

## WHATS NEW IN GENERAL PRACTICE?

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### CHAD 2 Score for Atrial Fibrillation

Recent changes to the Quality Outcomes framework has meant that General Practitioners will be using the CHADS 2 score routinely when assessing patients who have Atrial Fibrillation. The score is a clinical prediction tool which assesses their risk of developing a stroke. It can be used to determine whether or not to start anticoagulant therapy rather than use antiplatelets.<sup>1</sup>

The scores are assigned according to the risk factors that a patient has for a stroke as below.

<b>C</b> – Recent cardiac failure	1 point
<b>H</b> – Hypertension	1 point
<b>A</b> – Age 75+	1 point
<b>D</b> – Diabetes	1 point
<b>S</b> – Prior Stroke or TIA	2 points

If the score is 0 the patient should receive an antiplatelet alone, for 1 the patient can receive either an antiplatelet or anticoagulation and for 2 the patient should be anticoagulated. The score is a good guideline but not ideal as it does not include all the risk factors for stroke such as peripheral vascular disease. Despite this the CHAD 2 tool is simple and easy to use and it has been incorporated into the GP computer system to allow them to calculate the risk whilst in the patient record.

### Diagnosis Hypertension

A recent published paper assesses ambulatory monitoring of blood pressure when diagnosing hypertension.<sup>2</sup> It found that ambulatory monitoring of blood pressure was the most cost effective strategy and resulted in improved health outcomes. These outcomes were measured in terms of increased years of good health for patients. The results of those who had ambulatory blood pressure monitoring were compared against those who had home or clinic blood pressure monitoring. The paper goes as far to suggest that ambulatory monitoring should be done prior to starting anti-hypertensives as it would reduce misdiagnoses and reduce costs. A problem of moving to ambulatory blood pressure for diagnosis would be the lack of facilities in general practice. Currently patients attend secondary care to have the 24-hour blood pressure monitor fitted and the results downloaded. The cost calculation did not include the cost of buying the equipment for general practices, and once this is factored in the result of the cost benefit analysis could alter in favour of clinic or home blood pressure monitoring.

Costs aside the study did highlight that ambulatory blood pressure monitoring reduced the number of patients who had been misdiagnosed with hypertension. From a patient point of view this is an important outcome as moving to ambulatory blood pressure monitoring would reduce the number of people on unnecessary medication with their potential side effects. It is possible that in the future we will move to ambulatory blood pressure for diagnosis, but the resources to fund new equipment would need to be available.

### References

- 1) Gage, B. F., C. v. Walraven, et al. (2004). "Selecting Patients With Atrial Fibrillation for Anticoagulation." *Circulation* **110**: 2287-2292.
- 2) Lovibond, K., D. S. Jowett, et al. (2011). "Cost-effectiveness of diagnosis of high blood pressure in primary care." *Lancet* **378**: 1219-1230.