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stics and outcomes of atrial fibrillation and flutter at the Aga Khan University Hospital, Nairobi

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Abstract:

INTRODUCTION: Scant data exist on the epidemiology and clinical characteristics of atrial fibrillation in Kenya. Traditionally, atrial fibrillation (AF) in sub-Saharan Africa is as a result of rheumatic valve disease. However, with the economic transition in sub-Saharan Africa, risk factors and associated complications of this arrhythmia are likely to change. METHODS: A retrospective observational survey was carried out between January 2008 and December 2010. Patients with a discharge diagnosis of either atrial fibrillation or flutter were included for analysis. The data-collection tool included clinical presentation, risk factors and management strategy. Follow-up data were obtained from the patients' medical records six months after the index presentation. RESULTS: One hundred and sixty-two patients were recruited (mean age 67 ± 17 years, males 56%). The distribution was paroxysmal (40%), persistent (20%) and permanent AF (40%). Associated co-morbidities included hypertension (68%), heart failure (38%) diabetes mellitus (33%) and valvular abnormalities (12%). One-third presented with palpitations, dizziness or syncope and 15% with a thromboembolic complication as the index AF presentation. Rate-control strategies were administered to 78% of the patients, with beta-blockers and digoxin more commonly prescribed. Seventy-seven per cent had a CHA(2)DS(2)VASC score Ó2, but one-quarter did not receive any form of oral anticoagulation. At the six-month follow up, 6% had died and 12% had been re-admitted at least once. Of the high-stroke risk patients on anticoagulation, just over one-half were adequately anticoagulated. CONCLUSION: Hypertension and diabetes mellitus, not rheumatic valve disease were the more common co-morbidities. Stroke risk stratification and prevention needs to be emphasised and appropriately managed.