

# Irish Nurses Cardiovascular Association News

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## NEWSLETTER

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# Welcome Address from President Mary O'Connor



Mary O'Connor, President INCA

Dear Colleagues,

Welcome to our winter edition newsletter.

We're at a very busy time of year for INCA. Enclosed in this newsletter is a summary of our activities since the summer. A summary of the Irish Cardiac Society Nurses Study Day and abstracts from our 'ESC Highlights' Autumn Evening Meeting. Also included is a report from the Heart Failure Congress in Milan which was written by our educational bursary winner, Geraldine O'Donovan,

Thank you very much for all the very positive feedback that we have received at these recent meetings. It's nice to know that we are doing things well and are catering to your needs.

We are delighted to bring you a copy of the programme for the upcoming 9th Spring Meeting of Cardiovascular Nursing. In recent weeks both National and International Faculty have been invited to present at this conference and we believe that we have a truly dynamic and exciting programme for all delegates. Please book your place in advance as this is a conference not to be missed, we feel that we have really raised the bar for the annual CCNAP Spring Conference.

I must encourage all Irish Nurses and Allied Professionals to submit abstracts as we would like to have a strong representation of Irish work and it would be really good to showcase the very interesting and good work going on in Ireland.

I'm delighted to bring you news of our new website which is currently being developed. We have decided to leave the NCNM website and to host our own website. It will address our increasing needs as we continue to develop and go from strength to strength. The benefits of the new website are identified in the article enclosed.

I would encourage all people to renew their INCA membership and also to apply for the INCA Educational Bursaries to attend the 9th Spring Meeting of CCNAP.

Lastly, I know it's early but I would like to take this opportunity to wish you all a very Happy Christmas and Best Wishes for the New Year. We here at INCA are looking forward to the New Year and to what it entails.

Regards

**Mary O'Connor**

*President, Irish Nurses Cardiovascular Association*

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Michelle Lynch & Catriona Minnock  
(Chest pain representative)

## Summary of the 2008 Irish Cardiac Society Study Day *'Working Together in Cardiovascular Care'*

Thursday 9th of October 2008 at the Radisson Hotel, Galway.  
Ann Cantwell, Cardiac Rehabilitation Co-ordinator, MWRH, Nenagh.

The Radisson Hotel in Galway was the venue for the Irish Cardiac Nurses Scientific meeting which was hosted by INCA at the invitation of the Irish Cardiac Society. Ms. Patricia Hall got proceedings underway and extended apologies on behalf of The INCA President Ms. Mary O'Connor who was unavoidably indisposed.

**Dr. David Higginson, president of the Irish Cardiac Society** opened the conference and extended a warm welcome to everyone.

**Dr Emer Shelly, Specialist in Public Health Medicine, HSE** delivered the Keynote address; [The Stroke Audit: lessons for improving quality of Cardiovascular Care in Ireland](#). She discussed the priority for service development for stroke victims, mortality trends and the findings of the recent stroke audit. The focus of her presentation was on the findings of the Hospital Report. Findings indicate that the majority of patients with stroke were admitted to a general medical ward with a small percentage to Care of the Elderly Units. Recommendations included direct admission to a stroke unit, a lead physician, 24hr brain imaging, thrombolysis where indicated, specialist ward rounds, acute stroke guidelines/protocols and access to multidisciplinary services. Currently age limits access to services i.e. < 65yrs of age. The audit reflects poorer outcomes for stroke patients in Ireland by comparison to the UK. The focus needs to shift to health promotion, prevention and primary care with a co-ordinated care approach between hospital and community. Dr Shelly referred to Nurses as the glue in the system that enhance service delivery by communicating with patients, carers and other Health Care Professionals to promote holistic care. Priorities for the future include identifying a location for a stroke unit in every Network, raising the level of public awareness for stroke, clinical audit, information technology and multidisciplinary team work.

**Michelle Lynch, CNS, SJH, Dublin** presented an informative account on [Strategies for optimising outcomes in ACS](#). Ms. Lynch presented an analysis of low risk chest pain in patients admitted to a chest pain assessment Unit in Ireland. She posed the Question 'Was the profile of low risk patients different to high/intermediate risk patients? Patients were stratified according to treadmill test results i.e. positive or negative stress test. The positive treadmill group reported classic chest pain symptoms while the negative treadmill group reported sharp, stabbing pain. The positive treadmill group had higher BP levels, BMI and smoking levels, participated less in physical activity and reported lower levels of perceived stress. Diabetes as a diagnosis was similar in both groups. Raised cholesterol profiles and a positive family history in the positive treadmill group showed a significant statistical difference. Study findings revealed that 12% of the low risk group had a diagnosis of CAD diagnosed by angiography and women had a high incident of false/positive stress test findings.

**Dr. Donal Reddan, Consultant Nephrologist, UCHG/Merlin Park, Galway** gave an enlightening synopsis of [Renal disease in the Cardiovascular Patient](#). He referred to end stage renal disease as the tip of the iceberg and highlighted the need for early detection before individuals develop renal impairment. Monitoring Glomerular

## Summary of the 2008 Irish Cardiac Society Study Day continued...

Filtration Rate (GFR) is key to early diagnosis as there is no rise in creatinine rates in early renal insufficiency. Age, gender, creatinine and race impact on GFR. The prevalence of chronic renal disease is high in patient's post MI, therefore, haemodialysis patients who develop chest pain need to be carefully screened. In addition to traditional risk factor modification, renal patients need calcium and phosphate levels carefully monitored, anaemia addressed and intensive lipid profile management to lessen cardiovascular risk and improve quality of life.

**Mr. Kevin Malone, Staff Nurse CV Lab., UCHG** discussed the uses and benefits of the [Intra-Vascular Ultrasound](#). This advanced tool can be used to aid in the diagnosis and treatment of complex lesions, ostial disease, left main disease and bifurcation lesions. The cross section image of vessels evaluates distribution of disease and allows accurate measurement of lesions. Contrast resolution displays tissue structure and plaque type. Its use enhances stent selection, placement and facilitates complete stent expansion. It can be used to compliment interventional devices or therapeutic approaches.

**Prof. F. Woods, Cardiothoracic Surgeon, MMUH** got the afternoon session off to an intriguing start with a comprehensive presentation on [Cardiac Transplantation](#), from first inception right through to modern day transplantation and mechanical devices. He spoke of the indications for transplantation and the careful patient selection process. The mortality rate of patients on the transplant list is high with only 5% surviving beyond the 2nd year. Timing is of critical importance from the time a donor becomes available to harvesting and subsequent transplantation, with a window of just 4 hrs. Potential complications include graft failure, infection and rejection. Pharmacotherapy comprises corticosteroids, cyclosporin and azathioprine and compliance is vital. Prof Woods discussed how the future may lie in mechanical devices as destination therapy or xenotransplantation.

**Ms. Patricia Hall** Former INCA President promoted and encouraged the audience to attend the 9th Annual Spring Meeting on Cardiovascular Nursing in Dublin next April. She reminded delegates of dates for their diary including the deadline for abstract submission and early registration. She gave a brief outline of the exciting scientific programme including parallel sessions, debate etc. Ms. Hall announced that INCA is sponsoring 10 educational bursaries for paid up INCA members in 2009. The lucky recipients will be obliged to submit a written abstract on a topic of their choice for the INCA Newsletter and present this information at a future INCA Meeting.

**Ms. Cathy Farrell, CNS Letterkenny General Hospital** put Donegal on the map and spoke of her experience of [Working in isolation](#) as a Heart Failure Nurse Specialist. The emphasis of her service is to promote adherence and self care management through patient education. Her first point of contact is usually during patient hospitalisation and follow up includes telephone calls, home visits and remote monitoring. Challenges for the service include an ageing population, increased workload, lack of multidisciplinary specialist services and limited time to audit. Aspirations for the service includes nurse prescribing, more clerical support and enhanced community service links with a community based Heart Failure Nurse Specialist.

**Dr. Brendan O'Coilain, Consultant Cardiologist, The Galway Clinic** gave a detailed account of [Cardiac Resynchronization Therapy](#). Biventricular pacing is suitable for patients with left bundle branch block (LBBB) and

## Summary of the 2008 Irish Cardiac Society Study Day continued...

class III – IV Heart Failure as per The New York Heart Association Classification. It results in a significant improvement in symptoms and reduced mortality in this patient cohort. The mechanism of improvement includes more efficient left ventricle contraction, improved ejection fraction, reduced mitral regurgitation, fewer hospital admissions and improved quality of life.

**Dr. Brendan McAdam, Consultant Cardiologist, Beaumont Hospital** rounded up the day with an inspiring presentation of [The increasing use of newer imaging techniques in Cardiomyopathy](#). He gave a detailed classification of primary and secondary Cardiomyopathies. Among the genetic cardiomyopathies he mentioned were Long QT Syndrome and Brugada Syndrome. He also referred to acquired cardiomyopathies such as takostubo and Broken Heart Syndrome. Myocarditis and Hypertrophic Cardiomyopathies are significant players in sudden cardiac death in young patients. Dr McAdam spoke of the difficulty in differentiation between an athlete's heart and a cardiomyopathy. Cardiac MRI allows comprehensive evaluation of LV function, tissue characterisation, ejection fraction, response to treatment and prognosis.

**Rosemary Walsh, CCU, UCHG** was awarded a prize for the best poster, [‘Are patients with non STEMI managed comparably to patients with STEMI and in accordance with current guidelines?’](#)

The meeting was closed by Ms. Hall and sincere thanks were extended to everyone who helped to make this meeting an enjoyable and successful event.

## Irish Cardiovascular Nurses Association Autumn Evening Meeting 'Highlights of the 2008 ESC Congress, Munich'

*Guinness Store House, Dublin, 30th October 2008.*

Munich, Germany was the venue for the 2008 ESC Congress. The congress is a unique forum where the world's medical professionals meet with colleagues to exchange ideas and information in the field of cardiovascular medicine. Below are abstracts from the congress which were presented at our recent Autumn Evening meeting and also the 'best of the rest' from the ESC.

### **Percutaneous Aortic Valve Implantation**

Niamh Kiely, Advanced Nurse Practitioner in Cardiothoracic Surgery, St James's Hospital, Dublin.

Aortic stenosis is the most prevalent valvular heart disease in Europe and its prevalence increases with advancing age. Surgical replacement of the valve is considered the 'gold standard' treatment for severe aortic stenosis (ESC Guidelines 2008). However, Alec Vahanian (France) pointed out that; as operative mortality increases with advanced age, approximately 30% of patients with symptomatic aortic stenosis are either denied, or not referred for surgery due to comorbidities and fitness for surgery. The development of lesser invasive and potentially safer percutaneous techniques has provided an option for patients who would otherwise be considered not suitable for surgery.

Percutaneous valve implantation was first performed in April 2002 by A. Cribier (France). The procedure is carried out using a bioprosthesis made of three leaflets of equine pericardium sutured to a balloon expandable stainless steel stent. After balloon predilatation of the native valve, this bioprosthesis is crimped over a balloon catheter, and advanced over a stiff guidewire up to the diseased fibro-calcific native aortic valve, using regular cardiac catheterization techniques. Two approaches can be used, a retrograde approach, through the vessels via the femoral artery or alternatively, an anterograde/transapical approach via a mini thoracotomy. The bioprosthesis is then released by balloon inflation at

the mid-part of the native valve. The procedure is generally done using a light general anesthetic; however, some institutions are now performing the technique under local anesthesia and sedation.

There were many presentations on Percutaneous Valve Implantation during the ESC. Two stood out, a session entitled 'Percutaneous aortic valve implantation: a consensus between cardiologists and surgeons', was chaired by Alec Vahanian, (France), and F. Maisano (Italy) and a special focus session, also chaired by Alec Vahanian with F. Moher (Germany) During this session video recorded cases from The Bichat Hospital, Paris and the University of Lipzig, Germany were shown. Question and answer sessions provided answers regarding patient selection, imaging and outcomes.

### **Patient Selection**

At present due to lack of data on the long term outcomes following the procedure, it is reserved for high risk patients, with predicted high mortality or morbidity after surgical aortic valve replacement. Calculating this risk is not easy, it requires a collaborative effort between the surgeon and the cardiologist.

### **Imaging**

Mourat Tuzcu (Cleveland, USA) gave a broad overview on imaging for percutaneous valve implantation, demonstrating the key role played by imaging both before and during the procedures. There is a growing role for CT scan, although conventional angiography remains the main imaging

modality during the procedure. Echocardiography is very convenient for screening patients and although its role as a guidance tool during the implantation is questionable, it remains fundamental as a monitoring tool and for decision-making after valve implantation.

### Success of implantation procedures

Challenges remain as the procedure is complex when performed via the anterograde/trans apical route, whereas the less demanding retrograde route has been frequently associated with failures in crossing the native valve. What is known is that valve implantation is successful in the vast majority of patients (above 90%). Stroke rate is between 5 and 10% with the transfemoral approach. The rate is however decreasing due to better patient screening and to technical progress and experience of the operators. Stroke rate seems to be lower in selected centres adopting the transapical approach. In particular, Thomas Walter (Germany) reported a 0% stroke risk in his series of 160 patients treated by transapical approach. On the other hand, a number of patients in his series required open heart conversion for a variety of reasons, reinforcing the case that these are complex procedures, and operators have to be ready for the worst scenario in order to be prepared to deal with the complications.

Procedural mortality is around 10 to 15% in most series, and it looks to be similar among devices and different approaches. Although procedural mortality is lower than that predicted by Euroscore, both Walter and Patrick Nataf (France) pointed out that Euroscore tends to overestimate the risk and that surgical series have shown similar data. Peter De Jaegere (Rotterdam, NL) also highlighted that, in terms of safety and longevity of the implanted valves, data available is quite scattered and stems mainly from either single institution reports or company reports, there are currently two CE marked devices available for the procedure. It was stressed that it is important to collect further robust data on the procedure itself, rather than on the technology. The

need for a registry is mandatory to obtain reliable and independent data.

In conclusion, there is consensus between cardiologists and surgeons that percutaneous aortic valve implantation has become a clinical opportunity for high risk patients with calcified aortic stenosis. After more than 2500 implants worldwide with first generation devices, there is enough evidence at this time demonstrating the feasibility of the procedure, both via transfemoral and transapical approach. A valved stent can be implanted inside a stenotic aortic valve, obtaining a reasonably large effective valve orifice area, without compromising the coronary flow and with minimal aortic regurgitation in most occasions.

### Sugars Platelets and Cardiovascular Disease

Kate O'Donovan, Course Coordinator  
Post Graduate Diploma in Cardiovascular Nursing,  
Mater Misericordiae University Hospital, Dublin.

The most common cause of death in European adults with diabetes is cardiovascular disease, accounting for 44% of all deaths among patients with type 1 diabetes and 52% with type 2 (ESC 2007). In response to these statistics The European Society of Cardiology in association with European Association for the study of Diabetes launched the guidelines on diabetes, pre diabetes and cardiovascular disease in 2007. This document serves as a framework to guide clinicians working in the cardiovascular and endocrinology arena on best practice when treating diabetic patients with and without cardiovascular disease with particular emphasis on preventing cardiovascular disease in addition to slowing down disease progression and prevention of complications. To follow on to this Dr Bhatt from the United States gave a presentation on the role of platelets, anti platelet agents and the importance of glycaemic control in treating cardiovascular disease with particular focus on coronary artery disease (CAD).

Platelets have a pivotal role in the development of CAD but in those with diabetes there is increased level of platelet activity which leads to premature development as well as accelerated progression of the atherosclerotic process. It is postulated that hyperglycaemia which is the central characteristic of diabetes is closely linked to the excess mortality and morbidity from CAD and this has been the focus of much research and treatment strategies for those with diabetes and who are at high risk of developing CAD or who have experienced a CAD event.

Dr Bhatt alluded that hyperglycaemia and insulin resistance can lead to abnormalities in potentially all of the mechanisms regulating platelet function. He described abnormalities in platelet function as larger platelet size with a greater propensity for platelet aggregation and thrombus formation. Other platelet abnormalities described included increased production of Thromboxane A<sub>2</sub>, increased numbers of glycoprotein IIb/IIIa receptors and a decreased production in the vasodilatory and anti aggregatory nitric oxide. Blood coagulability is enhanced due to increased levels of thrombin, von Willebrand factor and decreased levels of endogenous anticoagulants such as protein c, which as a result enhances thrombus formation. Therefore, increased platelet activity coupled with a tendency for coagulation increase the risk for plaque rupture and the subsequent occurrence of an acute coronary syndrome.

Thus there is an apparent rationale for aggressive anti platelet therapy strategies for those with diabetes who are at high risk of developing CAD or who present with a CAD event. Despite a decline in CAD associated mortality and morbidity in the general population this has not been demonstrated in the diabetes population. This can be attributed to a greater complication rate such as development of recurrent ischaemia, symptomatic LV dysfunction and ventricular arrhythmias to name but a few. In addition Dr Bhatt stated that data from clinical studies have revealed that diabetic patients are not as well treated as those without diabetes with regard to

evidence- based therapies and coronary intervention. He gave two reasons why this may be so:

1. Diabetes is often complicated with autonomic neuropathy and therefore lack of typical ACS symptoms, which result in delay in presenting themselves to the hospital and diagnosis, thereby reducing the opportunity to administer appropriate evidence – based treatment.
2. The diabetic patient is considered more vulnerable and diabetes has been perceived as a relative contraindication to some of the treatment strategies such as thrombolysis.

In relation to anti platelet regimens Dr Bhatt referred to the 2007 guidelines on Diabetes and highlighted the following principles. For those presenting with AMI the most important goal of treatment is to restore coronary artery blood flow and preserve myocardial function. This can be achieved with thrombolysis or percutaneous coronary intervention. It is recommended that if percutaneous intervention is available this should be the choice of treatment with deployment of a drug eluting stent. In comparison to bare metal stents, drug eluting stents are associated with an 80% relative risk reduction for restenosis during the first year of follow up. Also recommended from an interventional perspective is the administration of a glycoprotein IIb/IIIa receptor antagonist. These agents in particular Abciximab have been found to improve outcome after percutaneous intervention. Dr Bhatt stated that a meta analysis of Abciximab demonstrated a 44% reduction of mortality after 1 yr, therefore, advocating its use in all patients with diabetes undergoing coronary intervention.

From a pharmacological perspective Dr Bhatt highlighted the principle of aggressive anti platelet therapy as a means to preventing an acute coronary event. Administration of Aspirin inhibits the production of pro aggregatory thromboxane A<sub>2</sub> by the platelet. According to the Anti thrombotic trialists (2002) the optimal effective aspirin dose is 75 – 150 mgs daily with a loading dose of 150 – 300 mgs.

When Clopidogrel is combined with Aspirin the anti platelet effect is more pronounced and beneficial. The outcome of the CURE trial (2001) demonstrated that dual anti platelet therapy in the form of Aspirin (75mgs to 100mgs daily) with Clopidogrel (75mgs daily) for 9–12 months post an acute coronary event and/or percutaneous intervention was shown to be superior to Aspirin alone in secondary prevention of ischaemic events in those with and without diabetes. In addition Clopidogrel has been shown to be superior to Aspirin especially in those with diabetes in the prevention of major adverse cardiovascular events such as reinfarctions and re hospitalisation for ischaemia.

Results from the recent pilot study OPTIMUS (Optimising Anti platelet Therapy in Diabetes Mellitus) were presented. The aim of this study was to assess the impact of a higher maintenance dose of Clopidogrel on platelet function in those with type 2 diabetes and CAD on long term dual anti platelet therapy. The study participants were eligible for this study if their serum platelet tests demonstrated suboptimal platelet inhibition. 64 participants took part in the study and were randomly assigned to a control group or to receive a higher maintenance dose of 150mgs of Clopidogrel for 30 days and then return to the 75mgs per day dose for a further 30 days. Platelet function was measured 3 times during the study duration. The results demonstrated that the 150mgs maintenance dose was associated with enhanced anti platelet effects compared with the standard 75 mgs per day dose but a proportion of participants demonstrated suboptimal platelet inhibition despite the increased dosing. This confirms that those with type 2 diabetes require more aggressive approach to anti platelet strategies and that an increased dose of Clopidogrel may improve platelet inhibition in high-risk patients. Those who demonstrated sub optimal platelet inhibition despite the increase dose highlighted the need for further improvement in anti platelet strategies, which need to be evaluated in larger clinical trials.

Aside from anti platelet therapies, effective glycaemic control is essential in the prevention of CAD related complications and mortality. As mentioned above hyperglycaemia and insulin resistance have been demonstrated as having a central role in CAD related mortality and morbidity. High blood sugars in those presenting with an acute coronary event are highly predictive for a poorer outcome in the short and long term. Two studies which support effective glycaemic control are DIGAMI I and II (Diabetes Glucose and Myocardial Infarction) trials which demonstrated a 11% reduction in mortality which was still apparent after 3 yrs implying one life saved for every nine patients treated. In type 1 diabetes the gold standard of therapy is intensified insulin therapy aiming at a HbA1c below 7%. The risk of hypoglycaemia should be titrated against this goal and severe episodes should be few. In type 2 diabetes a polypharmacy strategy is employed with the aim of a target HbA1c of 6.5% as recommended by the various diabetes associations. This includes early initiation to insulin if oral glucose lowering drugs and appropriate lifestyle measures do not reach desired targets. Dr Bhatt referred to the 2007 guidelines in that an intensive approach to glucose control has the potential to improve platelet function and decreased PAI – 1 activity (plasminogen activator inhibitor 1) thereby improving the chance for spontaneous fibrinolysis. Therefore based on the available evidence, an insulin infusion should be administered to those with diabetes who are admitted with an acute Myocardial Infarction with significantly elevated blood glucose levels in order to reach normoglycaemia as soon as possible. He does not specify what significantly elevated blood glucose levels are, nor does the guidelines. Patients admitted with relatively normal glucose levels may be treated with oral hypoglycaemic agents. In the long term setting strict glucose control is beneficial in preventing CAD complications. The treatment strategy includes diet, lifestyle modifications, oral hypoglycaemic agents and insulin. Dr Bhatt concluded that it is not the choice of agent that is important in glycaemic control but emphasised that reaching the target HbA1c is the focus in glucose lowering strategies in reducing the incidence of CAD with a 21% reduction for every 1% decrease in the HbA1c.

In diabetes the role of hyperglycaemia and insulin resistance is pivotal in the development of CAD. Treatment strategies aim at preventing an acute coronary event and delaying the progression of the atherosclerotic process. Dr Bhatt highlighted the benefit of anti platelet therapies in this setting, as platelet abnormalities are common in those with diabetes and lead to a higher predisposition for CAD as well as the potential for higher morbidity and mortality. Alongside anti platelet therapies intensive glucose lowering with a target HbA1c of less than 7% for type 1 diabetes and less than 6.5% for those with type 2. The HbA1c target is the most important factor in glucose control rather than the type of glucose lowering agent used as it is demonstrated that lowering the HbA1c reduces the incidence of CAD events.

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## What's new in heart failure management and related clinical trials

Laura O'Connor, Practice Development Nurse,  
St. Joseph's Raheny / Beaumont Hospital, Dublin.

Heart failure is a leading and increasing cause of cardiovascular mortality and morbidity. It is also one of the areas best covered by clinical research. Many research studies have had important implications for clinical practice and some have profoundly influenced the treatment of patients with heart failure. As a result there is always a lot of interest in the ESC's guidelines on heart failure and related clinical trials. The latest update of the guidelines was launched in Munich. They cover both acute and chronic heart failure. There is no revolution to report in either drug therapy or in the use of procedures or devices. In summarising the take home messages for practitioners on heart failure Dr. Komajda covered three main trials in heart failure, which were launched at the conference.

The 1st trial was the Beautiful trial [www.beautiful-study.com](http://www.beautiful-study.com), which assessed the morbidity and mortality

benefits of the heart rate lowering drug Ivabradine (Procoralan). Heart rate is increasingly being seen as a modifiable risk factor. The study wanted to investigate if heart rate reduction with drugs would reverse cardiovascular abnormalities. The study took place in 22 countries with some Irish sites. To be enrolled patients had to have documented CVD, ejection fraction <40%, SR with heart rates greater than 60. All patient's continued to receive their optimum cardiovascular treatment. The results showed that procoralan had no effect on the primary composite endpoints, death and admission to hospital for new or worsening heart failure. However in one group of patients there was a reduction of coronary events and admission to hospital with MI. A quote from Smith, Chapel Hill, USA at the conference was that "the results of the beautiful study were hypothesis generating and could not be incorporated into guidelines until prospective trials were undertaken".

The 2nd Trail was the GISSI-HF trial. It is a 2-part trial which looked at the effects of statins in patients with symptomatic heart failure. This large study of 5000 patients suggested that Rosuvastatin had no effect on clinical outcomes in patients with heart failure and patients with heart failure should not be started on statins. The results back up the findings of a previous study, the Corona study. The results were described as neutral rather than negative, as patients did not suffer harm on statins. A separate arm of the same study found that a simple fish oil supplement could benefit patients with heart failure. Patients given a supplement of n-3 poly unsaturated (1gm a day) saw an 8% reduction in their relative risk of mortality and admission to hospital for cardiovascular reasons. The benefit was moderate and smaller than expected, however the results were achieved in a population which was already well treated with recommended therapies.

The 3rd trial in Heart failure showed that intensified BNP guided therapy versus standard therapy did not improve the primary end point for heart failure patients.

Dr. Kamajo described the results off all three trials as disappointing.

## 'ESC - the best of the rest'

Laura O'Connor, Practice Development Nurse,  
St. Joseph's Raheny / Beaumont Hospital, Dublin.

### New guidelines

At the ESC congress in Munich the following guidelines were launched;

- Heart failure as discussed previously.
- The diagnosis and management of Pulmonary embolus (PE). Professor Jose. Zamorano described PE as a challenging disease in terms of diagnosis. The new guidelines include risk stratification and diagnostic algorithms.
- Acute MI – STEMI. The new guidelines include a flow chart of how to proceed with patients depending on their first medical contact. If primary PCI is possible within two hours, it is the treatment of choice. If not possible within two hours, thrombolysis should be performed as soon as possible.

These guidelines can be accessed from [www.escardio.org](http://www.escardio.org)

### Classification of MI

Information on the classification of MI, which Eamon Murphy, Chest pain nurse, presented at the INCA conference in April was presented again in Munich.

### Drug eluting stents

Controversy over drug eluting stents passes from scepticism to greater optimism; It was described in the ESC newsletter as "the come back kid of cardiology". There was much discussion at the conference on the different types of stents available and the evolution in stent manufacture, i.e.; the use of materials such as biodegradable polymer in stents which releases the drug into the vessel wall and not into the blood. However, despite these advances the problem of needing Aspirin and Plavix persists.

### Eurospire study results

It was not all good news from the Eurospire III findings which were presented at the conference by

Catherine Jennings, Research Nurse, London on behalf of the Euro Heart Survey. The Eurospire survey was to determine if the practice of preventive cardiology in patients with established CHD in Eurospire III had improved in comparison to I & II. A longitudinal comparison of all 3 surveys conducted in the Eurospire programme between 1995-2007 shows adverse trends in relation to overweight, obesity and diabetes in coronary patients. Most striking was the increase in obesity from 25% in the first survey to 38% in the third. Waist circumference (>88cm women, >102cm in men) 42% prevalence in the first compared to 55% in the third.

Also alarming is the prevalence of smoking in the coronary population which appears not to have changed across the three surveys, 20% in the first and 18% in the third. Cholesterol management had improved, as had statin prescribing.

The latest survey showed disappointing results in the management of blood pressure, 56% had a raised BP >140/90mmhg or >130/80mmhg in diabetics. 37% of people who were on treatment hypertension were not adequately controlled.

### Gourmand's heart

On a lighter note, there was a session called 'The key to the gourmand's heart' in which Prof. Giovanni de Gartano discussed the benefits of a little red wine, but not a little beer or green tea. Red wine in moderate amounts up to 150mls a day was found to reduce the risk of vascular disease. The investigators found less favourable results with moderate beer consumption. According to De Gartano the beneficial effects of wine are lipid metabolism, haemostasis, antioxidant and also the vaso relaxant properties of its constituents. These effects are also applicable to dark chocolate and green tea. A prudent recommendation from the ESC might be to take a cocoa drink for breakfast, drink green tea during the day, a glass of wine in the evening and a piece of chocolate before going to bed!!

## **A Report from the 2008 Heart Failure Congress**

**Milan, Italy. June 2008**

Geraldine O'Donovan, Lecturer Practitioner,  
Catherine McAuley School of Nursing and Midwifery,  
UCC, Cork.

Heart failure is by far the single biggest reason for acute hospital admission. Around 30 million people in Europe have heart failure and its incidence is still increasing. Improved treatment of most cardiovascular diseases and increased longevity are causing a steady increase in the number of persons affected by this syndrome. Professor Jeroen Bax, European Society of Cardiology Congress Programme Chair 2006-2008, has spoken of "an exponential growth in patients presenting with heart failure" and the American Heart Association recently described the prevention of heart failure as "an urgent public health need". According to Professor Kenneth Dickstein, President of the Heart Failure Association, heart failure comprises "an enormous population, but we have a hard time identifying that population". The mission of the Heart Failure 2008 Congress was to improve awareness of the condition, improve its diagnosis in primary care, and thereby improve the quality of life for those affected with reduced hospital admissions.

This congress creates the opportunity to gather all those interested in heart failure, including cardiologists, internists, general physicians, basic scientists, epidemiologists, cardiac nurses, industry affiliates and others. The meeting provided comprehensive state of the art views on the major aspects of heart failure including the most recent advances in basic cardiovascular sciences, epidemiology, prognosis and medical/surgical management. Over 3,000 delegates from 100 countries attended this conference in the beautiful city of Milan. There was a large Irish representation.

Encouraging patients to comply with treatment and adjust their lifestyles is a challenge for clinicians. A very useful website which can be used by doctors and

nurses is [www.heartfailurematters.org](http://www.heartfailurematters.org), a groundbreaking new educational website for people with heart failure, their families and carers. It was developed by cardiologists, nurses and primary care physicians from the Heart Failure Association of the ESC and provides comprehensive, practical information on living with heart failure, drugs, devices and diagnosis. It includes captivating animations, videos, patient stories and useful downloadable tools. It was officially launched at Heart Failure 2007.

Dr J.G.F. Cleland (Kingston Upon Hull, UK) presented a thought provoking session on "Treatment of heart failure in 2018: A European perspective". He envisages that BNP will replace ECHO as the gold standard in diagnosing heart failure. Aspirin will be contraindicated and ICD's will no longer be used. Palliative care will be a common alternative choice for heart failure patients and extended multidisciplinary teams will be using telehealth – personalised health care information, and home algorithms to manage patients.

I would like to express a big thank you to the Irish Nurses Cardiovascular Association for giving me the opportunity to attend this very interesting conference. It was a great opportunity to network, exchange knowledge and get updated on the latest developments in heart failure. Thank you.

## News Alert – New INCA website

Dear Members

I would like to take the opportunity to inform you that a new INCA website is being developed. The new website will be operational from January 2009. The committee feels that our current website is not as responsive to our needs as it should be.

There will be many benefits to the new website. The main ones are:

- INCA committee members will be able to enter and update information on the website, once submitted the information will appear instantly on the website. This will be relevant for news articles, educational materials, presentations and publications.
- There will be an online membership application form and membership renewal. It will also be possible to pay your membership fee online using your credit card. This service will be facilitated by Paypal. Online Conference registration and payment will be available through this facility.
- INCA members will be able to login using a username and password which will be issued on registering. This will enable members to view information, educational documents and presentations which will be restricted to official members only.
- INCA Committee members will be able to contact members via email through the administrative section of the site. Consequently email addresses will be mandatory for all of our membership from January 2009.
- An SMS service could also be setup whereby INCA committee members can contact one or all members via text message.
- Using a discussion forum, members would be able to interact with each other. Members can post comments or questions and other members can respond to them.

One of the major benefits of the new website is that INCA will move to email messaging for all of our correspondence. This will bring significant cost reductions in our business activities. Currently printing, postage and stationery costs are the main items in our expenditure. In addition we will be able to promptly bring to your attention notices from other significant bodies eg Irish Heart Foundation, Council on Cardiovascular Nursing and Allied Professionals (CCNAP) and Higher Education Institutes. Previously we have received alerts regarding Educational Bursaries/Grants and PhD grants but were unable to get them out to you within the timeframes.

The INCA committee looks forward to bringing this new website to you

**Mary O'Connor,**  
INCA President.

## 9th Annual Spring Meeting on Cardiovascular Nursing *“Addressing the Challenges in Cardiovascular Care”*

### SCIENTIFIC PROGRAMME FRIDAY 24TH APRIL 2009

<b>08.00</b>	<b>REGISTRATION, COFFEE &amp; EXHIBITIONS</b>	
08.30 – 10.00	Concert Hall	Opening of the 9th Annual Spring Meeting on Cardiovascular Nursing
08.30 - 08.35		Welcome on behalf of the Council on Cardiovascular Nursing & Allied Professionals
08.35 - 08.40		Welcome on behalf of the Irish Nurses Cardiovascular Nurses Association
08.40 – 08.50		Greetings from the ESC
08.50 - 09.20		Keynote Address: The changing face of Cardiovascular Disease
09.20 - 09.40		Hypertension and Cardiovascular Disease – a growing epidemiological problem
09.40 – 10.00		European Guidelines for Hypertension – what should we implement?
<b>10.00 – 11.00</b>	<b>COFFEE, MODERATED/POSTERS &amp; EXHIBITION</b>	
	Concert Hall	<b>Enhancing self-care in the Heart Failure population</b> <ul style="list-style-type: none"> <li>• Using information technology for patient education</li> <li>• Telemonitoring in Heart Failure</li> <li>• Exercise prescription and functional capacity in Heart Failure</li> <li>• Palliative Care Guidelines for HF patients in Ireland – challenges and opportunities</li> </ul>
	Clyde Room	<b>Challenges in Revascularisation</b> <ul style="list-style-type: none"> <li>• Use and Abuse of biomarkers in ACS</li> <li>• The challenges of a Primary Percutaneous Coronary Intervention Programme</li> <li>• Changing Roles, changing skill sets</li> <li>• Revascularisation challenges in Stable Angina</li> </ul>
12.45 – 13.45	Concert Hall	Satellite Symposium
14.00 – 15.30	Concert Hall	Oral Abstract Session (4-5 abstracts)
14.00 – 15.30	Clyde Room	<b>Joint session CCNAP and PCNA:</b> <b>Global Cardiovascular Disease Prevention: A call to action</b> <ul style="list-style-type: none"> <li>• Primary Prevention of CVD: Guidelines For Children and Youth</li> <li>• Assessing Cardiovascular Risk: Why, When &amp; How?</li> <li>• Behavioural Skills Training: What’s most important in Effecting Change?</li> <li>• Making Prevention Part of Everyone’s Practice</li> </ul>
15.30 – 16.30		Coffee, Posters & Exhibition
16.30 – 18.00	Concert Hall	<b>Implantable Cardioverter Defibrillation</b> <ul style="list-style-type: none"> <li>• ICD Storm: A Patients Insight</li> <li>• Coping with ICD shocks or storms: A Psychological Perspective</li> <li>• ICD: Effective follow up</li> <li>• The Value of Cardiac Rehab in the ICD population</li> </ul>
16.30 – 18.00	Clyde Room	<b>Ventricular Assist Devices</b> <ul style="list-style-type: none"> <li>• The VAD experience in Ireland</li> <li>• The extended role of the nurse in care of the VAD patient</li> <li>• The transition from VAD to transplantation</li> <li>• The patient experience</li> </ul>
18.00		Adjourn
20.00		Reception at Trinity College Dublin

## 9th Annual Spring Meeting on Cardiovascular Nursing "Addressing the Challenges in Cardiovascular Care"

### SCIENTIFIC PROGRAMME SATURDAY 25TH APRIL 2009

<b>08.00</b>		<b>REGISTRATION, COFFEE &amp; EXHIBITIONS</b>
08.30 – 08.50	Concert Hall	<b>Key note address : To be decided</b>
08.50 – 10.00	Concert Hall	<b>Sudden Cardiac Death</b> <ul style="list-style-type: none"> <li>• What causes Sudden Cardiac Death?</li> <li>• Screening for Sudden Cardiac Death</li> <li>• Unveiling the mystery behind Sudden Cardiac Death- Pathologists Perspective</li> </ul>
10.00 – 11.00		Coffee, Moderated/Posters & Exhibition
11.00 – 12.30	Concert Hall	Parallel Oral Abstract Session (4-5 abstracts)
11.00 – 12.30	Clyde Room	<b>Who is Really Managing Heart Disease?</b> <ul style="list-style-type: none"> <li>• The Challenge of Collaboration: How to Make it Work</li> <li>• Successful Community Models for CVD Prevention and Risk Reduction</li> <li>• Managing Heart Failure in Primary Care: A community model</li> <li>• Managing Angina</li> </ul>
12.45 – 13.45	Concert Hall	Satellite Symposium
14.00 – 14.50	Concert Hall	After Lunch Debate: Advanced practice nurses and PhD nurses do not add anything to patient care?
14.50 – 15.50	Concert Hall	<b>How to session: Increase Research Capacity</b> <ul style="list-style-type: none"> <li>• Where to look for funding: European funding sources</li> <li>• Tips on developing a successful research proposal</li> <li>• Successful collaborations – UNITE</li> </ul>
14.50 – 15.50	Clyde Room	<b>How to session: Increasing Nursing Knowledge – Cardiovascular Assessment</b> <ul style="list-style-type: none"> <li>• Taking a Cardiac Nursing History</li> <li>• Lub &amp; Dub of Heart Sounds</li> <li>• The ABC of echo interpretation</li> </ul>
15.50 – 16.10	Concert Hall	Meeting the challenges in cardiovascular care: a personal perspective.
16.10 – 16.30	Concert Hall	Closing Ceremony Announcements & Awards Welcome to the Spring Meeting 2010 Adjourn

## Dates For your Diary

### **ESC 9th Annual Conference on Cardiovascular Nursing**

24th & 25th April 2009

RDS, Dublin, Ireland

Abstract submission from 1st October – 1st December 2008

Online pre registration (early fee deadline) 25th February 2009

Online pre registration deadline 10th April 2009

### **EuroPREvent**

6th – 9th May 2009

Stockholm, Sweden.

### **Heart Failure Congress**

30th May – 2nd June 2009

Nice, France.

### **ESC Congress 2009**

29th August – 2nd September 2009

Barcelona, Spain.

[www.escardio.org](http://www.escardio.org) for further information on the above conferences

*Any submissions/suggestions for newsletter please forward to [nikiely@stjames.ie](mailto:nikiely@stjames.ie)*