to be less than 2, anticoagulation may not be recommended. If the score is found to be equal to or greater than 2, then anticoagulation is recommended. The second major step in the management of rate controlled AF is to determine which form of anticoagulation is most appropriate via the SAMe-TT$_2$R$_2$ score. A VKA will likely be sufficient in a patient with a score of one or zero. A score greater than one may require a DOAC as an effective means of anticoagulation. The third major step is to assess the patient’s bleeding risk via the HAS-BLED score. A score of three or greater is indicative of a high risk of bleeding. AF: Atrial Fibrillation; VKA: Vitamin K Antagonist; DOAC: Direct Acting Anticoagulant

---

1Third year medical student, New York Institute of Technology College of Osteopathic Medicine, Old Westbury, New York, USA

Correspondence: Christopher L. Hoehmann, New York Institute of Technology College of Osteopathic Medicine, Northern Boulevard, Old Westbury, New York 11568 USA, Telephone 631-520-1416, e-mail choehman@nyit.edu

Received: January 04, 2017, Accepted: February 16, 2017, Published: February 18, 2017

This open-access article is distributed under the terms of the Creative Commons Attribution Non-Commercial License (CC BY-NC) (http://creativecommons.org/licenses/by-nc/4.0/), which permits reuse, distribution and reproduction of the article, provided that the original work is properly cited and the reuse is restricted to noncommercial purposes. For commercial reuse, contact reprints@pulsus.com
no survival advantage over rate control and anticoagulation (13). The Rate Control Versus Electrical Cardioversion (RACE) trial demonstrated similar findings (14). Thus, the American College of Cardiology (ACC), American Heart Association (AHA), and European Society of Cardiology (ESC) 2006 guidelines state that rate control is a "reasonable" strategy for managing AF (8,15).

**CHADS2-VASc score**

AF can cause blood stasis to uncoordinated atrial muscle contraction in the upper chambers of the heart. Non-synchronous atrial contraction predisposes to mural thrombus formation, which can dislodge causing a stroke (16). This process can be mitigated with the use of anticoagulation medication; however, due to an increased risk of hemorrhage, anticoagulation therapy is not indicated for all patients (8). The CHADS2-VASc score was developed to help identify which patients may benefit from anticoagulation therapy (Table 1).

**TABLE 1**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Congestive heart failure (or left ventricular systolic dysfunction)</td>
</tr>
<tr>
<td>H</td>
<td>Hypertension: blood pressure consistently above 140/90 mmHg (or treated hypertension on medication)</td>
</tr>
<tr>
<td>A1</td>
<td>Age ≥75 years</td>
</tr>
<tr>
<td>A2</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>D</td>
<td>Prior Stroke, thromboembolism, or TIA</td>
</tr>
<tr>
<td>S2</td>
<td>Vascular Disease (PAD, MI, aortic plaque)</td>
</tr>
<tr>
<td>V</td>
<td>Age 65-74 years</td>
</tr>
<tr>
<td>A</td>
<td>Sex category (i.e. female sex)</td>
</tr>
<tr>
<td>Sc</td>
<td>Race (non-Caucasian)</td>
</tr>
</tbody>
</table>

Each letter corresponds to a stroke risk modifier in the CHADS2-VASc score. Any individual with a total score of at least two points should be recommended oral anticoagulation therapy. A male with a total score of one should be considered for oral anticoagulation. A male with a total score of zero, or a female with a total score of zero or one should not be recommended oral anticoagulation.

Further research by Estrov-Pastor et al. validated the score as an effective means of identifying patients requiring anticoagulation (17). A patient with a higher score is more likely to suffer a stroke (18) (Table 2).

**TABLE 2**

<table>
<thead>
<tr>
<th>CHADS2-VASc score</th>
<th>Annual Stroke Risk %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>4</td>
<td>4.0</td>
</tr>
<tr>
<td>5</td>
<td>6.7</td>
</tr>
<tr>
<td>6</td>
<td>9.8</td>
</tr>
<tr>
<td>7</td>
<td>9.6</td>
</tr>
<tr>
<td>8</td>
<td>12.5</td>
</tr>
<tr>
<td>9</td>
<td>12.2</td>
</tr>
</tbody>
</table>

A patient in rate controlled atrial fibrillation with a higher total CHADS2-VASc score is more likely to suffer a stroke (25).

The CHADS2-VASc score has shown additional utility in other areas as well. Recent research by Mlodawska et al. suggests the score may be used to predict unsuccessful electrical cardioversion (19). Other recent research by Saliba et al. suggests the score may be useful when calculating a patient’s risk for stroke in patients without AF and that the score may also be used to detect the likelihood of new-onset AF (20,21).

The CHADS2-VASc score has superseded the similar CHADS2 score. An investigation of the Central Registry of the German Competence NETwork on Atrial Fibrillation (AFNET) registry, which included 8,847 patients with nonvalvular atrial fibrillation, found the CHADS2-VASc score to be more sensitive than the CHADS2 score for risk stratification of thromboembolic events (22). Furthermore, according to the Assessment of Cardioversion Using Transesophageal Echocardiography (ACUTE) trial sub study, the CHADS2-VASc score was found to be more reliable in predicting left atrial appendage thrombus formation, especially in those with a low or intermediate risk score (23).

When considering oral anticoagulation therapy, there are a number of options available. The disadvantage of the CHADS2-VASc score is that it cannot suggest which oral anticoagulant is appropriate for each individual. Therefore, the SAME-TT2R2 score may be utilized for this purpose.

**SAME-TT2R2 scoring system**

A number of options exist for anticoagulation in rate-controlled nonvalvular AF. Oral anticoagulation can be achieved with a Vitamin K antagonist (VKA), such as warfarin, with greater than 70% time in the therapeutic range (TTR) and an international normalized ratio (INR) between 2.0-3.0 (24,25). Recent research has shown the newer direct-acting oral anticoagulants (DOAC), such as dabigatran, rivaroxaban, edoxaban, and apixaban, to be effective as well (24). SAME-TT2R2 may be used as a tool to help the clinician decide whether to use a VKA or DOAC in order to anticoagulate a patient in rate-controlled AF (24,27) (Table 3).

**TABLE 3**

<table>
<thead>
<tr>
<th>Condition / Influencing Factor</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (female)</td>
<td>1</td>
</tr>
<tr>
<td>Age (60 years)</td>
<td>1</td>
</tr>
<tr>
<td>Medical History (two of the following: HTN, DM, MI, PAD, CHF, stroke, and pulmonary, hepatic, or renal disease)</td>
<td>1</td>
</tr>
<tr>
<td>Treatment (interacting medications – amiodarone)</td>
<td>2</td>
</tr>
<tr>
<td>Tobacco use (within 2 years)</td>
<td>2</td>
</tr>
<tr>
<td>Race (non-Caucasian)</td>
<td>2</td>
</tr>
</tbody>
</table>

The SAME-TT2R2 score constitutes a variety of factors or conditions that can influence TTR. A score of zero or one is likely to achieve greater than 65% in TTR and is therefore suitable for VKA therapy, such as warfarin (24). A score of two or greater is not likely to meet this criteria and is not suitable for VKA therapy. In this scenario, DOAC therapy may be initiated along with education for the patient regarding anticoagulation control [24]. HTN Hypertension; DM Diabetes mellitus; MI Myocardial infarction; PAD Peripheral arterial disease; CHF Congestive Heart Failure; TTR Time in therapeutic range; VKA Vitamin K antagonist; DOAC Direct acting anticoagulation

Additionally, clinicians should also consider patient preferences and comorbidities, including bleeding risk, renal function, and interaction with other medications (24).

The function of the SAME-TT2R2 score is to predict the quality of VKA as measured in the TTR (25,26). Thus, the score can identify which patients will not perform well with a VKA, as they will not reach the adequate TTR (25). For these patients, a DOAC may be recommended in place of a VKA (25). However, only the use of a VKA may be recommended when treating AF in the context of rheumatic mitral valve disease or a mechanical heart valve prosthesis (8,15).

Although DOAC medications have been shown to be effective, they have certain impediments (24). With a VKA such as warfarin, it is possible to evaluate the TTR by monitoring the INR; currently, there is no such lab value available to monitor the TTR of DOAC medications (24,25). Furthermore, unlike VKA medications such as warfarin, which can be reversed with Vitamin K or fresh frozen plasma, many of the DOAC medications currently do not have approved reversal medications. As such, investigational research is underway to identify mechanisms to monitor DOAC therapeutic levels. Moreover, reversal agents have been identified for many DOAC medications, such as idarucizumab for dabigatran, andexanet alfa for factor Xa inhibitors, and ciraparantag as a universal reversal agent (25,28).

**HAS-BLED score**

Patients with rate controlled AF are at increased risk of hemorrhage secondary to the use of anticoagulation therapy. Therefore, an assessment of bleeding risk is indicated. The HAS-BLED score, derived via data...
We would like to thank Michael Casey for his knowledge, guidance, and wisdom in preparing this manuscript.

REFERENCES


23. Yarmohammadi H, Varr BC, Puwanant S, et al. Role of CHADS2 score collected from 3,978 patients in the Euro Heart Survey, was developed in order to assess one-year risk of major bleeding in patients with AF (29) (Table 4).

In this instance, a major bleeding event is defined as intracranial bleeding, hospitalization, a decrease in hemoglobin greater than 2 grams per deciliter, or requiring a blood transfusion (30).

In addition to the HAS-BLED score, there are multiple clinical prediction rules for the purpose of assessing bleeding risk in those with AF, such as the HEMORR HAGES score, Outcomes Registry for Better Informed Treatment (ORBIT) score, and also the Anticoagulation and Risk Factors in Atrial Fibrillation (ATRIA) score (31). However, the HAS-BLED score has outperformed all of these other scores in large-scale clinical trials (31-33). This is likely due to inclusion of the criterion of labile international normalized ratios by the HAS-BLED score, which is not included in other similar risk scores (31,33). Furthermore, the HAS-BLED score was applied to a population of 9,621 patients with AF taking rivaroxaban and was successful in its ability to predict major bleeding (34).

CONCLUSION

Herein, we have illustrated a simple algorithm using clinical prediction rules determined by large-scale clinical trials that clinicians may follow when managing patients with AF. Using these guidelines, a clinician can know when to use anticoagulation, how to choose the appropriate method of anticoagulation, and when to anticipate a high risk of major hemorrhage.


