Heart Disease & Stroke Cross Party Group

Tuesday 20th June 2017

Minutes of meeting

MSPs in attendance
Maree Todd (Co-Convenor)
Colin Smyth (Co-Convenor)
Emma Harper (Chaired meeting)
Alexander Stewart

Other attendees
Professor Frederike van Wijck, Glasgow Caledonian University
Paul Hodson
Professor Martin Dennis
Dr Terry Quinn, University of Glasgow
Dr Christine McAlpine, Glasgow Royal Infirmary
Dr Fergus Doubal, University of Edinburgh
Tracey Bowden, Pfizer
Colin Oliver, Stroke Association
Chris Macnamee
Martin Coombes, Bristol-Myers Squibb Pharmaceuticals Ltd
Carleen Smith, BHF
David McColgan, BHF
Ellen Arrowsmith, BHF
Jim Bruce
Mark McDonald, Stroke Association
Professor Lis Neubeck
Angela MacLeod, Stroke Association
Katherine Byrne, CHSS
Kylie Barclay, BHF
Wendy Armitage, CHSS
Mark Cook, Medtronic UK

1. Welcome & Introductions

Emma Harper MSP introduced herself and explained that she was chairing the meeting as both convenors (Colin Smyth MSP and Maree Todd MSP) would be dipping in and out of the meeting due to other commitments.

There was a roundtable of introductions and a recap of the previous meeting.

Kylie Barclay explained to the group how to submit questions during the meeting via Slido.com.

2. Minutes of last meeting (28th March 2017)

Proposed by Emma Harper; seconded by Fergus Doubal and Katherine Byrne.

3. Topic discussion: Atrial Fibrillation: Diagnosis, Treatment and Care

a. **Professor Lis Neubeck**

Professor Neubeck gave an explanation of what atrial fibrillation is and its prevalence in Scotland (92,000 people diagnosed). AF rates are predicted to rise by 2050. She highlighted that the condition increases the risk of stroke fivefold. AF related strokes tend to be more severe, causing more death, longer hospital stays and increased disability compared to non AF strokes. AF strokes in Scotland cost three times as much as non AF strokes.

Diagnosis is a problem. A number of people have no symptoms. For every person diagnosed it is thought that there is another person who doesn't know that they have AF. Early detection and successful treatment is crucial. Currently, anti-coagulation use is sub optimal.

Prof Neubeck highlighted the increase in diagnosis through repeated screening in high risk individuals compared with single time point screening.

She also drew attention to new screening devices available, pointing out that a number of these devices were reliable.

b. **Dr Terry Quinn**

Dr Quinn reiterated that AF strokes are particularly bad in terms of outcomes such as initial disability, time in hospital and mortality. From a health economist point of view this means poorer economic outcomes.

Dr Quinn discussed the medicines used to treat AF and some of the issues surrounding treatment. Warfarin has been one of the most powerful tools for treating AF (62% reduction in stroke). This potency comes with a correspondingly strong risk of bleeding. 1-2% of people on Warfarin are having a major bleed each year. People at highest risk of stroke are often less likely to receive treatment. Newer agents are available for treating AF.

Dr Quinn mentioned that there are potential links between vascular dementia and atrial fibrillation although more data and research is needed on this.

Improved usage of available data could improve AF treatment and care.

c. **Paul Hodson**

Paul outlined his experience of living with AF and as a stroke survivor. His atrial flutter was first noticed in December 2010.

4. Questions and discussion focused on the following issues:

1. **Anti-coagulation:** Members discussed the reasons why people who were at highest risk for stroke might be among those most likely not to be anti-coagulated. It was largely felt that this was related to a corresponding increase in risk for bleeds and over estimation of these risks. The need for an electronic decision support tool was highlighted.

2. **Diagnosis:** Manual pulse checks by health care professionals were raised. Prof Neubeck highlighted that this was effective but not as much as other methods. It resulted in a lot of false positives and requires very good clinical skills. The 15secs x 4 method does not work for picking up AF. In Australia AF is tested for during flu jabs for over 65s. Phase 1 of this study is complete. There have been some challenges mainly relating to competing demands taking precedence during what is a very busy time. Wearable technologies were mentioned. Prof Neubeck said that no current wearable trackers pick up AF other than those specifically designed and marketed for AF diagnosis. It is important to think about the process of treatment and care in addition to diagnosis. Community pharmacy's role was highlighted. Prof Neubeck highlighted that blood pressure cuffs with built in AF detectors could be a good option for pharmacies.

   Action Point: Secretariat to check to see if any primary care physicians/representatives are part of the group and extend an invite if not.

3. **Lifestyle factors:** AF is not inevitable. There are a number of modifiable risk factors which contribute to AF. There should be support mechanisms to manage lifestyle factors and people diagnosed with AF should also receive lifestyle advice.

4. **Sign Guidelines**: In need of updating. The landscape relating to AF is changing rapidly and the guidelines have not kept pace with this.

5. **Psychological support**: There are no formal systems that take the psychological consequences of stroke into account.

6. Other business

Next meeting date to be arranged for September, focusing on Rehabilitation