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ASSOCIAZIONE INTERREGIONALE CARDIOLOGI E SPECIALISTI MEDICI AMBULATORIALI

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UOC Medicina d'Urgenza
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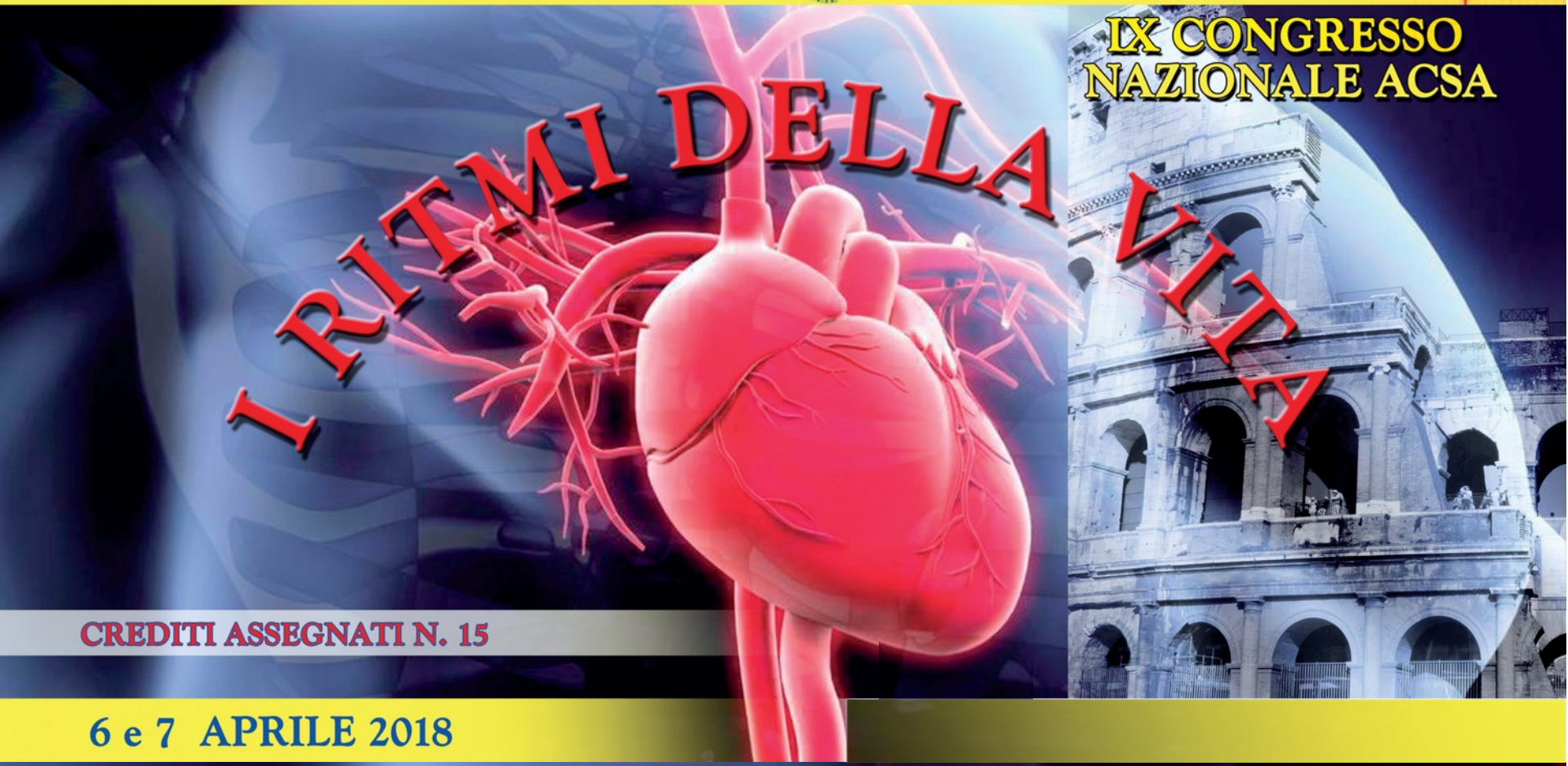

CREDITI ASSEGNATI N. 15

6 e 7 APRILE 2018

Un ambulatorio ideale per lo scompenso cardiaco: Un nuovo modello di cooperazione

Auditorium Ospedale G. Vannini
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Pietro Lentini

MI = myocardial infarction

1. Mozaffarian D, Benjamin EJ, Go AS, et al; for American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart disease and stroke statistics—2015 update: a report from the American Heart Association. Circulation. 2015;131(4):e29-e322. 2. Global Burden of Disease Study 2013 Collaborators, Global regional and national incidence prevalence and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013, Lancet 2015. 3. Velagaleti RS, Vasan R. Epidemiology of heart failure. In: Mann DL, ed. Heart Failure: A Companion to Braunwald's Heart Disease. 2nd ed. St Louis: Saunders; 2011. 4. Ponikowski P, Anker SD, AlHabib KF, et al. Heart failure: preventing disease and death worldwide. ESC Heart Failure. 2014;1(1):4-25.

Heart failure hospitalisation statistics

Heart failure patients are at high risk of repeated hospitalisation

Nº1

CAUSE OF HOSPITALISATION
FOR PATIENTS AGED >65 YEARS
IS HEART FAILURE[1]

Circa la metà dei pazienti con insufficienza cardiaca di età superiore ai 75 muoiono entro un anno dal ricovero in ospedale.[1]

1. Cowie MR, Anker SD, Cleland JGF. Improving Care for Patients With Acute Heart Failure: Before, During and After Hospitalization. Oxford PharmaGenesis; 2014. http://www.oxfordhealthpolicyforum.org/AHFreport. Accessed February 18, 2015.

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Heart failure hospitalisation statistics

Heart failure patients are at high risk of repeated hospitalisation

1 IN 4 HEART FAILURE PATIENTS AGED ≥65 YEARS ARE REHOSPITALISED WITHIN 30 DAYS OF DISCHARGE[1]

L'insufficienza cardiaca è una condizione degenerativa complessa caratterizzata da uno squilibrio neuro-ormonale, che porta a una spirale di peggioramento della malattia con episodi acuti di scompenso che si traducono in ricoveri ripetuti che portano a un peggioramento della patologia.[2]

After a hospitalisation, heart failure patients may never regain their previous quality of life.[3]

1. Krumholz HM, Merrill AR, Schone EM, et al. Patterns of hospital performance in acute myocardial infarction and heart failure 30-day mortality and readmission. Circ Cardiovasc Qual Outcomes. 2009;2(5):407-413. 2. Fauci AS, Braunwald E, Kasper DL, et al, eds. Harrison's Principles of Internal Medicine. 17th ed. New York: McGraw-Hill; 2008. 3. Cowie MR, Anker SD, Cleland JGF. Improving Care for Patients With Acute Heart Failure: Before, During and After Hospitalization. Oxford PharmaGenesis; 2014. http://www.oxfordhealthpolicyforum.org/AHFreport. Accessed February 18, 2015.

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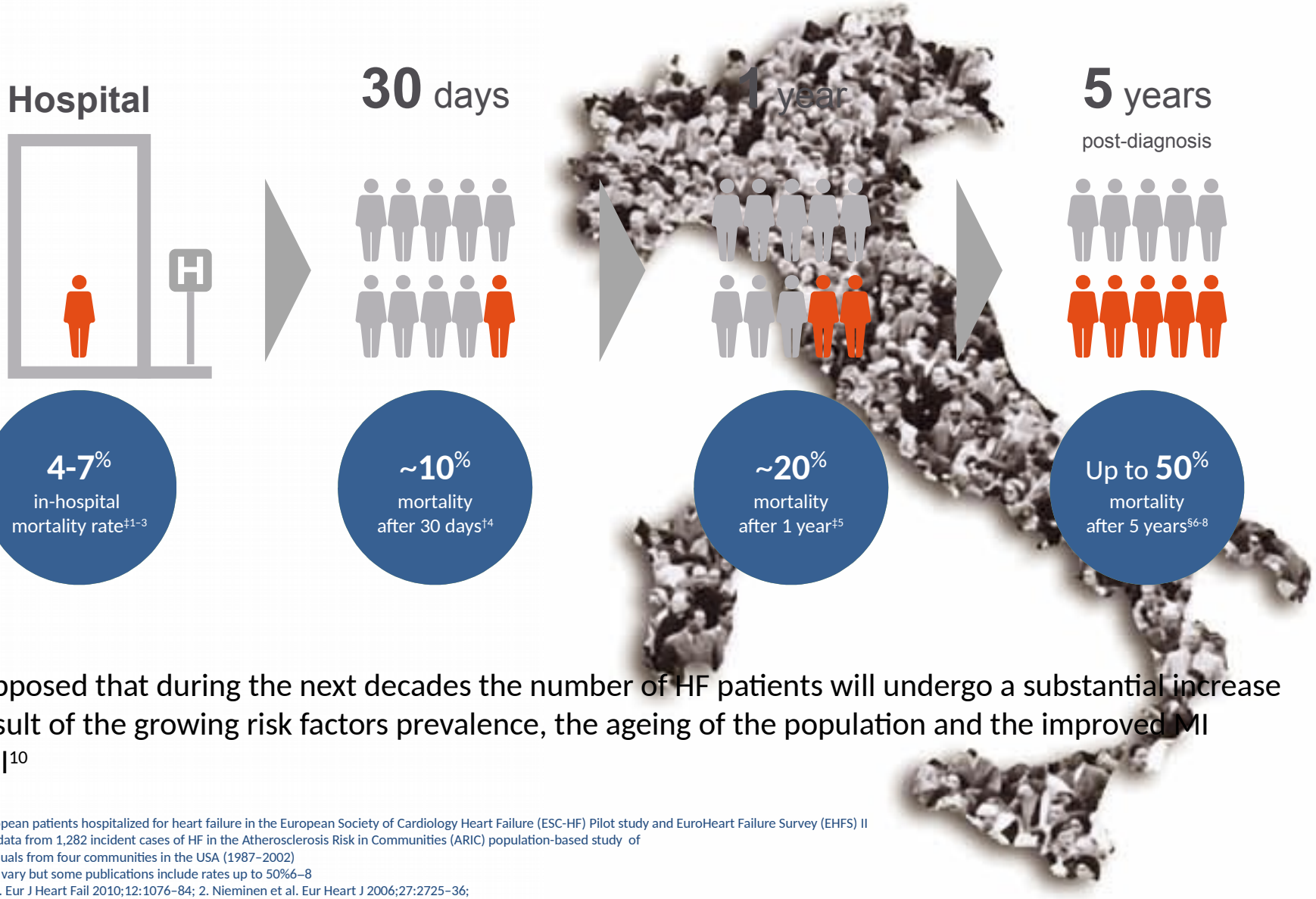
Morbidity and mortality in Heart failure



It is supposed that during the next decades the number of HF patients will undergo a substantial increase as a result of the growing risk factors prevalence, the ageing of the population and the improved MI survival[10]

HF=heart failure
‡Data from European patients hospitalized for heart failure in the European Society of Cardiology Heart Failure (ESC-HF) Pilot study and EuroHeart Failure Survey (EHFS) II
†Analysis of HF data from 1,282 incident cases of HF in the Atherosclerosis Risk in Communities (ARIC) population-based study of n=15,792 individuals from four communities in the USA (1987–2002)
§Reported rates vary but some publications include rates up to 50%6–8

1.Maggioni et al. Eur J Heart Fail 2010;12:1076–84; 2. Nieminen et al. Eur Heart J 2006;27:2725–36;
3. Cleland et al. Eur Heart J 2003;24:442–636; 4. Loehr et al. Am J Cardiol 2008;101:1016–22;
5. Maggioni et al. Eur J Heart Fail 2013;15:808–17; 6. Roger et al. JAMA 2004;292:344–50;
7. Levy et al. N Engl J Med 2002;347:1397–402; 8. Askoxylakis et al. BMC Cancer 2010;10:105
10. Hunt et al. J Am Coll Cardiol 2009;53:e1–90

Il Continuum Cardiovascolare

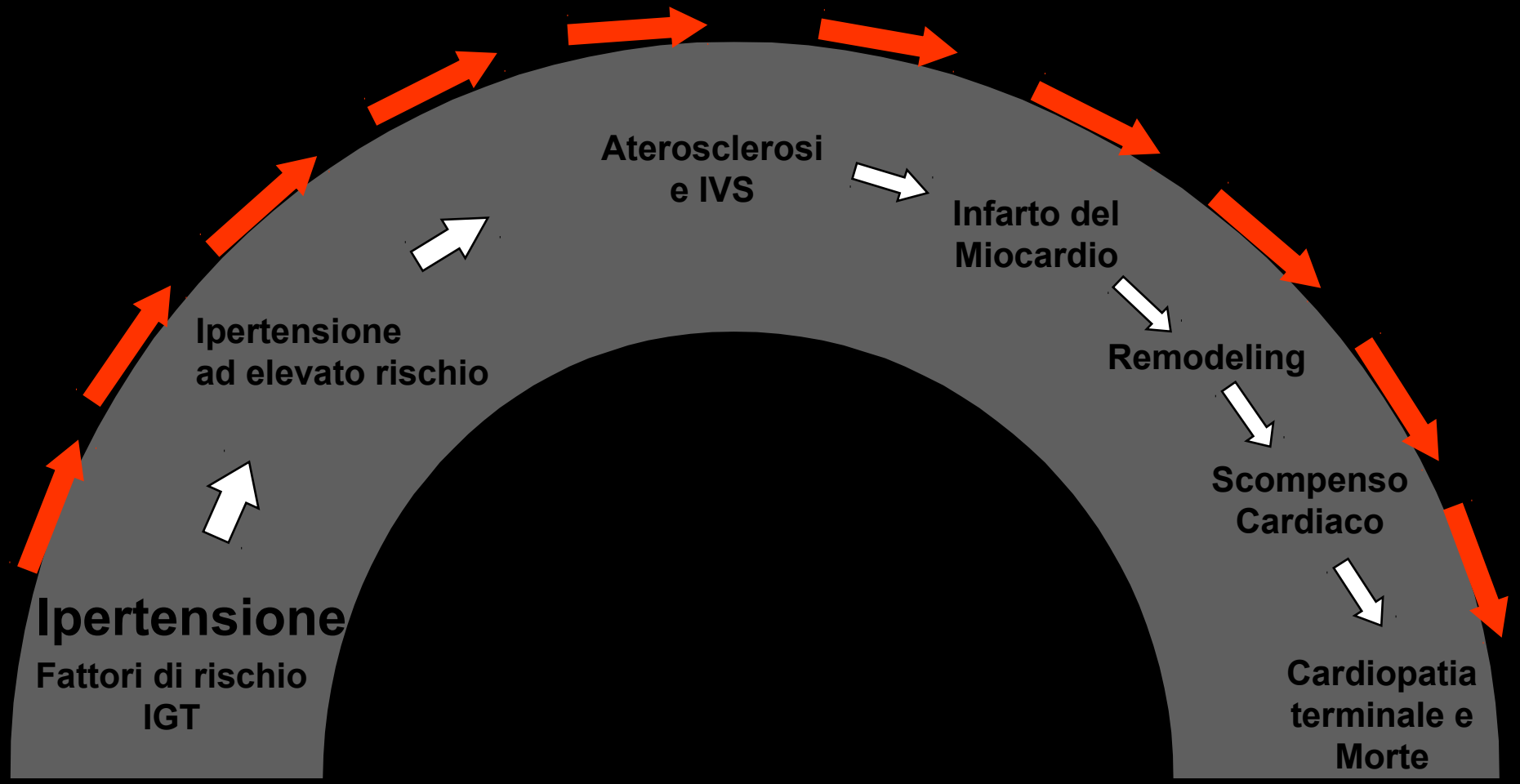
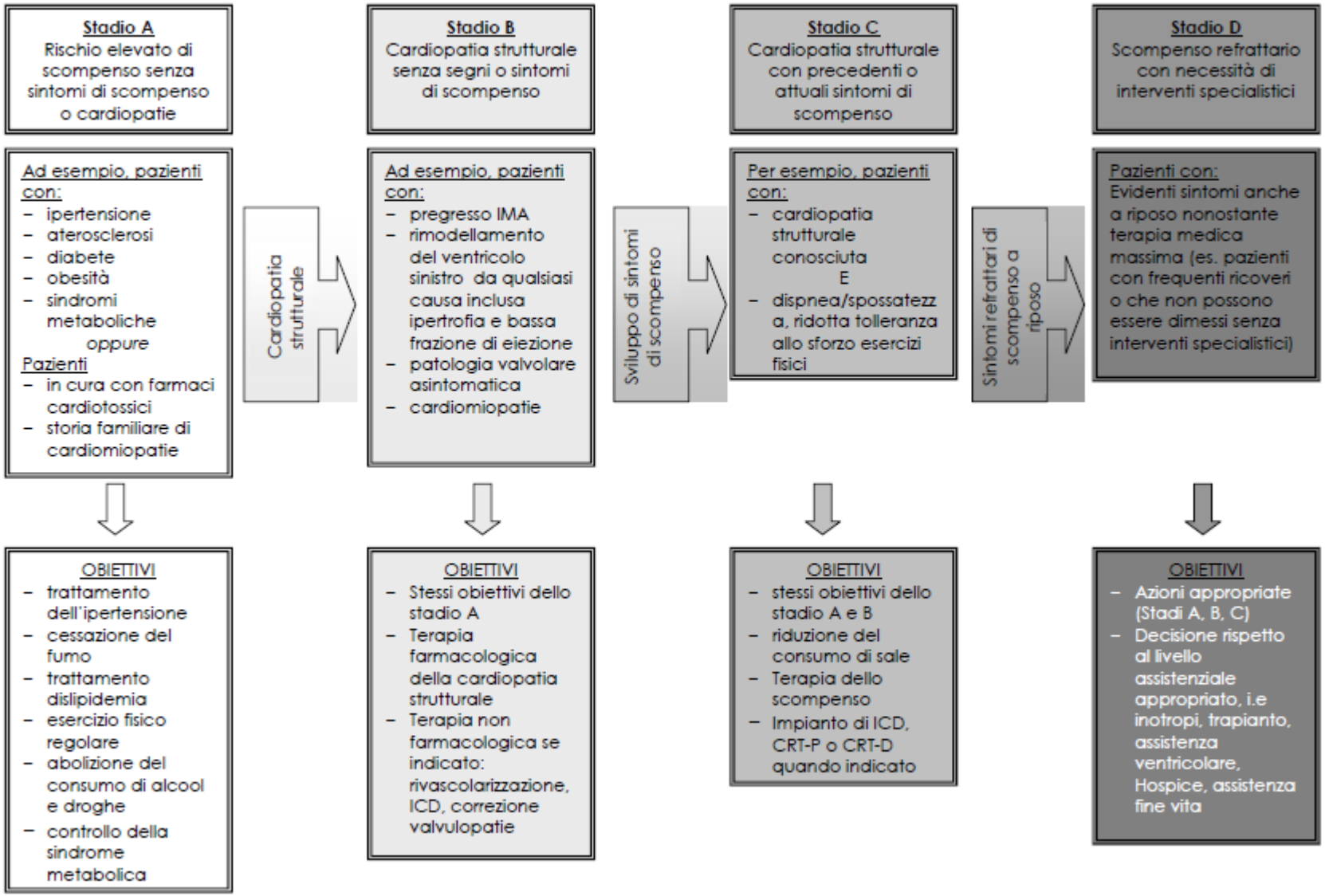
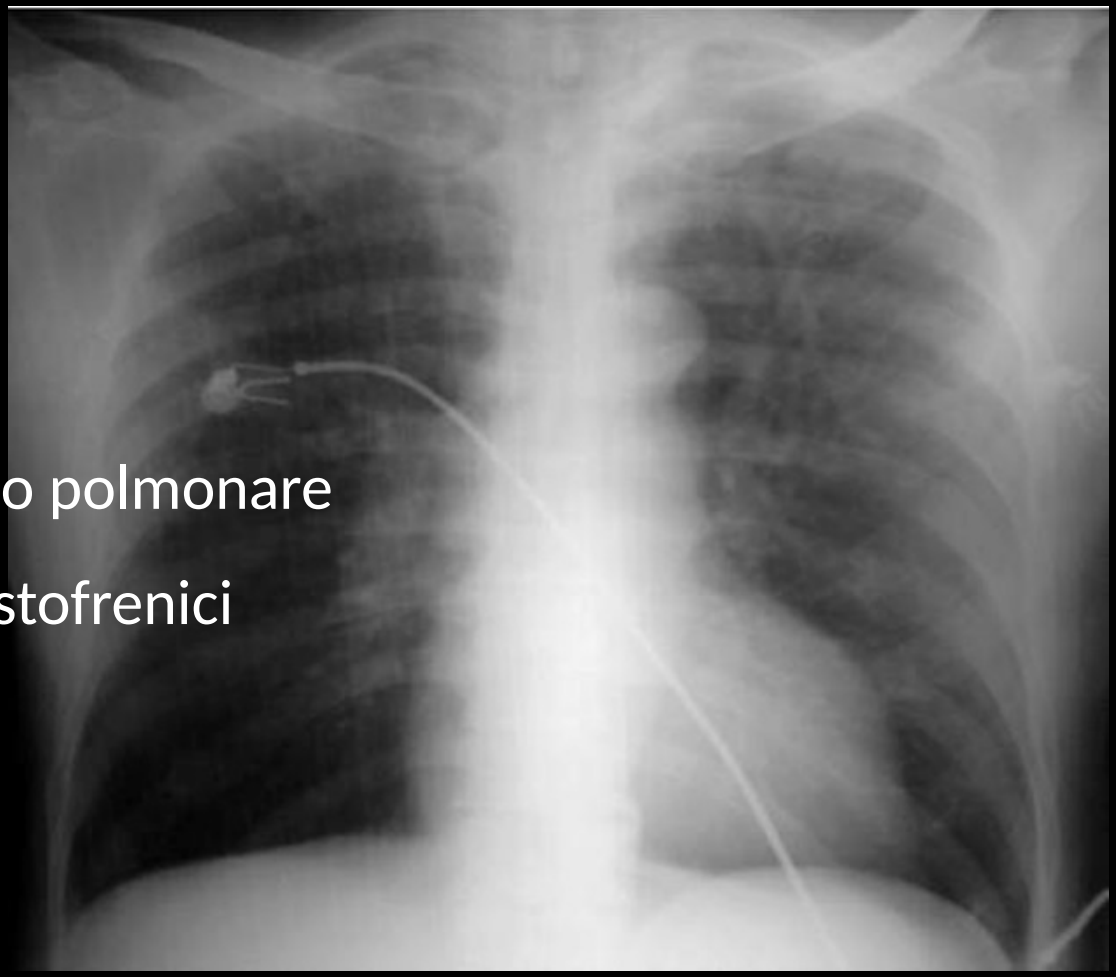


Figura 1 - Classificazione dei pazienti con scompenso (ACC, 2009)



DIAGNOSTICA : RX torace

- cardiomegalia
- redistribuzione circolo polmonare
- obliterazione seni costofrenici




Prelievo di sangue
BIOMARCATORI
CHLORIDE
CO2 Content
GLUCOSE, AC
GLUCOSE, PC
GLUCOSE, Random
mmol/L

Measurement of BNP

I IIa IIb III

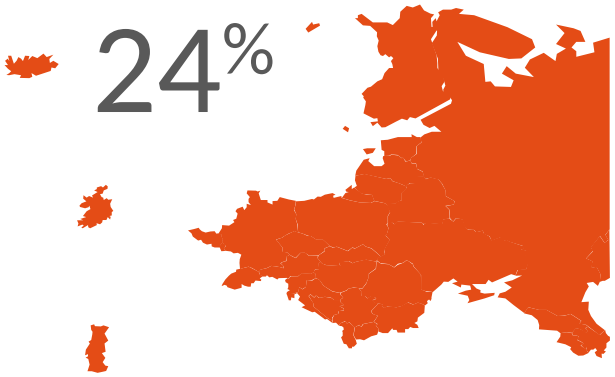
A

Measurement of natriuretic peptides (BNP or NT-proBNP) can be useful in evaluating patients presenting in the urgent care setting in whom the clinical diagnosis of heart failure (HF) is uncertain. Measurement of BNP or NT-proBNP can be helpful in risk stratification. Modified

spettro dei pazienti scompensati, dalla fase
azione ACC/AHA) alla fase sintomatica (stadi C–D)
funzionale endocrina cardiaca.

Il dosaggio del BNP oggi è utilizzato per distinguere la dispnea cardiaca da quella respiratoria.

Unmet therapeutic need in acute HF:
Many patients are discharged with unresolved congestion, which is associated with poor long-term outcomes



OF PATIENTS HOSPITALIZED FOR HF IN EUROPE HAVE SIGNS OF

CONGESTION AT DISCHARGE[1]

PERSISTENT CONGESTION AFTER HOSPITALIZATION FOR HF PREDICTS POOR SURVIVAL‡[2]

HF=heart failure

‡Patients with New York Heart Association class IV heart failure (HF; n=146) were re-assessed for signs of congestion 4–6 weeks after discharge. Criteria for congestion were orthopnea, raised jugular venous pressure, the need to increase the dose of diuretic during the past week, attending staff assessment of weight, and peripheral edema

1. Maggioni et al. Eur J Heart Fail 2010;12:1076–84; 2. Lucas et al. Am Heart J 2000;140:840–7

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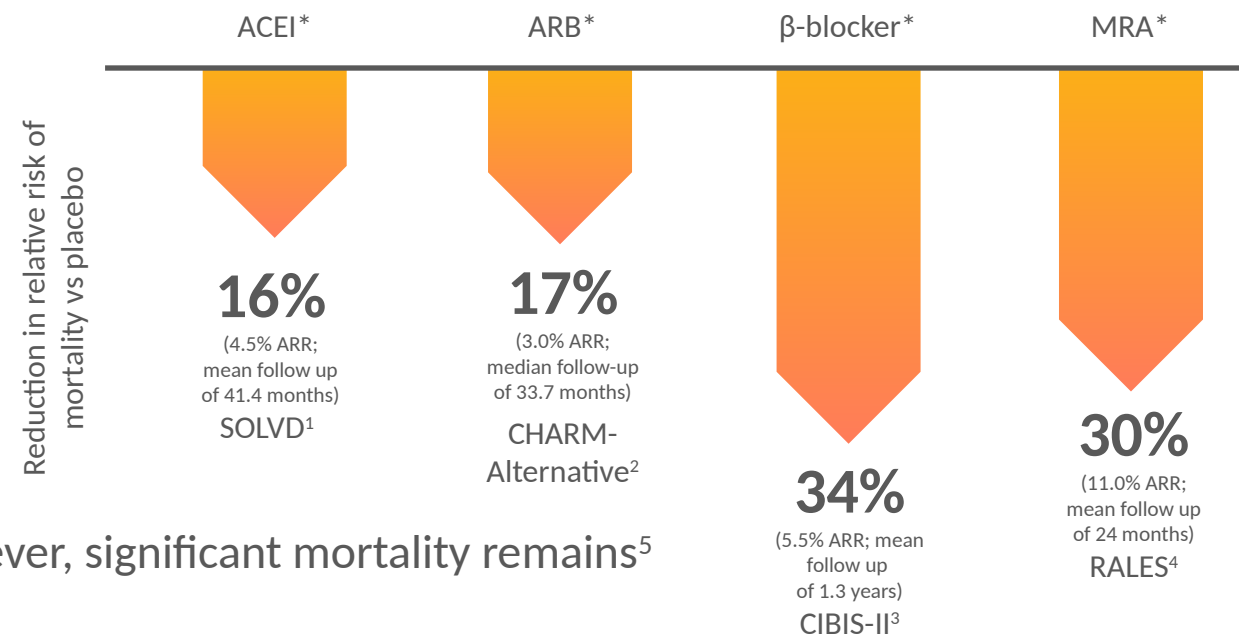
Unmet therapeutic need in chronic HF:
HFrEF mortality remains high despite the introduction of new therapies that improve survival

- HFrEF survival rates have improved over time with the introduction of new therapies



- However, significant mortality remains[5]

*On top of standard therapy at the time of study (except in CHARM-Alternative where background ACEI therapy was excluded). Patient populations varied between trials and as such relative risk reductions cannot be directly compared. SOLVD (Studies of Left Ventricular Dysfunction), CIBIS-II (Cardiac Insufficiency Bisoprolol Study II) and RALES (Randomized Aldactone Evaluation Study) enrolled chronic HF patients with LVEF≤35%. CHARM-Alternative (Candesartan in Heart failure: Assessment of Reduction in Mortality and Morbidity) enrolled chronic HF patients with LVEF≤40%.

ARR=absolute risk reduction; HF=heart failure; MRA=mineralocorticoid receptor antagonist; RRR=relative risk reduction

1. SOLVD Investigators. N Engl J Med 1991;325:293–302; 2. Granger et al. Lancet 2003;362:772–6; 3. CIBIS-II Investigators. Lancet 1999;353:9–13; 4. Pitt et al. N Engl J Med 1999;341:709-17; 5. Roger et al. JAMA 2004;292:344–50

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life is why

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sificare

ridotto del 30%i le visite al pronto soccorso
dovute al rapido peggioramento dei sintomi

European Heart Journal
doi:10.1093/eurheartj/ehw128

2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure – Web Addenda

The Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC)

Developed with the special contribution of the Heart Failure Association (HFA) of the ESC

Web Table 7.1 **Major clinical trials of therapeutic interventions in patients with heart failure with reduced ejection fraction**

ARNI					
PARADIGM-HF[167]	Sacubitril/valsartan (n = 4187) vs enalapril (n = 4212).	NYHA II–IV, LVEF ≤40% (amended to LVEF ≤35%), BNP ≥150 pg/mL or NT-proBNP ≥600 pg/mL, or if HF hospitalization within recent 12 months BNP ≥100 pg/mL or NT-proBNP ≥400 pg/mL.	2.3 y	Composite of death from cardiovascular causes or a first HF hospitalization reduced by 20% (22% vs 27%, P < 0.001).	Reduction in all-cause mortality by 16% (P < 0.001) and cardiovascular mortality by 20% (P < 0.001). Reduction in HF hospitalization rate by 21% (P < 0.001).
I_f-channel blocker					


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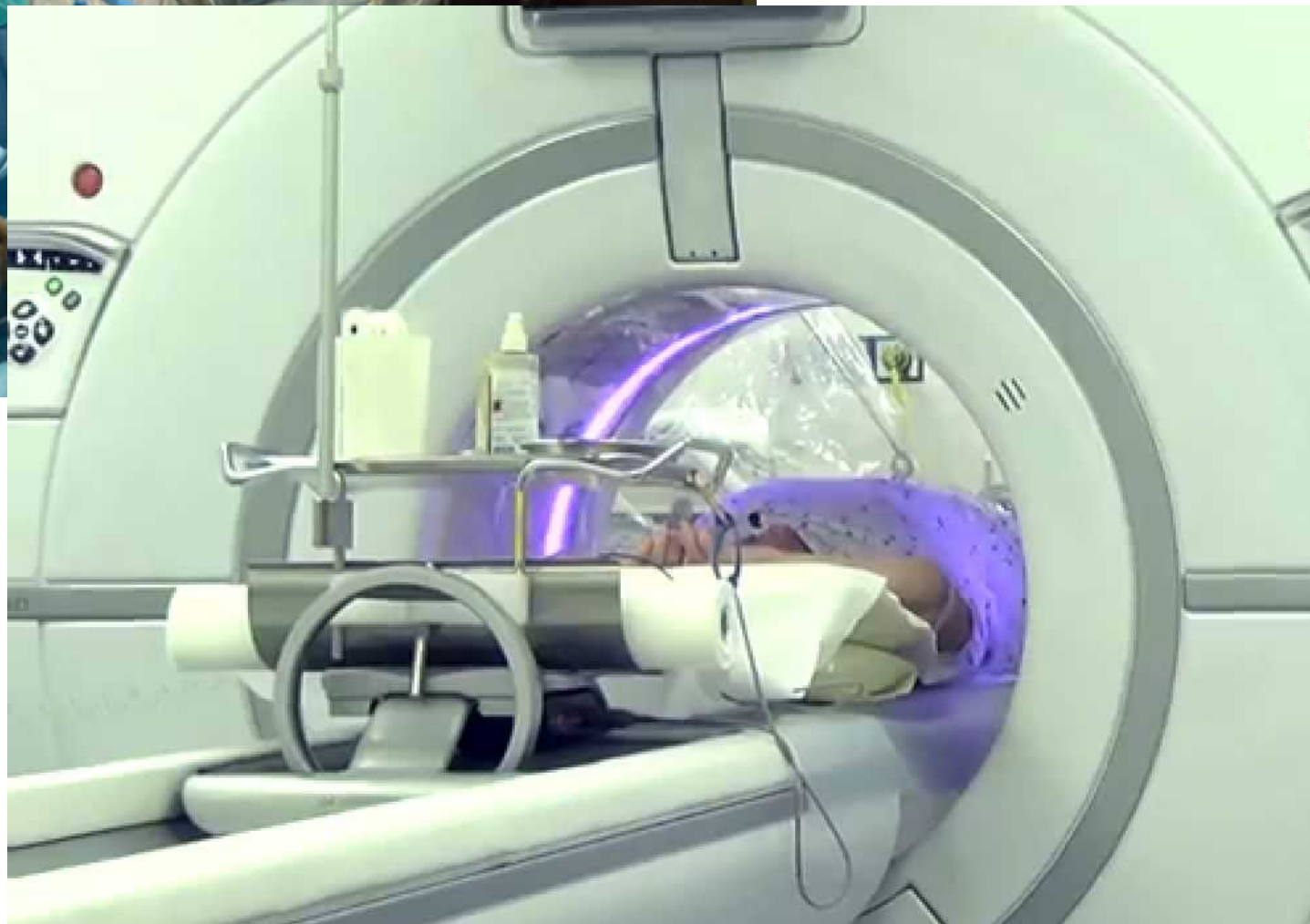
particularly suitable for those patients who have a low risk, but are subject to major complications and who have been admitted for routine monitoring



Heart failure patient quality of life statistics

Heart failure can severely affect patients' social capacity and emotional health[1]

63%

OF HEART FAILURE PATIENTS REPORT SYMPTOMS THAT ARE CONSISTENT WITH DEPRESSION[2]

Heart failure patients often suffer from anxiety or depression, feel a loss of self-control, and have difficulty performing daily activities.[3]

Gli operatori sanitari possono fare una differenza significativa nella vita dei pazienti con insufficienza cardiaca.

1. Calvert MJ, Freemantle N, Cleland JGF. The impact of chronic heart failure on health-related quality of life data acquired in the baseline phase of the CARE-HF study. Eur J Heart Fail. 2005;7(2):243-251. 2. Moser DK, Dracup K, Evangelista LS, et al. Comparison of prevalence of symptoms of depression, anxiety and hostility in elderly heart failure, myocardial infarction and coronary artery bypass graft patients. Heart Lung. 2010;39(5):378-385. 3. Cowie MR, Anker SD, Cleland JGF. Improving Care for Patients With Acute Heart Failure: Before, During and After Hospitalization. Oxford PharmaGenesis; 2014. http://www.oxfordhealthpolicyforum.org/AHFreport . Accessed February 18, 2015.

The role of the multidisciplinary team of health care professionals is essential for the treatment of heart failure

Heart failure can place a huge burden on patients, their families and the whole society[1]

YOUR EXPERTISE
CAN MAKE A MEANINGFUL
DIFFERENCE IN THE LIVES OF PATIENTS

La abilità del medico e la capacità di migliorare i risultati clinici sono in grado di fare la differenza vera e propria nella vita dei pazienti con insufficienza cardiaca.[1,2]

1. McMurray JJV, Adamopoulos S, Anker SD, et al. ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2012: the Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology. Developed in collaboration with the Heart Failure Association (HFA) of the ESC. Eur Heart J. 2012;33(14):1787-1847.2. Ponikowski P, Anker SD, AlHabib KF, et al. Heart failure: preventing disease and death worldwide. ESC Heart Failure. 2014;1(1):4-25.

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L' IMPORTANZA DI UNA DIAGNOSI PRECOCE: DALLE MALATTIE METABOLICHE ALLE MALATTIE RARE

Ambulatorio Biagio Valente	16 settembre 2017
Ambulatorio Claudio Prono	14 ottobre 2017
Ambulatorio Pasquale Micò	28 ottobre 2017
Ospedale M.G. Vannini	18 novembre 2017

Comitato scientifico:
Pietro Lentini – Felice Strollo

Lo scompenso cardiaco: la diffusione dellaconoscenza della malattia tra i pazientialla base di un corretto, precoce ed efficace intervento terapeutico.

Bisogna partire da una medicina di base che anche con la collaborazione degli specialisti ambulatoriali, porti all' ambulatorio dello scompenso le richieste di una assistenza esperta nei confronti del paziente affetto da scompenso cardiaco.

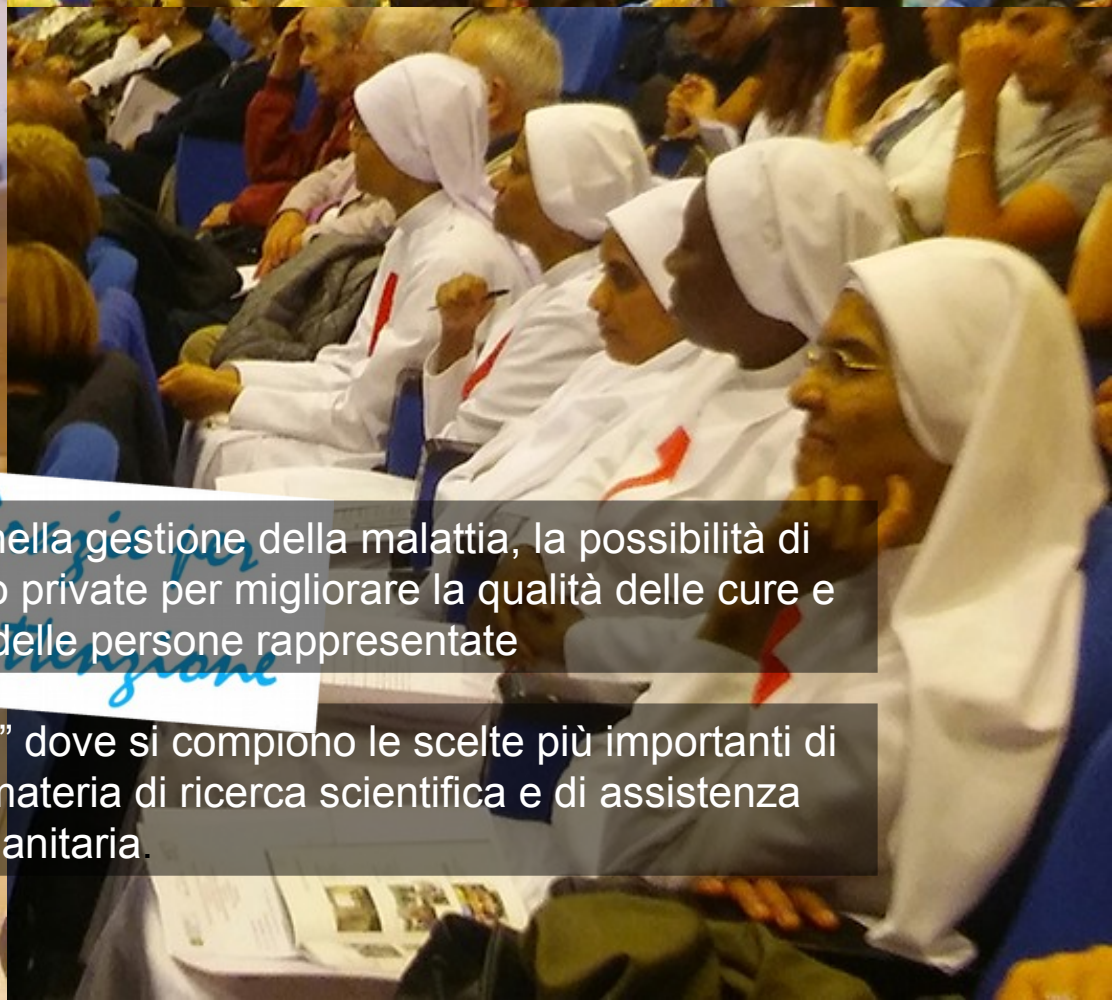
CENTRO IPERTENSIONE

Medicina d' Urgenza

Ospedale G.Vannini

Il Centro Ipertensione è più che mai pronto a giocare questo prezioso ruolo di collegamento tra le diverse aree territoriali che solo se unite potranno vincere questa lotta contro una patologia così diffusa e subdola nel suo insorgere.

Perchè il miracolo si compia manca il ruolo attivo del paziente scompensato e dei suoi familiari e care giver ai quali solo una associazione come AISC ha dimostrato di conferire valore decisivo.



devono rivendicare un ruolo attivo nella gestione della malattia, la possibilità di ottenere e gestire risorse pubbliche o private per migliorare la qualità delle cure e la qualità della vita delle persone rappresentate

il diritto di sedere ai “tavoli decisionali” dove si compiono le scelte più importanti di indirizzo delle risorse pubbliche in materia di ricerca scientifica e di assistenza sanitaria.