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The US Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific preventive care services for patients without obvious related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

Summary of Recommendation and Evidence

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for atrial fibrillation with electrocardiography (ECG) (I statement) (Figure 1).

Rationale

Importance

Atrial fibrillation is the most common type of cardiac arrhythmia (irregular heartbeat), and its prevalence increases with age, affecting about 3% of men and 2% of women aged 65 to 69 years and about 10% of adults 85 years and older. Atrial fibrillation is a major risk factor for ischemic stroke, increasing risk of stroke by as much as 5-fold. Approximately 20% of patients who have a stroke associated with atrial fibrillation are first diagnosed with atrial fibrillation at the time of stroke or shortly thereafter.
about 10% of adults 85 years and older. Atrial fibrillation is a major risk factor for ischemic stroke, increasing risk of stroke by as much as 5-fold. Approximately 20% of patients who have a stroke associated with atrial fibrillation are first diagnosed with atrial fibrillation at the time of stroke or shortly thereafter.

**Detection**

The USPSTF found inadequate evidence to assess whether screening with ECG identifies adults 65 years and older with previously undiagnosed atrial fibrillation more effectively than usual care.

**Benefits of Early Detection and Intervention and Treatment**

The USPSTF found inadequate evidence directly assessing the benefit of screening for atrial fibrillation with ECG on clinical outcomes. The USPSTF found adequate evidence that treatment with anticoagulant therapy reduces the incidence of stroke in patients with symptomatic atrial fibrillation. Given the inadequate evidence on screening with ECG for the detection of atrial fibrillation in asymptomatic adults, there is inadequate evidence to determine the magnitude of benefit of screening with ECG followed by treatment.

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**Figure 1. USPSTF Grades and Levels of Evidence**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Suggestions for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
<td>Offer or provide this service for selected patients depending on individual circumstances.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
<td>Discourage the use of this service.</td>
</tr>
<tr>
<td>I statement</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
<td>Read the Clinical Considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.</td>
</tr>
</tbody>
</table>

**USPSTF Levels of Certainty Regarding Net Benefit**

<table>
<thead>
<tr>
<th>Level of Certainty</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.</td>
</tr>
<tr>
<td>Moderate</td>
<td>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as the number, size, or quality of individual studies. Inconsistency of findings across individual studies. Limited generalizability of findings to routine primary care practice. Lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</td>
</tr>
<tr>
<td>Low</td>
<td>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of the limited number or size of studies. Important flaws in study design or methods. Inconsistency of findings across individual studies. Gaps in the chain of evidence. Findings not generalizable to routine primary care practice. Lack of information on important health outcomes. More information may allow estimation of effects on health outcomes.</td>
</tr>
</tbody>
</table>

The USPSTF defines certainty as “likelihood that the USPSTF assessment of the net benefit of a preventive service is correct.” The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.
Atrial fibrillation is strongly associated with older age and obesity. Other risk factors include high blood pressure, diabetes, heart failure, prior cardiothoracic surgery, current smoking, prior stroke, sleep apnea, alcohol and drug use, and hyperthyroidism.

The USPSTF found inadequate evidence to assess whether screening with electrocardiography identifies older adults with previously undiagnosed atrial fibrillation more effectively than usual care.

Treatment of atrial fibrillation has 2 components: managing arrhythmia and preventing stroke. In general, these treatment goals are independent of each other. Arrhythmia can be managed by controlling the heart rate to minimize symptoms (usually through medication) or by restoring a normal rhythm. Treatment with anticoagulant therapy reduces the incidence of stroke in patients with symptomatic atrial fibrillation and high stroke risk.

The USPSTF has made recommendations on many factors related to stroke prevention, including screening for high blood pressure, use of statins, counseling on smoking cessation, counseling to promote healthful diet and physical activity, and use of low-dose aspirin for certain persons at increased risk of cardiovascular disease.

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to https://www.uspreventiveservicestaskforce.org.
that they have it. For approximately 20% of patients who have a stroke associated with atrial fibrillation, stroke is the first sign that they have the condition.7 If persons with undiagnosed atrial fibrillation could be detected earlier and start preventive therapy earlier, some of these strokes might be avoided.

Potential Harms
The performance of ECG itself is not associated with significant harm, although abnormal results may cause anxiety. Misinterpretation of ECG results may lead to misdiagnosis and unnecessary treatment. Treatment of atrial fibrillation includes anticoagulant therapy for stroke prevention, which is associated with a risk of bleeding, and pharmacologic, surgical, endovascular (eg, ablation), or combined treatments to control heart rhythm or heart rate. In addition, ECG may detect other abnormalities (either true- or false-positive results) that can lead to invasive confirmatory testing and treatments that have the potential for serious harm. For example, angiography and revascularization are associated with risks, including bleeding, contrast-induced nephropathy, and allergic reactions to the contrast agent.

Current Practice
Few data are available on the current prevalence of screening for atrial fibrillation with ECG or the frequency with which pulse palpation or heart auscultation are performed in the United States.

Treatment and Interventions
Treatment of atrial fibrillation has 2 components—managing arrhythmia and preventing stroke. In general, these treatment goals are independent of each other, because even restoring sinus rhythm does not necessarily reduce stroke risk enough to change how anticoagulant therapy is managed, given the potential for subsequent recurrence of atrial fibrillation. Arrhythmia can be managed by controlling the heart rate to minimize symptoms (usually through medication) or by restoring a normal rhythm. Methods for restoring normal rhythm include electrical or pharmacologic cardioversion and surgical or catheter ablation. Some evidence suggests that selected patients may be able to reverse atrial fibrillation through lifestyle changes that address the underlying causes of atrial fibrillation.8 Stroke risk for persons with nonvalvular atrial fibrillation can be estimated with tools such as CHADS 2 (congestive heart failure, hypertension, age $\geq$75 years, diabetes mellitus, prior stroke or transient ischemic attack or thromboembolism [doubled]) (developed by Gage and colleagues, Washington University School of Medicine) or its updated version, CHA2DS2-VASc (congestive heart failure, hypertension, age $\geq$75 years [doubled], diabetes, stroke/transient ischemic attack/thromboembolism [doubled], vascular disease [prior myocardial infarction, peripheral artery disease, or aortic plaque], age 65-74 years, sex category [female]) (Lip and colleagues, University of Birmingham Centre for Cardiovascular Sciences). These tools use somewhat different combinations of patient characteristics and presence or absence of comorbid conditions, as outlined above, to estimate annual risk of stroke and guide decisions about anticoagulation therapy. For patients with atrial fibrillation and high stroke risk (defined as a CHA2DS2-VASc score of $\geq$2), this risk can be reduced with anticoagulant therapy—either vitamin K antagonists (eg, warfarin) or, more recently, non–vitamin K antagonist oral anticoagulants.

A device that blocks off the atrial appendage to prevent blood clots has also been recently approved by the US Food and Drug Administration as a nonpharmacologic alternative to anticoagulant therapy for selected patients.

Additional Approaches to Prevention
The Million Hearts campaign provides tools and protocols to support the prevention of ischemic heart disease, one of the major causes of atrial fibrillation.9 The Centers for Disease Control and Prevention also provides information about programs and resources for the prevention of heart disease.10

Useful Resources
The USPSTF has made recommendations on many factors related to stroke prevention, including screening for high blood pressure,11 use of statins,12 counseling on smoking cessation,13 and counseling to promote healthful diet and physical activity.14 In addition, the USPSTF recommends use of low-dose aspirin for certain persons at increased risk of cardiovascular disease.15

Other Considerations
Research Needs and Gaps
The connection between atrial fibrillation and stroke is well established, as is the existence of undiagnosed atrial fibrillation, especially among older adults. Randomized trials enrolling asymptomatic persons that directly compare screening with usual care and that assess both health outcomes and harms are needed to understand the balance of benefits and harms of screening for atrial fibrillation. Other research needs include understanding how to best optimize the accuracy of ECG interpretation. Although the evidence review for this recommendation statement focused on screening with ECG, the effectiveness of newer technologies capable of assessing pulse and heart rhythm as potential screening strategies should be evaluated. In addition, as ECG and other technologies (eg, AliveCor Kardia system [AliveCor Inc, discussed in the context of the REHEARSE-AF trial below]) are used to record heart activity for longer periods and thus are able to detect shorter episodes of arrhythmia, understanding the stroke risk associated with brief episodes of subclinical atrial fibrillation, and the potential benefit of anticoagulation therapy if risk is significant, is another important research need.

Several ongoing trials may help to fill these evidence gaps. The STROKESTOP study (ClinicalTrials.gov identifier NCT01593553) randomized 28 768 Swedish adults aged 75 to 76 years to be invited or not invited for screening, first with 12-lead ECG and then intermittently with a single handheld lead over 2 weeks. The primary outcome is stroke incidence. The SCREEN-AF study (ClinicalTrials.gov identifier NCT02392754) randomized more than 800 participants to a 2-week ambulatory ECG patch monitor or usual care. The primary outcome is new diagnosis of ECG-confirmed atrial fibrillation or flutter, but clinical events are included as secondary outcomes. The IDEAL-MD study (ClinicalTrials.gov identifier NCT02270151) randomized 16 000 adults older than 65 years to screening with a single-lead ECG device or usual care. The primary outcome is new diagnosis of atrial fibrillation over 1 year; secondary outcomes include major
cardiovascular events and all-cause mortality. Last, the Detecting and Diagnosing Atrial Fibrillation (D2AF) study (Netherlands Trial Register No. NTR4914) is a cluster randomized trial that compares different approaches to case-finding among adults 65 years and older. The primary outcome is the difference in detection rate of new atrial fibrillation cases over 1 year compared with usual care; however, the study does not include clinical outcomes.

**Discussion**

**Burden of Disease**

Atrial fibrillation affects more than 2.7 million individuals in the United States. The prevalence of atrial fibrillation increases with age, from less than 0.2% among adults younger than 55 years to 10% among those older than 85 years. Although the age-adjusted hospitalization rate for atrial fibrillation among adults older than 65 years has stabilized since 2006, it has steadily increased for younger adults. A meta-analysis of 19 studies found that about 1% of the adult population may have undiagnosed atrial fibrillation, although the prevalence varies among different populations. Atrial fibrillation may progress over time, causing worsening symptoms and exacerbating heart failure. Atrial fibrillation is also an important cause of stroke, affecting those with persistent atrial fibrillation. Atrial fibrillation in asymptomatic persons who noted symptoms (palpitations or “other symptoms”).

**Scope of Review**

The USPSTF commissioned a systematic review to evaluate the evidence on the benefits and harms of screening for atrial fibrillation with ECG in older adults. The effectiveness of screening with ECG for detecting previously undiagnosed atrial fibrillation compared with usual care (including prompted pulse palpation), and the benefits and harms of anticoagulant or antiplatelet therapy for the treatment of screen-detected atrial fibrillation in older adults.

**Detection of Previously Undiagnosed Atrial Fibrillation**

Three fair-quality randomized clinical trials in the United Kingdom assessed screening for atrial fibrillation with ECG. The first study randomized 3001 patients (mean age, 75 years) to prompted pulse palpation (clinicians and nurses were encouraged to record the patient’s pulse and follow up an irregular pulse with 12-lead ECG); this strategy was termed “opportunistic screening” in this study and in the SAFE study, below) or systematic screening (inviting to attend nurse-led screening with pulse palpation and single-lead ECG). The study found no statistically significant difference between systematic screening with ECG and prompted pulse palpation (risk difference, 0.003 [95% CI, –0.002 to 0.009]), although there were few cases of atrial fibrillation and the confidence interval was wide.

The second study (Screening for Atrial Fibrillation in the Elderly [SAFE]) randomized 50 primary care practices (N = 14,802; mean age, 75 years) to usual care or intervention; patients in the intervention practices were randomized to prompted pulse palpation (clinicians and nurses were encouraged to check the patient’s pulse and follow up an irregular pulse with 12-lead ECG) or systematic screening with ECG (inviting to attend nurse-led screening with pulse palpation and 12-lead ECG). The SAFE study found that both prompted pulse palpation and systematic screening increased detection of atrial fibrillation by 0.6% over baseline prevalence but found no difference between prompted pulse palpation and systematic screening in the detection of new cases. The study reported that 29% of cases detected with prompted pulse palpation and 43% of cases detected with systematic screening had a CHADS2 score of 2 or greater and thus would be eligible for anticoagulant therapy for stroke prevention. The SAFE study also reported subgroup analyses by age and sex. Age had no effect on detection rates; however, while both prompted pulse palpation and systematic screening significantly increased the odds of detecting atrial fibrillation among men (odds ratio, 2.33 [95% CI, 1.30–4.15] and odds ratio, 2.68 [95% CI, 1.52–4.73], respectively), neither screening approach improved detection rates among women.

The SAFE study also assessed the accuracy of diagnosis by comparing ECG interpretation at primary care clinics with a reference standard consisting of 2 cardiologists assigned to interpret the same results (with a third cardiologist as arbiter of any disagreements). The primary care clinics, which had general practitioners reading 12-lead ECG results, had relatively low sensitivity (79.8% [95% CI, 70.5–87.2]) and specificity (91.6% [95% CI, 90.1–93.1]).

**Effectiveness of Early Detection and Treatment**

The USPSTF found 1 randomized clinical trial that reported clinical outcomes from a screening program to detect atrial fibrillation using ECG. In the REHEARSE-AF study, there was a similar number of strokes or transient ischemic attacks in the ECG screening and control groups (6 vs 10 cases; P = .34); however, this study was not powered to detect differences in clinical outcomes. Four cohort studies suggested that persons with asymptomatic atrial fibrillation have an increased stroke risk similar to that of persons with symptomatic atrial fibrillation, although the risk of lesion bias, ascertainment bias (for determining symptom status),
and confounding were high. Six RCTs and 7 systematic reviews (>100,000 persons with atrial fibrillation) concluded that anticoagulant therapy reduces all-cause mortality by about one-third and ischemic stroke by about two-thirds over 2 years among persons with atrial fibrillation and high stroke risk (usually determined by CHADS2 or CHA2DS2-VASC score). However, most participants in these trials had established persistent nonvalvular atrial fibrillation, and the prevalence of symptoms was generally not reported.

**Potential Harms of Screening and Treatment**

Only 1 included study directly examined the harms of screening. The SAFE study reported anxiety, but only for the intervention group, thus precluding comparative assessment. One potential source of harms from screening with ECG is additional testing that leads to harms (eg, complications from unnecessary stress testing or angiography performed on the basis of false-positive results suggesting ischemic heart disease). Based on large population-based registries that include symptomatic persons, angiography is associated with a serious harm rate of 1.7%, including arrhythmia (0.40%), death (0.10%), stroke (0.07%), and myocardial infarction (0.05%). Treatment with anticoagulant therapy for stroke prevention also increases the risk of serious bleeding.

**Estimate of Magnitude of Net Benefit**

Most older adults with previously undiagnosed atrial fibrillation have a stroke risk above the threshold for anticoagulant therapy and would be eligible for treatment. Anticoagulant therapy is effective for stroke prevention in symptomatic persons with atrial fibrillation. However, the USPSTF found inadequate evidence to determine whether screening with ECG and subsequent treatment in asymptomatic adults is more effective than usual care. At the same time, the harms of diagnostic follow-up and treatment prompted by abnormal ECG results are well established. Given these uncertainties, it is not possible to determine the net benefit of screening with ECG.

**Response to Public Comment**

A draft version of this recommendation statement was posted for public comment on the USPSTF website from December 19, 2017, to January 22, 2018. In response to comments, the USPSTF clarified the intervention (screening with ECG) and comparison groups (usual care, including prompted pulse palpation) considered for this recommendation. The USPSTF also added the REHEARSE-AF study to the “Discussion” section and added the need to understand the stroke risk associated with brief episodes of atrial fibrillation to the “Research Needs and Gaps” section. In response to requests that the USPSTF not exclude studies of persons with heart failure or with implantable cardiac devices, the USPSTF notes that it is charged with evaluating the benefits and harms of screening and clinical preventive services in generally healthy, asymptomatic persons. Last, the USPSTF added the guidelines of the European Society of Cardiology to the “Recommendations of Others” section.

**Recommendations of Others**

In 2014, the American Heart Association and the American Stroke Association stated that active screening for atrial fibrillation in the primary care setting among persons older than 65 years using pulse assessment followed by ECG, as indicated, can be useful. The European Society of Cardiology recommends opportunistic screening by pulse palpation or an ECG rhythm strip in persons older than 65 years and recommends considering systematic screening to detect atrial fibrillation in persons older than 75 years or those at high risk of stroke.

**ARTICLE INFORMATION**

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**REFERENCES**


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USPSTF Recommendation: Screening for AF With Electrocardiography


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