

Irish Nurses Cardiovascular Association News

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Newsletter June 2007

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www.ncnm.ie/inca

Hello from your new President

Firstly I would like to thank Patricia for all her hard work as President in leading the association to its current very strong position. In addition I would like to congratulate the Committee on a very successful Scientific Meeting held in Galway in April. The feedback has been very positive. The second day dedicated to the Special Interest Groups proved to be very popular and the general consensus is that we will host a two-day annual conference from now on.

The Irish Nurses Cardiovascular Association has been invited to co-host the Council on Cardiovascular Nursing and Allied Health Professionals (CCNAP) Annual Spring Meeting in Dublin in 2009. While a huge challenge we're looking forward to show casing the best of cardiovascular nursing in Ireland and abroad. Details will follow in due course. Lots of planning and preparation precede it first though.

In this newsletter we have reviews of our 11th Annual Scientific Conference in Galway and from the 7th Annual Spring meeting of European Cardiovascular Nurses. The Heart Failure Nurses have provided a report from the annual European Heart Failure Conference in Hamburg. We also have a report on The European Heart Health Charter. The aim of the Charter is to reduce substantially the burden of cardiovascular disease in Europe.

We look forward to meeting you at the Irish Cardiac Society Nurses Scientific Meeting in Belfast on October 11th and at our ESC 2007 Highlights Autumn Meeting on November 8th in the Guinness Storehouse.

Hopefully better weather will appear soon and we can enjoy what's left of the summer.



Mary O'Connor

Mary O'Connor

President

Irish Nurses Cardiovascular Association

Committee Members 2006-2007

Executive Committee

President: Mary O'Connor

Vice President/PRO: Vacant

Treasurer: Laura O'Connor

Scientific Secretary: Kate O'Donovan

General Secretary: Josie Dillon

Committee

Ann Cantwell

Fiona Colbert

Niamh Dixon

(Stroke Nurse Representative also)

Maeve Frawley

Niamh Kiely

Ann Mc Shane

Elizabeth Reilly

Mary Ryder

(Newsletter Editor)

Sinead Van Der Hoeven

Ex-Offiliate

Patricia Hall

Noeleen Fallon

Honorary Committee Members

Siobhan Kelly (North North West representative)

Ann O Dwyer (South South West representative)

Carol Condon (ESC Council on Cardiovascular Nursing)

Michelle Carney (Heart failure representative)

Lisa Browne (Chest pain representative)

Siobhan Milliken
(Interventional Cardiology Nurses Representative)

Retiring

Catherine Bellew

Liz Curtin

Maeve Cusack

Avril Lowry

Shelia O'Connor

Congratulations to

*Kate O'Donovan, Clinical Facilitator,
Mater Misericordiae University Hospital
and Mary Ryder, Advance Nurse
Practitioner in Heart Failure on success
as Nurse Fellowship With ESC*

11th Scientific & Annual General Meeting

By Elizabeth Reilly
Specialist Co-ordinator / Nurse Tutor

The 11th Scientific Conference and Annual General Meeting were held on April 20th and 21st 2007 at the Radison Hotel, Galway. The conference was opened by the out going president, Ms. Patricia Hall who gave a very heart warming and welcoming open address. She gave a comprehensive overview of the progress made by INCA to date and reiterated the need to continue with this momentum.

Keynote speaker was **Dr. Ann Henrick, Nurse Lecturer and Nurse Consultant.**

Dr. Ann Henrick provided a very interesting and thought provoking presentation on "Heart Disease in the Older Person; Where are we going?" Within this presentation Dr. Henrick explored the concept of how the public underestimate the nurses' role and contributions to the management of older persons living with heart disease and highlighted the need to change this perception and reflect their true value.

Demographic trends show people are living longer and accompanying longevity is an increase in numbers of older persons living and coping with chronic conditions such as heart disease. Many factors contribute to this including early access to a better health care service, earlier diagnosis, and improved medical management of symptoms. In addition, it is the general public's perception that the medical staff are central to this development. However, Dr. Henrick feels this is a very simplistic view of who the actual key players are in this process. In particular, she is referring to the nurses whom she sees as central to this care. Nurses not only have the knowledge and skills to combine the bio-psychosocial dimensions and related health care problems to formulate an individualised plan for patients, they also have the knowledge and skills to empower patients and families to ultimately incorporate this plan into their everyday life in a meaningful and fruitful way.

Dr. Henrick states that the public have great regard for nurses but have little understanding of the

complexities of their roles and functions. She states that nurses need to make explicit their role and contribution to the delivery of patient care. Coping with chronic heart disease is not just about making a diagnosis, undergoing a treatment, writing a prescription and receiving advice it is much more than this. It is about having the evidence based knowledge, knowing the patient and assessing their ability to understand, cope and adjust to their new found circumstances, assessing their support structure and social situation and bringing all this together so that patients are adequately equipped to continue with their lives. The public need to know and understand this work in order to get the recognition nurses truly deserve.

Ms Kate O'Donovan, Post – Graduate Diploma Cardiovascular Coordinator, MMUH gave an excellent presentation on the "*Nuts and Bolts of Ventricular Assist Devices and the Nursing Implications*".

She informed that audience that the profile of patients presenting with advanced ventricular failure is changing from that of the 60 - 70 year old to a much younger and sicker patient. These younger patients are often receiving maximum support at a much earlier stage with little effect. Thus, cardiologists have had to seek alternative ways of managing ventricular failure in these younger and sicker patients. Kate states that one very promising option is to use a surgically implanted "ventricular assist device". This device acts as a circulatory support and enhances / assumes the workload of the failing ventricle. During the presentation Kate gave a detailed description of the ventricular assist devices including the advantages and expected haemodynamic and systemic outcomes of the device over conventional therapy.

As with the introduction of any new initiative Kate highlighted the importance of appropriate education. The education package should include the general

pre and post-operative care however, more significantly it should address the patients and families' psychological / psychological care needs.

Kate concluded by predicting an increase in the number of patients with ventricular failure been managed by having a ventricular assist device implanted as a result of the findings from the Rematch Trial. She also identified the need for a comprehensive educational programme, effective psychological care and further research into the quality of life for the patient and effects on the main caregiver.

Ms Tanya Fawcett, Clinical Manager, UK/Ireland, Datascope gave a comprehensive overview of the "*Principles of Intra Aortic Balloon Counterpulsation*" and the positive outcomes for cardiac patients.

Tanya defined the intra-aortic balloon pump as a temporary cardiac assist device designed to allow patients survive acute insults until more definitive treatment is performed. A detailed description of the device including the application of counterpulsation therapy was outlined. Tanya described a range of clinical situations where by the IABP is most likely to be used. A number of observational studies including the GUSTO 1&2, KOVACK, SHOCK, NRMI and a randomized control trial 'TACTICS' were utilised to demonstrate the advantages of this device for patients and clearly demonstrates that the IABC is worth the effort.

Dr., Jim Crowley, Consultant Cardiologist, UCGH. Spoke on the issue of "*PCI for Chronic Total Occlusion*" and the challenges attached.

Dr. Crowley stated that chronic total occlusions are often found accidentally whilst treating other lesions. These lesions are difficult to treat, require additional time in the cath-lab i.e. > 60 minutes and there is increased risk of problems associated with increased use of contrast.

Traditionally PCI was attempted in only 8–15% of all identified chronic total occlusions. In addition, the findings from the EAST Trial indicated that a chronic

total occlusion was the most common reason why patients were referred for coronary artery bypass graphs. However this pattern is changing due to the discovery of better techniques and advances in technology, especially the use of tip head hard wires. Dr. Crowley states that approximately 70 % of identified chronic total occlusions can be treated during PCI today and there is a notable reduction in the need for CABG.

However, more research data is required to direct treatment of PTO's.

The afternoon sessions were equally informative with **Ms. Veronica O'Doherty, Clinical Psychologist, AMNCH:** who spoke on the "*Psychosocial Issues in Cardiology*".

Veronica begin her presentation by reminding the audience that psychosocial issues are multi-factorial and inter-actional in nature and that no one factor can be considered in isolation. The evidence suggests there is a high prevalence of psychosocial issues among cardiac patients and in particular depression and its associated features. Veronica went on to say that studies demonstrate that depression is a far stronger predictor of health related quality of life than the severity of cardiac illness itself. These studies also suggest that depression should be given the same level of acuity as that of diabetes mellitus. Furthermore all cardiac patients should be screened as part of a comprehensive screening/assessment process for all patients admitted with CAD.

Veronica identified a number of effective programmes aimed at helping patients take control of their depression. In particular, many studies show that CBT works in a range of patient populations. However, long term maintenance of relapse for depression and reduction in mortality rates remains a problem.

With regard to the management of CAD and chronic conditions in general Veronica highlighted a growing interest in generic 'patient education' and "self management" programmes. In particular, the self-management programmes are designed to facilitate patients/groups take control of the management of their own conditions.

Dr. Yvonne Smyth, SPR Cardiology, UCGH spoke on *"Cholesterol Management – and the evidence"*.

Dr. Yvonne Smyth introduced her presentation by giving an update on the extent of the burden CAD both at an individual and economic level. She discussed the pathogenic process of atherosclerotic formation and the progressive nature of this disease. In addition, she reviewed the known causative factors with particular emphasis on an elevated LDL-C. This factor is seen as the single most important causative factor.

An overview of the findings from some of the studies was presented. The overwhelming message emanating from these studies is for continued aggressive management of all risk factors. Looking towards the future Dr. Yvonne Smyth advocated the introduction of new cholesterol lowering drugs such as those aimed at blocking cholesterol biosynthetic pathways during its first stages and the CETP inhibitors, which are intended to raise the HDL.

Dr. Gordon Pate, Consultant Cardiologist, Galway spoke on the *"Management of Atrial Fibrillation: Drugs vs Cardioversion"*.

Dr. Pate began his presentation with a brief historical overview of the detection, ECG characteristics and associated features of atrial fibrillation. He emphasised the importance of undertaking a detailed assessment of pulse rate, in particular, the need to determine the difference between the radial and apical pulse and the difference between the heart rates during rest and exercise. The heart rates of patients with atrial fibrillation accelerate much quicker and are much slower to return to normal than those of non-atrial fibrillation patients. This invariably will incur additional workloads on the heart and predispose patients to premature heart failure. Patients can be treated either electrically, chemically and/or have the maze procedure.

With electrical cardioversion there is a 40–60 % chance of achieving a successful conversion. In addition electrical conversion is the preferred option

for patients in the acute phase of atrial fibrillation. Amiodarone is the drug of choice when using chemical conversion.

Patients with chronic atrial fibrillation may be managed electrically or chemically. The drug of choice in chemical conversion of chronic atrial fibrillation is Metoprolol/ Dilzem.

Patients with untreated atrial fibrillation have a 6% risk of developing a stroke. This is reduced to 4% if receiving aspirin. The risk is further reduced to 1% for patients in atrial fibrillation and treated with warfarin. However, this reduction is offset by a 1% risk of having a significant bleed.

Finally, select patients can be treated using the MAZE procedure.

To conclude the presentations a number of abstracts were presented by cardiovascular nurses. The topics included:

- *"Delivering quality care in the West of Ireland"*, Sue Hennessy, Project Manager, Cardiovascular Services, University College Hospital, Galway.
- *"Smoking prevalence amongst qualified nurses and their role in smoking cessation"* Geraldine O'Donovan, Lecturer, Catherine McAuley School of Nursing and Midwifery, Brookfield Health Sciences Complex, University College Cork
- *"Survival to discharge after out of hospital cardiac arrest"* Lisa Browne, Advance Nurse Practitioner Cardiology, Mater Misericordiae University Hospital, Dublin 7.
- *"Healthy Denial: A strategy for palliating the emotional strain of living with advance CCF"*. Marie Anne Ryan, Clinical Educational Facilitator for Cardiac Nursing, St. James' Hospital, Dublin 8.

Overall the day was a wonderful success.

Specialist Heart Failure Group Update from Hamburg 2007



The Annual ESC Heart Failure Congress was held in Hamburg this year. A strong contingent of Irish Heart Failure Physicians, Nurse Specialists and Allied Health Professionals attended. A wide variety of heart failure topics were accepted for poster presentation from Irish centres (see below for list of abstracts). Oral presentations were given by Dr. Ken Mc Donald SVUH on 'Monitoring weight – How useful and reliable in measuring deterioration' and Mary Ryder ANP, SVUH on 'How to evaluate the effects of patient education'. Overall the feeling was that the congress covered a variety of key issues in the area of heart failure management. It also facilitated the sharing of experiences and knowledge with our peers from both Ireland and Europe. Truly a valuable experience!

Mortality in patients with heart failure is associated with lower body weight and functional capacity independent of LV function and weight changes

S. Fall, M. Carey, S. Tekle, B.U. Khan, M. Habib, T. Kiernan, E. Ho, V. Maher
Adelaide & Meath Hospital, Tallaght, Cardiology Dept., Dublin, Ireland

Diagnostic difficulty with new onset heart failure in the community. A modest improvement over time but ongoing need for specialist assessment

G. Mak, M. Ryder, C. O'Loughlin, C. Conlon, M. Ledwidge, D. McCaffrey, K. McDonald
St Vincents University Hospital, Heart Failure Unit & Department of Cardiology, Dublin, Ireland

Prospective study of an out-patient based intravenous diuretic programme for acute decompensated heart failure

M. Ryder, D. McCaffrey, C. O'Loughlin, C. Conlon, M. Ledwidge, K. McDonald
St Vincent's University Hospital, Heart Failure Unit, Dublin, Ireland

A review of the actual need and evolution of need for device therapy in a community heart failure population

H.M. Sulaiman, C. O'Loughlin, C. Conlon, D. McCaffrey, M. Ledwidge, K. McDonald
St Vincent's University Hospital, The Heartbeat Trust, Heart Failure services, Dublin, Ireland

Discontinuation of heart failure medical therapy in a disease management programme predicts poorer outcome and increased costs

M. Mockler¹, C. O'Loughlin², C. Conlon¹, K. McDonald¹, M. Ledwidge¹
¹ University College Cork, Pharmacology, Cork, Ireland; ² St Vincent's University Hospital, Heart Failure Unit, Dublin, Ireland

Elevated B-type natriuretic peptide is associated with the presence of diastolic abnormalities in an asymptomatic, at-risk community population: The Screening To Prevent Heart Failure (STOP HF) Study

C. Conlon¹, C. O'Loughlin¹, A. Patle¹, K. Kinch¹, A. Whelan¹, C. Kelleher², M. Ledwidge¹, K. McDonald¹, the STOP HF Investigators

¹ St Vincent's University Hospital, The Heartbeat Trust, Heart Failure Research, Dublin, Ireland; ² University College Dublin, Public Health and Population Science, Dublin, Ireland

The prevalence of elevated BNP in an asymptomatic population with cardiac risk factors

C. Conlon¹, C. O'Loughlin¹, A. Patle¹, K. Kinch¹, A. Whelan¹, C. Kelleher², M. Ledwidge¹, K. McDonald¹, The STOP HF Investigators

¹ St Vincent's University Hospital, The Heartbeat Trust, Heart Failure Research, Dublin, Ireland; ² University College Dublin, Public Health and Population science, Dublin, Ireland

Should we be cautious when recommending exercise in patients with chronic heart failure?

E. Saeed¹, S. Leonard², J. Davidson², A. Cunningham², N. Daly², H. Melanson², P. Marsden², P. Shiels², Cardiac Department, Tullamore Regional Hospital, Ireland
¹ Tullamore, Ireland; ² Midland Regional Hospital at Tullamore, Cardiology Department, Tullamore, Ireland

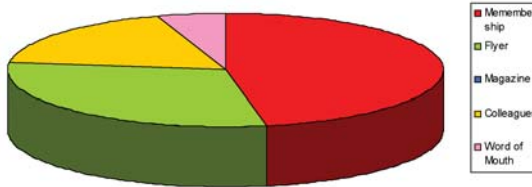


Mary Ryder ANP St. Vincent's University Hospital, presenting her poster at the recent ESC Heart Failure Conference in Hamburg

Evaluation Results (96 Returned)

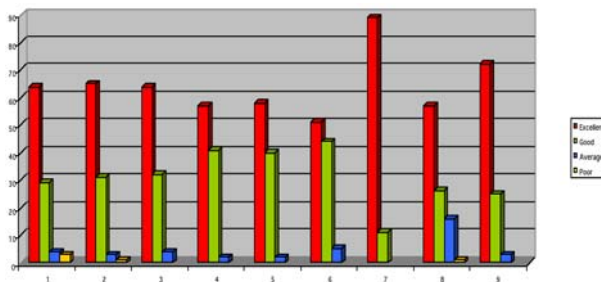
How did you hear about the Scientific Meeting?

Renewal of Membership Notification	Flyer	Nursing Magazine	Colleagues	Word of Mouth
47%	30%	-	18%	5%



Presentation	Excellent	Good	Average	Poor
1. Heart Disease in the older person	64%	29%	4%	3%
2. Nuts and bolts of ventricular assist devices	65%	31%	3%	1%
3. Principles of Intra Aortic Balloon Counter pulsation	64%	32%	4%	--
4. Recommendations vs. Suitability for ICD	57%	41%	2%	--
5. PCI for Chronic Total Occlusion	58%	40%	2%	--
6. Psychosocial Issues in Cardiology	51%	44%	5%	--
7. Cholesterol Management – The Evidence	89%	11%	--	--
8. Atrial Fibrillation: Drugs vs. Cardioversion	57%	26%	16%	1%
9. Pulmonary Vein Isolation/Ablation treatment for Atrial Fibrillation	72%	25%	3%	--

Quality of Speakers & Presentation:



Presentation	Excellent	Good	Average	Poor
a. Venue, Location, Accessibility	84%	15%	--	1%
b. Facilities, dining area, rest rooms	79%	11%	8%	1%
c. Conference Room	76%	15%	8%	1%
d. Sound System	67%	29%	4%	--
e. Poster Stands	75%	22%	3%	-

Heart Failure Nurses Special Interest Group

At the recent 11th Scientific & Annual INCA General Meeting in Galway the Irish Heart Failure Nurses Association had a breakout session on the Saturday on 'Heart Failure updates and new research'. Oral presentations were given by Sarah Fall CNS, AMNCH on the "Latest Advances in the treatment of patients with Acute Heart Failure" based on a recent update programme at the European Heart House, Nice. Mary Ryder ANP, SVUH delivered a case presentation, which highlighted many common experiences and was a great learning opportunity for all of us working in the area. Finally, Marie Ryan CNS, SJH gave a very interesting and unique presentation on "Living with an unfixable heart: - a qualitative study on the experience of living with advanced heart failure". This was a phenomenological study carried out on 10 participants with NYHA class IV. The overall finding revealed that the participants each described an exhausted and fearful sort of living. The main themes identified in the study were that many patients live in the shadow of fear, especially at night; many felt as though they were

running on empty, out of energy and out of hope; many felt restricted by this life and the experiences from repeated visits to A&E and readmissions. Marie concluded that a challenge to all us will be to "find ways to help patients live with rather than fix their situations of infirmity" and to "help them find hope and health within illness". This presentation clearly highlighted a greater awareness is needed of the psychosocial and spiritual needs of this vulnerable patient group. A very touching presentation.

Best Poster was awarded to Mary Ryder and the St. Vincent's University Hospital heart failure team with their poster "[Diagnostic difficulty with new onset heart failure in the community. A modest improvement over time but ongoing need for specialist assessment.](#)"

Best abstract was awarded to Lisa Browne and the team at The Mater Misericordiae University Hospital with their abstract "[Survival to discharge after out of hospital cardiac arrest](#)"

Irish Cardiac Society

in association with

Irish Nurses Cardiovascular Association

present

NURSES SCIENTIFIC PROGRAMME

**THURSDAY 11th OCTOBER
CULLODEN HOTEL, BELFAST**

REGISTRATION 10.10 –10.50 HRS

Cost: Free

Topics:

Arrhythmias, Endocarditis,
Cardiac Rehab

Travel Information:

Note: connecting train (Bangor line)
from Belfast Central to Cultra Station
(Culloden Hotel)

If travelling by rail please check the
following websites:

www.irishrail.ie
www.nirailways.co.uk

The 7th annual spring meeting on cardiovascular nursing

A meeting of the European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions, in collaboration with the British Association for Nursing in Cardiovascular Care and the Greater Manchester and Cheshire Cardiac Network, took place in Manchester on 23–24 March.

Rebecca Cosgrave reports on some of the highlights.

The 7th annual spring meeting on cardiovascular nursing that was held in Manchester was a busy couple of days. Not only were there the main sessions, but there were also parallel sessions and poster presentations, representing the many developments that are taking place in cardiovascular nursing throughout Europe. It was impossible to get to everything, but there was a great deal to choose from.

Research

The main sessions on Friday morning focused on the care of the patient with an ST elevation myocardial infarction (MI). However, it opened with a talk by Anna Stromberg from Linköping University Hospital in Sweden who discussed the challenges of changing practice and improving care. She discussed two approaches: a top-down approach, from research to clinical practice; and a bottom-up approach, from clinical practice to research. Anna emphasized the importance of research, which is designed to generate knowledge and will guide nursing practice. It is important for everyone to work together to implement the research and its recommendations for best practice. It is also vital for the findings to be communicated and this can be achieved by writing for publication, delivering lectures and writing guidelines.

Caring for patients with an ST elevation myocardial infarction

Which treatment is better? Discussion took place which, considered whether pharmacological and mechanical treatments were mutually exclusive. Tom Quinn of Coventry University in the UK told us that, for many patients, the location of an interventional centre is such that thrombolysis is a vital treatment, which can be offered by ambulance services. Some

would argue that primary percutaneous coronary intervention (PCI) is considered to be a more effective treatment than hospital-based thrombolysis. Indeed, Tom went on to tell us that a PCI may have a short-term clinical advantage but this may not be maintained. A study in the *European Heart Journal* suggested that after 5 years, patients who underwent a PCI fared better than those who had received thrombolysis. Time is a major consideration and although evidence shows that those who undergo a primary PCI fare better, if time is an issue, pre-hospital thrombolysis is a better option than in-hospital thrombolysis. Following this Dr Farzin Fath-Ordoubadi from Manchester Heart Centre, UK explained why primary PCI is the best option for patients who have experienced an ST elevation MI. He told us that the most important determinants of the patient's clinical outcome were to achieve rapid, complete and sustained coronary reperfusion. Farzin explained that there was a tradeoff between thrombolysis and primary PCI. The mortality risks are the same but thrombolytic therapy presented a higher risk of stroke and bleeding. In addition, PCI has more benefits as it allows more of the myocardium to be salvaged; after 5 years it sustains its benefits more than thrombolytic therapy and the patient is less likely to develop heart failure or angina in the future. In addition, it enables more complete reperfusion, has lower rates of reocclusion and allows risk stratification to be conducted. However, if thrombolytic therapy can be administered very early (within 2 hours), it can be very beneficial to the patient.

Issues in changing practice

Joanne Whitmore from Pennine Acute Hospital NHS Trust, UK, discussed how improvements could be made in improving time to treatment for those

receiving thrombolysis. In the area covered by her Trust there is a high prevalence of chronic disease and poor health. Hospitals are expected to deliver thrombolysis to everyone within an hour of the call to the ambulance service and treat 75% of patients within 30 minutes of their arrival in hospital. However, the guidelines are now rather old. There are two nurse models for the administration of thrombolysis: nurse initiated, whereby the patient is diagnosed and thrombolysed by the nurse; and nurse-led, whereby the nurse assesses the patient's suitability for the treatment and refers him/her to the medical staff. Both models have been shown to reduce door to needle time and the number of inappropriate thrombolysis cases. Joanne also stressed the importance of education, communication and team work in improving the care of this group of patients.

Christer Axelsson, an anaesthetic nurse from the ALS ambulance in Gothenburg, Sweden discussed the nursing role in the ambulatory hospital. In his area there are three special ambulances, which are staffed by one anaesthetic nurse and one experienced paramedic. Christer told us how important good communication with both the patient and his/her family is when attending someone who is experiencing chest pain. The health professional should listen and take everyone seriously. It is important to treat the symptoms as quickly as possible but he/she must not forget the bystanders. The next of kin are part of the patient. Indeed it can sometimes be appropriate for a relative to be involved in resuscitating the patient. The health professional needs to remain calm, never rush and take command as this will instill confidence in those around. In his area it is possible to transmit a copy of the electrocardiogram (ECG) from the ambulance to the hospital. This can enable a decision to be made about whether the patient should receive thrombolytic therapy or PCI.

Dr Farzin Fath-Ordoubadi spoke again, but this time about organizing regional health services for primary PCI. He told us that in Manchester there are two PCI centres: the Manchester Royal Infirmary and

Wythenshawe Hospital and there are a number of considerations to be made when deciding how to change or expand a service. For example, district general hospitals (DGHs) may feel that they already have a good thrombolysis service so why change to an approach that adopts PCI as best practice? DGHs may be concerned about their star status and how the issues of research, consent and responsibility will be addressed. Centres offering primary PCI may also have concerns about issues such as bed waiting times, availability of beds, trolley waits and whether or not there are enough intensive care unit beds or staff to deal with an increase in the number of people undergoing primary PCI. Ambulance staff will also be affected by change. They may be concerned about how changes will affect their response times and the fact that, out of the many people who complain of chest pain, only a few infarct and there are not enough resources for direct transfers. To respond to all these concerns, forums for ratification can be set up to include groups such as cardiac networks, hospital trusts, ambulance services, those working in critical care and patient forums. By working together and conducting audits they can assess whether the services are being improved, and make changes in response to these findings. If everyone works together, the service can move towards operating on a 24-hour basis, as it does in Sweden.

To emphasize the European theme of the Manchester meeting, Hai-Shiang Lee, a Consultant Cardiologist from Wythenshawe Hospital, UK gave an overview of the care offered to patients with ST elevation MI across Europe. Hai-Shiang told us how people from Eastern Europe have a higher standardized mortality ratio (SMR) than those in western Europe. He used the European Heart Survey to describe these inequalities in standards of health and healthcare across Europe. For example, Britain is not doing as well as other parts of Europe in providing primary PCIs. The healthcare system in Britain does not offer a combination of PCI and thrombolysis, a treatment offered in many other parts of Europe and, across Europe, there are wide differences in the number of people who are offered thrombolytic therapy. This

ranges from 15% to 60%. Hai-Shiang did, however, conclude that although there are large variations in care, there is an increased uptake of evidence-based practice across Europe in terms of medical and reperfusion therapy.

Improving care in heart failure

Barbara Riegel of the University of Pennsylvania School of Nursing, USA opened this session by discussing the issue of self-care in heart failure. She described self-care as a naturalistic decision-making process involving a choice of behaviours that maintain physiological stability, as well as the patient's response to symptoms as they occur. It is an interactive process involving the person, the problem and the environment. The success of self-care maintenance and management involves the patient's ability to respond to symptoms and evaluate his/her treatments. Self-care can be made better by improving the patient's knowledge, skill and level of confidence. However, some patients may not be able to adopt a self-care approach and this may be because of a certain level of cognitive impairment.

Anders Brostrom from the Swedish Institute for Studies in Education and Research told us that sleep-disordered breathing affects up to 80% of patients with heart failure. Of these, 40% have central sleep apnoea (the cessation of airflow for at least 10 seconds, causing a waxing and waning breathing pattern) and 36% have obstructive sleep apnoea (cessation of airflow but with abdominal movement while the patient is trying to breathe). Poor sleep patterns can affect the symptoms of people with heart failure and improvements can lead to a reduction of symptoms and an improvement in the patient's quality of life. Treatments for obstructive sleep apnoea include oral appliances, surgery and weight reduction. However, poor levels of adherence have been shown in the use of oral appliances. Treatments for central sleep apnoea include oxygen

therapy, the servo ventilator and continuous positive airway pressure ventilation.

In conclusion, Anders told us that shortness of breath is very prevalent in those with heart failure and this leads to fragmented sleep patterns and a reduction in the patient's quality of life. Randomized controlled trials are needed to work out the best treatment for sleep-disordered breathing. Martin Gibson from Manchester University, UK discussed new approaches in the treatment of diabetes and heart failure. Although the predominance of type 1 diabetes remains stable, the levels of people affected by type 2 diabetes is increasing rapidly. Martin told us how obesity is increasingly measured in terms of waist circumference rather than body mass index and waist circumference correlates directly with the risk of developing coronary heart disease in women. Diabetes damages your heart because it leads to an increase in the chance that myocardial cells will die. As a result the heart muscle shrinks and this puts the patient at an increased risk of developing heart failure. In addition, the heart becomes stiffer because of interstitial fibrosis. There is very little evidence for the best treatment of patients with diabetes who also have heart failure. Poor glucose control is linked to a worse outcome but there is no evidence linking good glucose control with a better outcome. Fibrosis may be reduced with angiotensin converting enzyme inhibitors and angiotensin II receptor blockers. These can be particularly helpful against the progression of sub-clinical disease. Metformin is also associated with some improvements. In conclusion, diabetes is an epidemic, which predisposes patients to heart disease and prevention is better than cure. The usual cardiac medications are effective for people with diabetes, but additional attention must be paid to glucose treatments as these may prove to be beneficial to patients with, or at risk of, heart failure.

The European Heart Health Charter

By Patricia Hall, Mater Cardiology Group, Mater Private Hospital, Dublin.

In 2004, the European Union Council Conclusions, drawn up under the Irish Presidency at the time, called upon the European Commission and EU Member States to ensure that appropriate action is taken to address cardiovascular disease. The European Heart Health Charter is the result of this brought together after the Luxembourg Declaration 2005 further established agreement to initiate or strengthen comprehensive prevention plans across Europe.

On 12th June 2007, WHO/Europe joined the European Commission, European Heart Network and European Society of Cardiology to formally launch the European Heart Health Charter. The creation, endorsement and launch of this Charter are the first phase of a new 3-year project of the European Heart Network.

The aim of the Charter is "to reduce substantially the burden of cardiovascular disease ... and to reduce inequities and inequalities in disease burden within and between countries."

It stresses the need for increased public awareness of risk factors and the responsibility of both the individual and political bodies to address these risks. More information can be found on the website dedicated to the European Heart Health Charter at: www.heartcharter.eu

To date, 14 European Health Promotion Organisations have officially endorsed the Charter.

The Irish Nurses Cardiovascular Association, amongst several other health organisations, has been asked to become a key signatory to the Charter at national level in Ireland. As health care professionals we can help to provide visibility for the Charter and emphasise the need to address cardiovascular disease at local, regional and national level.

The formal launch in Ireland is Wednesday 11th July 2007.

References

[The European Heart Health Charter](#)

[The European Guidelines on CVD Prevention in Clinical Practice](#)

[Screening of family members of patients with premature coronary heart disease - Results from the EUROASPIRE II family survey - European Heart Journal \(2003\) 24, 249-257](#)

[Lifestyle and risk factor management and use of drug therapies in coronary patients from 15 countries - Principal results from EUROASPIRE II - European Heart Journal \(2001\) 22, 554-572. EUROASPIRE Study Group. Clinical reality of coronary prevention guidelines: a comparison of EUROASPIRE I and II in nine countries. Lancet 2001; 357:995-1001](#)

Educational Dates, National and International for your 2007 Calendar

European Society of Cardiology Annual Congress

Date: 1-5th September 2007

Venue: Vienna, Austria

Details: www.escardio.org

Irish Cardiac Society AGM

Date: 11-13th October 2007

Venue: Culloden Castle Hotel, Belfast

Web: www.irishcardiacsociety.com

INCA Autumn Evening Meeting

Date: 8th November 2007

Venue: Guinness Store House, Dublin 8.

Web: www.ncnm.ie/inca

Heart Failure Specialist Interest Group Annual Refresher/AGM

Date: November 2007

Venue: Killiney Castle Hotel, Dublin

Any submissions/suggestions for newsletter please forward to m.ryder@stmichaels.ie