

REFERRAL THRESHOLDS FOR CARDIOLOGY

Arrhythmias

Acute and recent onset AF

Refer immediately if symptomatic or if onset within 72 hours for possible immediate cardioversion.

Otherwise initiate rate control and appropriate antithrombotic treatment, and refer for possible cardioversion.

Chronic AF including AF detected incidentally

Rate control and referral for anti-coagulation should be managed in general practice.

All patients with newly diagnosed AF should have an ECHO to look for underlying valve lesions and LV function

Consider referral for cardioversion in patients with :-

1. A clear precipitant for the AF (e.g. UTI, chest infection, recent surgery, etc)
2. Normal or mild dilatation of LA size on ECHO (suggests recent onset AF)
3. Impaired LV function (might improve LV if in sinus rhythm)

SVT, paroxysmal AF

Symptomatic SVT should be referred for consideration of ablation if symptoms not controlled on medical therapy

Paroxysmal AF should be anti-coagulated and referred if frequent symptoms not controlled with standard therapy.

Syncope

Refer if recurrent syncope likely to be of cardiovascular origin or if not typically vasovagal (e.g. rapid palpitations, chest pain, murmur on examination). Otherwise manage in primary care.

Murmurs

Children and young adults with low intensity mid-systolic murmurs and no other abnormalities should be observed in primary care.

Otherwise patients with newly recognised murmurs should initially be referred for ECHO assessment unless acutely ill (then refer immediately).

Chest Pain

Acute chest pain where cardiac cause suspected and unstable angina – refer immediately (give aspirin, etc)

Recent onset exertional angina and worsening exertional angina despite medical therapy – refer rapid access chest pain clinic.

Refer stable angina :-

1. If medical therapy not providing adequate symptom control.
2. If recurrent angina post CABG or post stenting

Patients with “normal angiogram” within past 4 years could be managed in primary care with therapeutic trial of different antianginals, CBT, etc.

Palpitations

Only refer to cardiologist if

- Evidence of significant structural heart disease,
- Sustained rapid irregular or regular palpitations and ECG indicator
- Syncope, or ischaemic chest pains with palpitations
- “Failure” of a therapeutic trial of low dose beta-blocker

Indications for Ambulatory ECG monitoring

1. Daily/frequent symptomatic palpitations associated with dyspnoea, presyncope or chest pain, not otherwise documented.
2. Daily/frequent palpitations which are interfering with subject's confidence or ability to continue usual activities, not otherwise documented.

Hyperlipidaemia

In general this is managed in primary care according to NICE guidance.

Hypertension

If no Hypertensive crisis, consider referral to cardiologist only if inadequate control remains after third-line drug therapy in patient who is adhering to treatment and not taking NSAIDs

Malignant hypertension – refer immediately

Secondary hypertension – refer to appropriate speciality

Heart Failure

Acute heart failure – refer immediately

Suspected heart failure – do ECG and refer for echo if abnormal

Chronic stable heart failure – refer when optimal medical management fails or if not tolerated