

# Irish Nurses Cardiovascular Association News

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## NEWSLETTER

DECEMBER 2007

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### Inside this Issue

- Update from Interventional Cardiology Nurses Group
- ESC 2007
- Europrevent 2007
- International Symposium on ACS
- Autumn Evening Meeting ESC Highlights
- ICS Cardiac Nurse Scientific Meeting
- Arrhythmia Alliance

# Hello from your President

Dear All,

We're delighted to bring you our last newsletter of 2007. It contains an overview of our activities since the end of the summer. It's been a busy time, plenty going on.

Also of interest is an item on the Arrhythmia Alliance. If you have anything on less well known or new cardiovascular related patient support groups that you consider relevant for other cardiovascular nurses please bring it to our attention.

I would like to take the opportunity to thank the committee for all their hard work and effort throughout the year. We're already planning for 2008. In addition we're delighted to be co-hosting the Council on Cardiovascular Nurses and Allied Professionals (CCNAP) Meeting in Dublin on April 24th & 25th 2009. Work has already commenced on that programme. We hope to have a large Irish attendance.

I wish all our members a very Happy Christmas and New Year. We look forward to your continued membership and support in 2008. Enjoy the holiday season.



Mary O'Connor

## Mary O'Connor

President

Irish Nurses Cardiovascular Association

### Committee Members 2007-2008

#### 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)

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 & Allied Professionals)

Michelle Carney (Heart failure representative)

Lisa Browne (Chest pain representative)

Siobhan Milliken

(Interventional Cardiology Nurses Representative)



INCA Committee Members: Pictured above are (from left):  
Kate O'Donovan, Noeleen Fallon, Laura O'Connor, Mary Hannon and Catherine Bellew.

## Cath-Lab Nurses Special Interest Group: April 2007

By: Siobhan Milliken  
(Interventional Cardiology Nurses representative)

**The cath lab meeting was co-chaired by  
Kate O'Donovan and myself - and thank you Kate for your support.**

There were 3 speakers. Therese Maloney (CNM2, Cath lab, Beacon hosp), gave a very informative presentation on the role of CNS within the Cath lab, with particular regard to education of nursing staff in the Cath lab.

Mary Maxwell (Cath lab Sister, Belfast City hosp) then spoke on induction and training of nursing staff within her cath lab suite and the Queen's University module on Cath lab training for nurses - most informative. Final presentation was from Dr Brendan O'Coilain, (consultant cardiologist and electrophysiologist, Galway Clinic). He gave a very interesting presentation on sudden cardiac death. Mary and Brendan's presentations can be accessed on the INCA website.

There was plenty interaction through the meeting. It was well attended (16 - not bad for a starter association). I presented the results of a country-wide questionnaire I carried out to assess staffing levels, support staff, activity and facilities in labs around the country. There was good response and I would hope to repeat this yearly to track developments and progress.

We would like to thank all the speakers who made the day so enjoyable.

## A report from the ESC congress Vienna 2007

# New Approaches to the Management of Hypertension and Cardiovascular Complications:

By Noeleen Fallon Cardiac Rehabilitation Co-ordinator, AMNCH, Dublin 24.

Hypertension plays a pivotal role in the development of CVD. New European guidelines launched at this Congress highlight the importance of lowering BP to target. Blood pressure levels in hypertensive patients should be <140/90mmHg and <130/80mmHg in all hypertensive patients at high risk of CV events (those with diabetes, renal disease, coronary heart disease or cerebrovascular disease). All patients should be classified not only in relation to the grades of hypertension, but also in terms of their total CV risk ie presence of other CV risk factors, target organ damage (TOD) and disease.

Anti-hypertensive treatment is associated with a clear-cut reduction in the incidence of cardiovascular mortality and morbidity. Anti-hypertensive agents that act on the renin-angiotension system (RAS) could have an important role to play in prevention or retarding the progression of CV, cerebrovascular and renal disease.

As various stimuli increase BP in daily life, it is necessary to achieve smooth and continuous BP control throughout the day and night. Some anti-hypertensive are effective at achieving this. At the same time these agents may also demonstrate other protective effects elsewhere in the body. Recent clinical evidence suggest that sustained BP control and RAS inhibition over 24hours and early morning BP surge would represent a key element for such protection.

Poor 24-hour control of BP is associated with TOD and early morning increase in BP is clearly associated with an increased incidence of CV events. Available

angiotension receptor blockers have pharmacological differences that can influence clinical effects leading to prolonged and sustained 24 hour BP reduction.

Hypertension plays a major role in developing proteinurea in patients with chronic renal disease, particularly patients with diabetic nephropathy. The detection of microalbuminurea, a marker of CVD is important as it increases CV risk and vascular dysfunction. In order to prevent stroke and CV events, proteinurea must be reduced. Inhibition of the RAS by angiotension converting enzyme inhibitors (ACE I) or angiotension receptor blockers (ARB's) has renoprotective effects leading to a reduction in renal disease as demonstrated in trials such as the RENAAL, IDNT and MARVAL.

Effective BP control with anti-hypertensive therapy along with use of statins and antiplatelet therapy might improve stroke protection. Effective 24hour control particularly prevention in morning surges is necessary. Data from the ACOPE, VALUE and MOSES trials clearly demonstrate that ARB's benefit beyond BP lowering. The pleiotropic effects that may contribute to cerebrovascular protection in at risk patients, including reduced central BP and cardiac hypertrophy, less atrial fibrillation, improved endothelial dysfunction, less inflammation and insulin resistance.

Remember as little as 2mmHg reduction in systolic BP leads to a 7% reduction in ischaemic heart disease and 10% reduction in CV mortality (Lewington, 2002).

## EUROPREVENT 2007 IN MADRID SPAIN

**S**hanthi Mendis (Switzerland) discussed new Guidelines on Primary Prevention of CVD that will be launched by the WHO this year. These guidelines will focus on CV risk. There is a shift from individual risk to absolute risk as this is more cost effective. Individual risk reduction is only cost effective if the individual is high risk. A population approach is cost effective and necessary as out of pocket expenditure on health is 60-80% in developing countries such as China and Indonesia compared to 10-15% in developed countries. The nature of risk is continuous and involves multiple RF's.

The objective to match available resources with costs is ongoing. By adopting a total risk approach with regard to smoking, BP, diet and exercise, incidence of MI and stroke are decreased. The benefit depends on the total risk, the higher the risk the greater the benefit. Evidence has demonstrated that it is cost effective to prescribe Statins if CV risk is > 20%. If total Chol is >8mmol/L, medication is required. If BP is > 160/100mmHg, anti-hypertensives such as Thiazide diuretics, CCB, ACE I and/or BB are recommended. If total CV risk is > 20% medications such as Aspirin, Statins and antihypertensives are recommended. Effective use of limited resources is necessary when competing for expensive treatments.

**Les Ryden, (Sweden)** gave an enlightening presentation on the challenges for CVD prevention in Europe. The ESC is working toward a European Heart Health Charter. CVD had 40% mortality rate in 2002. The Euroheart survey in 2006 demonstrated reduced mortality, increased longevity with CVD but increased prevalence of Diabetes (56 million predicted for 2025). A unified approach with collaboration from governments and communities is required while respecting each country's autonomy. In order to improve adherence and compliance we must have

belief and persistence.

CVD needs a political agenda. Heart disease kills more people in the EU than any other disease and spends more money. Lifestyle factors such as food composition, consumption, smoking and medical factors such as obesity and hypertension all need to be addressed. 2% of trans fatty acids increases CVD by 25%. No more "political obstacles". The Danes now have a ban on high levels of trans fatty acids > 2% in foods. Finland is another good example. In the 1970's the number of MI 's in 35-year-olds was increasing. Risk factor's (RF) were examined and by lifestyle measures such as a reduction in smoking and controlling cholesterol and BP levels, mortality improved. The 1980's saw a further improvement with the introduction of Statins and intervention cardiology, but lifestyle changes had a similar effect until then.

The ESC has lead a unified approach over the years by updating guidelines for treatments in CVD and by research studies, EUROASPIRE 1 and 2 and Interheart in order to improve adherence and compliance. Unfortunately, EUROASPIRE 2 demonstrated total cholesterol remained > 5mmol/L in 50% of the population studied and obesity (BMI >30) in 30%.

With patients and persistence the European heart health charter had been born. This hopefully will give every child born in the millennium the right to live beyond 65years free from CVD.

**Bob Lewin (UK)**

**Uptake of CR and the campaign to improve this**

In 2002, a target was set of 85% of MI and revascularised patients should be offered Cardiac Rehabilitation (CR) and when this target was achieved, then extend the invitation to all other cardiac patients.

### Problems are:

1. Under treatment: not enough CR programs, patients not invited or patients choose not to attend.
2. Inequalities: ethnic minorities, women, elderly, place of residence, post code.
3. Variation in resources and staffing
4. Increase crisis in the health service and CR services under threat of closure.

### UK Plan included:

- A. National audit of service- who has what
- B. National Standard of Care
- C. Enlist other groups for support i.e. Diabetes UK, Arrhythmia Alliance BSC etc
- D. Steering group
- E. Launch campaign to Press/ Public with 5 demands
  1. Every patient can attend
  2. Alternative method of CR i.e. home based
  3. Rehab for under represented groups
  4. CR program meets the minimum standard
  5. Monitored by the National Audit of CR

Postal campaign to target patients, GPs, politicians, health authorities, radio networks and press.

CR promotes recovery and reduces disability and prevents further illness where as secondary prevention tends to focus on the latter using lifestyle and medications.

### Social patterning of CVD

The Interheart study demonstrated that both men and women respond to stress. Combined with low SEG, work stress can lead to CVD, although work stress may be less of an issue for women.

There is a social gradient in health. Cumulative socioeconomic disadvantages increase the risk of CHD. Lower income families tend to smoke, take less physical activity and have a propensity towards obesity. Adoption of healthy lifestyle and support is required during pregnancy, early childhood and for school children.

Psychosocial factors such as social isolation, stress and negative emotions impact on disease.

Knowledge about CVD and healthy lifestyle may lead to self monitoring of individual and their stress responses and cognitive restructuring (replacing the negative with positive) and skill training such as assertiveness, problem solving and relaxation. Balancing work with family life leads to less anxiety and depression and a higher self-esteem with a positive effect on survival over 10 years.

### Long-term outcomes in CR

Exercise and physical fitness are independent predictors of long-term survival and help to attenuate progression of atherosclerosis. CV risk factors influence life expectancy. Cardiac Rehab programs may also influence life expectancy. EUROASPIRE 1 and 2 demonstrated very little improvement in control of traditional RF such as smoking and obesity and hypertension. These are present in 80-90% of CV patients. Intraheart identified 9 simple RF's. It is important that patients understand the relationship between behaviour and the disease. The GOSPEL study (Long-term RF intervention and lifestyle behavioural change after MI) demonstrated a significant reduction in MI (50%) over 3 years. There was a significant reduction in readmission in the intervention group. Although there was no change in smoking status, there was a significant change in other RF and improved adherence to meds.

## The first International Symposium on Progress in Acute Coronary Syndromes (ACS) Rome Oct 07.

By Noeleen Fallon, Cardiac Rehabilitation  
Co-ordinator AMNCH, Dublin 24

The focus of this conference was to provide a comprehensive update on ACS in all aspects from the basic science to clinical issues and secondary prevention, including the latest clinical trial results and new guidelines.

One of the most interesting developments in Europe was the confirmation of the large number of hospitals who are participating in pre-hospital thrombolysis for the management of acute ST-segment Elevation Myocardial Infarctions (STEMI). A number of hospitals have developed a multidisciplinary approach to aid in the rapid administration of thrombolysis to patients experiencing an STEMI at the earliest possible time by paramedics and doctors in the community. It has been recommended that pre-hospital thrombolysis is the ideal treatment if no more than 2 hours has elapsed since the onset of chest pain and symptoms. The alternative treatment of primary Percutaneous Coronary Intervention (PCI) should be within 90mins after first medical contact as recommended by the European Society of Cardiology. If this is possible then it appears to be the more favorable approach for the treatment of STEMI. However the debate regarding thrombolysis or primary PCI as the preferred treatment of STEMI in the patients who present early (<2 hours from the onset of symptoms) continues.

The time delays in the administration of thrombolysis and the time delays associated with organizing primary PCI were highlighted as a topic of grave importance as ischaemia is only reversible if treated early. The identified time delays were: no awareness on the patients behalf of the importance of getting their chest pain investigated, patients choosing their General Practitioners as the first point of medical contact therefore leading to longer delay times before reaching the hospital, patients presenting to hospitals with no onsite interventional cathlab. It was recommended that

each organization needs to evaluate the time delays associated with their organization. This should be followed by a multidisciplinary team approach to combat these time delays. Increasing public awareness of the importance of presenting to the hospital with chest pain especially in the presence of risk factors for Coronary Heart Disease is one such strategy. This has been achieved in France by the distribution of flyers on the importance of chest pain and the continuous public advertising. Pre-hospital thrombolysis is one of the greatest influences in reducing the time delays for these patients.

Patients' lack of adherence to their medication post ACS was highlighted as a phenomenon that is on the increase. Evidenced based therapies used in the treatments of ACS can reduce the relative risk of subsequent cardiac events by 68% over the subsequent 2 years (LaBresh 2007). Reasons for poor adherence included: ease of use, accessibility, cost, patients perceptions on the need for their medication. Education on adherence to medication enhances the patients' convictions that the recommended therapies are important and beneficial. Therefore patient education was highlighted as pivotal in ensuring that patients adhere to their drug therapies.

### Areas under research:

- 1) Diabetic patients presenting with ACS require very aggressive treatment at the earliest possible time and there is a high risk of mortality associated with these patients. The question of diabetic patients requiring intensive insulin therapy on admission to the hospital is under research at present.
- 2) There is new Troponin I & T assays under development with improved sensitivity.

I would like to extend my heart felt thanks to the Irish Nurses Cardiovascular Association for giving me the opportunity to attend this very interesting conference. Thank you.

## Autumn Evening Meeting: "4th Highlights of ESC"

By Noleen Fallon Cardiac Rehabilitation  
Co-ordinator AMNCH

The 4th "Highlights of the ESC" was held in the Guinness Storehouse on Thurs 8th November 2007. Catherine Bellew, a recipient of the travelling fellowship, delivered a very informative report on the results of Eurospire III with emphasis on the role of the nurse in secondary prevention.



Catherine Bellew

Eurospire I was conducted in 1995-96 and was an evaluation of cardiovascular risk factors in participants of 9 European countries. Eurospire II was conducted in 15 countries over 1999-00 and Eurospire III was conducted in 22 countries in 2006-7. Ireland was involved in Eurospire II and III.

Comparison was made between Eurospire I and II with Eurospire III.

**Diagnosis and Intervention:** the number of participants who had a diagnosis of MI and ischaemia was reduced and PTCA numbers were increased.

### Risk factors:

**Smoking:** one fifth of the patients continue to smoke with increasing prevalence in females < 50 years. In Ireland smoking prevalence is reduced to 17.9%, probably reflective of the smoking ban introduced in 2004.

**Blood pressure:** 50% of all patients are not treated to target. Therapeutic control was similar over the three studies, with no major improvements.

**BMI:** 4-5% of the patients are overweight with BMI > 25 kg/m<sup>2</sup>. BMI levels are increased in 70-80% of the patients on average. In Ireland 74% of patients were overweight in Eurospire II but this has increased to 78% in Eurospire III. There is evidence of lack of attention to weight with reduced documentation regarding body composition measures i.e. weight and waist circumference.

**Lipids:** Total cholesterol values improved i.e. TC < 5 mmol/L from 13% in Eurospire I to 72% in Eurospire III. There is increased therapeutic control 4-9% increased to 48-72%, particularly with increased prescriptions of statins.

**Diabetes:** Increased numbers in Ireland from 9% in Eurospire II up to 14.5% Eurospire III. Undiagnosed DM is estimated at 3.8% (Eurospire I), 15.3% (Eurospire II) and 14.8% (Eurospire III). Therapeutic control has disimproved.

**Physical activity:** 14% of participants engage in PA. In Europe, 44% of patients and in Ireland 88% were invited to attend cardiac rehabilitation. Uptake was 34% in Europe and 67% in Ireland.

**Medication:** There was increased prescription of Betablockers, antiplatelet treatment, ACE I, ARB, diuretics and statins with slight reduction in Calcium Channel blockers.

**In conclusion** there is an increase in obesity particularly central obesity, increase in diabetes with less therapeutic control (93% >6.1mmols target BSL). 61% had BP > 140/90 mmHg and 42% had total cholesterol >4.5mmol/L. Patients require professional support and investment in prevention. A comprehensive program is necessary with lifestyle and medication counselling. Nurses are in an excellent position to deliver such a program in conjunction with a multidisciplinary team.

**Anne Gallagher**, the second recipient of the travelling fellowship delivered informative "short stories". Her first story related to **Blood pressure control** and she highlighted that BP reduction is protective whatever medication was prescribed. Assessment of **total** cardiovascular risk is important and use of the new SCORE tables is recommended. 1 in 4 people are hypertensive, 1 in 3 are hypertensive at 50 years and 1 in 2 at 70 years in the industrialised world. **Rule of halves** still applies. If blood pressure was controlled there would be a 50% reduction in numbers of MI and CVA. It is important to assess for sub clinical organ damage using ankle brachial index or pulse wave velocity.

**Lifestyle factors** are important and personal responsibility coupled with public health issues together will gain benefit. **ABPM** is recommended as 20% of patients present with white coat hypertension and 10% with masked hypertension. It is integral part of practice for guiding treatment, in diabetes and pregnancy and in the elderly, who may be hypotensive.

Other short stories related to **Euroaction**, a RCT involving CV patients who attend GP's and/or hospitals with emphasis on family involvement. There has been some improvement in BP and lipids but not glucose control. **Euroheart** was a 3-year project developed by the ESC and European Heart Network and involved 21 countries. 25 countries have signed up for the European heart health charter.

**Physical activity** was discussed with emphasis on aerobic fitness. Peak oxygen uptake is the most accurate predictor of all cause mortality. The benefits of PA in middle aged and older adults are well defined and older people respond as well as young. Try and encourage activity 7 days of the week as this will lead to activity 5 days perhaps.

**Dr Declan Sugrue** discussed **MI and subsequent treatments**. Primary PCI is the best treatment provided resources are available and it makes clinical sense. Numbers of STEMI are reduced and ACS is increased. For non-occlusive ischaemia, thrombolysis is not relevant but careful management with early angiogram is required.

He discussed PCI and the history of stenting. Drug eluting stents have dramatically reduced in-stent stenosis and late stent restenosis is only seen in .2-.5% of the population but they are more expensive.

In relation to the economics: an ounce of prevention is greater than a pound of cure!!

Mortality from MI remains 50% with little change over the past 50 years. In hospital mortality has improved particularly in CCU.

## Cardiac Nurses Scientific Meeting at the Irish Cardiac Society "The Future of Nursing in the Cardiovascular Arena"

Thursday 11th of October 2007 in the Culloden Castle Hotel, Belfast.

By: Fiona Colbert CNM 1, CCU Beaumont Hospital, Dublin and  
Laura O'Connor, Practice Development Nurse, St. Josephs, Raheny.

For the second year in a row INCA were asked by the Irish Cardiac Society to organise the nurse's day at their 2007 annual scientific meeting. The meeting was held in the Culloden Castle Hotel, Belfast on Thursday 11th October.

Dr David Higginson, president of the Irish Cardiac Society opened the meeting by welcoming us all to Belfast. He spoke of the great opportunity to develop cross boarder links for the future, and that it was also a chance to open the gates of communication and sharing of ideas among colleagues north and south of the border. He then spoke about Holywood as it was his home town and he gave details on its attractions and hot spots!!



Dr. David Higginson

Keynote speaker was Dr. Fiona Timmins, Nurse Lecturer, Trinity College, Dublin. She discussed "The Future of Nursing in the Cardiovascular Arena" and began the presentation by looking first at our past. She discussed the Profession of Nursing and how we are redefining the nurse's role, with expansion of current roles and the development of specialist roles such as Clinical Nurse Specialist and Advanced Nurse Practitioners. This offers nursing more autonomy and independent practice. In summary she concluded that cardiovascular nurses are facing unprecedented changes the future is continual education and professional development for staff at all levels.

Dr Deirdre Ward, Consultant Cardiologist, AMNCH, Dublin gave a very interesting and informative presentation on *Risk stratification in Sudden Cardiac Death*. Her clinic targets first degree relatives of victims of SCDS and provides genetic counselling services and risk stratification to those found to be at risk. She discussed the different causes of SCDS and highlighted the challenges faced, the benefits and limitation of current risk stratification methods. Overall a very powerful and thought provoking topic. Her presentation was followed by *The Nurse's Perspective on Adult Sudden Death Screening*, which was presented by Ms. Catherine O'Donnell from The Sudden Cardiac Death Screening Clinic, MMUH, Dublin. This clinic also targets first-degree relatives (parents, siblings and the deceased children) of victims of SADS although on occasion has also screened second degree relatives. The screening process involves ECG, ECHO, TMET, and Holter monitoring. These are reviewed and if necessary ICD implantation is recommended. Catherine discussed how this service is run on charitable donations and free to attend. It is not currently funded by any government body. Catherine told us of an interesting fact that in patients with LQT2, static from a mobile

phone can trigger their arrhythmia. For information on drugs that prolong QT, try [www.qtdrugs.org](http://www.qtdrugs.org).

**Ms. Maria Mooney, Cardiac Rehab Co-ordinator, Belfast Trust City Hospital** gave a very interesting talk on the Development of a *Cardiac Rehabilitation Programme for those awaiting Surgery*. This was developed as their waiting list for heart surgery in the North of Ireland is at least 6 months and patients had little or no support during this time. It was a 6 and 12-week programme with telephone follow up available too. The pilot was very successful and proved the need for this service and none of the patients had adverse effects or events during exercise. RCN Cardiovascular Nurses Network, [www2.rcn.org.uk/cvnetwork](http://www2.rcn.org.uk/cvnetwork).

#### Two Abstracts were presented

- Introducing an Extended Role for CCU Nurses in the Management of Patients with Temporary Venous Pacemakers. Ms Siobhan Quinn, CCU, Beaumont Hospital, Dublin.
- A Community Model of Cardiovascular Disease Prevention: 2-Year Results. Ms Irene Gibson, Croi, Galway.

#### The Afternoon Session

The afternoon session began with Mr. David Tumelty a physical activity referral officer with the Eastern Health and Social Services board in Northern Ireland.

To follow two abstracts were presented by cardiovascular nurses. The topics included:

- "The clinical value of 24 hour ambulatory Blood Pressure Monitoring in Cardiac Rehabilitation"

Ms. Noleen Fallon, Cardiac Rehabilitation Department, Adelaide and Meath Hospital, Dublin.

- " Women's experiences of attending Cardiac Rehabilitation: A Qualitative Study" Ms. Denise Duggan, Northern Health and Social Care Trust.

Ms. Carol Condon, Nurse Lecturer, UCC and Secretary of the Council of Cardiovascular Nurses and Allied Health Professionals gave an outline of the work of the Council.

Dr. Jim O'Neill, Consultant Cardiologist, Connolly Hospital, Dublin provided an entertaining and informative presentation on Endocarditis.

Ms. Kate O'Donovan, Course Co-ordinator gave an excellent overview of advances in Cardiovascular care in three main areas, pharmacology, device and guidelines.

Ms. Patricia Hall, past president of INCA announced the winner of the best abstract and best poster.

Best abstract was awarded to Siobhan Quinn, CCU, Beaumont Hospital with her abstract "[Introducing an extended role for CCU nurses in the management of patients with Temporary Venous Pacemakers](#)".

Best poster was awarded to Barbara Doyle & Donna Fitzsimons "[Understanding dietary decision making in patients attending secondary prevention clinics](#)".

## Dates For your Diary

**Council on Cardiovascular Nurses and Allied Professionals (CCNAP) Meeting in Dublin on April 24th & 25th 2009**

## Arrhythmia Alliance- the Heart Rhythm Charity

By: Catherine McMahon, Cardiology Co-ordinator, St. James's Hospital.

A meeting was held recently in Clontarf Castle to inform interested parties of the Arrhythmia Alliance. Present were Doctors, Nurses, Irish Heart Foundation nurses and members of support groups such as sudden cardiac death group and long QT. The aim of the meeting was to inform the Irish group of the aims of both the STARS and Arrhythmia alliance Group.

The A-A is essentially a coalition of charities, patient groups, carers and medical professionals who work together under the A-A umbrella to promote timely and effective diagnosis and treatment of arrhythmias. The A-A supports and promotes the aims and objectives of the individual groups. A-A was formed by Trudie Lobban who also formed STARS (Syncope Trust and Reflex anoxic Seizures)

In 2003 STARS joined forces with Arrhythmia Alliance its aim being to improve awareness, diagnosis and treatments leading to a better quality of life for those with Cardiac Arrhythmias. It also aimed to prompt the government to set targets for arrhythmia diagnosis and treatment. Their progress in affecting health policy has been dramatic. In 2003 there were no plans to extend the National Service Framework (NSF) for Coronary Heart Disease. By lobbying, and letter writing to all levels of government they received a promise by Government officials to amend the NSF (National Service Framework) with a new chapter on arrhythmias. This is now known as chapter 8 on Coronary Heart Disease –Arrhythmias and Sudden Cardiac Death- NHS.

AA now works in partnership with Government, Dept. of Health, Task Forces, and the British Heart

Foundation on steering groups affecting both nurses and patient education. Their visit here was to discuss the possibility of an alliance with them.

We have many smaller groups in Ireland – ie. Support groups who work within a small group trying to increase awareness and patient education in Arrhythmias. It can often be difficult to bring about change with small groups who essentially have many of the same aims in attempting to influence government health policies and increase public awareness of heart disease. An alliance gives force in numbers and the benefit of a wide range of expertise. Governments listen to the voter!. The AA database includes Cardiologists, EP's, Nurses, Physiologists, GP's Practice Nurses, Paediatricians, Geriatricians, Cardiac Networks, Patient Groups, Industry, Patients and carers. A larger lobby group who work together can be more effective in bringing about change.

Their website [www.hearhythmcharity.org.uk](http://www.hearhythmcharity.org.uk) had 2.14 m hits in 2006, already this year they have had almost 4 million hits. On a practical level they provide accredited information on bradycardia, tachycardia ICD/CRT, Pacemakers, how to establish rapid access clinics, care pathways, job descriptions, and many other information leaflets. I definitely feel that an alliance with the Irish Heart Foundation and INCA would be of benefit to both parties. A further meeting with the Irish Heart Foundation is planned some time in the future. Do check out the site. They can personalise education material for your own hospital. For a small joining fee extra information can be accessed.

### Dates For your Diary

#### **EINCA AGM**

Date: April 11th & 12th  
Venue: Dublin

#### **Acute Cardiac Care**

Date: 11th-14th October 2008  
Venue: Versailles, France

#### **ESC Congress 2008**

Date: 30 Aug 2008-03 Sept 2008  
Venue: Munich, Germany

#### **EuroPrevent**

Date: 1st-3rd May 2008  
Venue: Paris, France

#### **Heart Failure**

Date: 14th-17th June 2008  
Venue: Milan, Italy

*Any submissions/suggestions for newsletter please forward to [m.ryder@stmichaels.ie](mailto:m.ryder@stmichaels.ie)*