Inside this Issue: REPORTS FROM

- CCNAP Annual Spring Meeting: Euro HeartCare, Stavanger, Norway. April 2014
- INCA 17th Annual Scientific Conference, Dublin, April 2014
Hello to all INCA Members,

Thank you for taking the time to read our newsletter.

Congratulations to our educational bursary winners – Patricia Hall, Pat Kerrigan, Loreena Hill and Deirdre McGuone. Thank you to all applicants. Feedback from the conferences and courses our winners attend will be featured in our 2015 newsletter.

**Date for your 2014 Autumn Diary**

The Irish Society of Cardiology Nurses’ day in association with INCA will be held on **Thursday October 16th 2015 at the Sheraton Hotel, Athlone**. The day is free to all nurses or allied healthcare professionals. Please email our secretary@incanursing.ie to secure your place. This year’s theme is “Mind your Heart – The Cycle of Care”. The programme is informative and educational with a high standard of speakers to look forward to. We look forward to seeing you on the day!

INCA’s Autumn Evening Meeting will be held on **Thursday 20th November 2014 The Hilton Hotel Kilmainham, Dublin 8**. It is a relaxed evening with an opportunity to meet like minded people interested in cardiovascular nursing. There will be light refreshments and interesting presentations. All are welcome.

Unfortunately we have had some committee members leave and I would like to take this opportunity to thank them. Kate O’Donovan, who held many roles on the committee, particularly as president. Her commitment and dedication to INCA was truly remarkable. Her enthusiasm for cardiovascular education was infective and inspirational. Eric Reyes, who held the role of scientific secretary for many years was a valuable, committed member and will be sadly missed. Finally, Cecelia Tracey who represented heart failure specialist nurses and kept our INCA members up to date on all the latest news thank you for your hard work and expertise. INCA wishes you all the very best in your future endeavours.

Thankfully, we have new blood coming onto the committee Marie Hayes and Nessa Gillian I look forward to working with you both in the coming year.

Finally, to the INCA committee members who volunteer their time, knowledge and expertise. Your support and passion are appreciated and I look forward to working with you all in my final year as president.

Kindest regards,
EMER LODGE
President INCA
INCA membership

You can renew your membership or new members can join by logging on to www.incanursing.ie. INCA uses PayPal for transactions. This is a secure and safe method of payment. We look forward to your continued support.

The membership cost is €30: Membership can be easily renewed via www.incanursing.ie

Benefits of membership include:

- Autumn Evening Meeting containing highlights from European and National cardiovascular conferences and overview of upcoming events.
- Eligibility criteria for applying for the Educational Bursary and Travelling Fellowship
- Reduced delegate fees to conferences and educational meetings organised by INCA
- Access to conference presentations on the INCA website
- Information on upcoming conferences and educational events
- Receive notifications regarding all forthcoming conferences and events of the Association

Further details can be found on www.incanursing.ie

The educational bursaries and travelling fellowship established by INCA provide members with a wonderful opportunity to attend a European conference or complete a postgraduate course relevant to cardiovascular nursing.

Don’t forget to log on to our website for further updates www.incanursing.ie

Irish Nurses Cardiovascular Association Facebook Page

Find us on Facebook https://www.facebook.com/www.inca.ie or simply search Irish Nurses Cardiovascular Association and keep up to date on events.

Committee Members

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Are you interested in becoming a committee member? We are always seeking to recruit new members for the committee from across the country. We frequently use teleconference to conduct our meetings. Please contact us!
Brendan Cavanagh delivered a comprehensive presentation outlining the acute coronary syndrome (ACS) programme’s aims and objectives. The aim of the programme is to save lives by standardising the care of ACS patients in Ireland. The programmes objectives are:

• For every patient with an ACS according to a protocol including early angiography for non ST elevation myocardial infarction (NSTEMI)
• That every patient with an ACS is diagnosed correctly and without delay.
• To reduce the median length of stay for STEMI and non STEMI (NSTEMI)

Brendan explained that “Code STEMI” indicates a diagnosis of STEMI. This term is recognised by the national ambulance service for inter hospital transfer to primary percutaneous coronary intervention (PPCI) centres to be treated as an emergency transfer which requires a signal and protocol.

Patients who have had a STEMI are rescued in the community by an ambulance and diagnosed via a 12 lead ECG as a STEMI and are also deemed “Code STEMI” with both ambulance control and the relevant PPCI centre. The Code STEMI guidelines for transferring a STEMI patient for PPCI from a non PPCI to a PPCI hospital where transport time is within 90 minutes. This process involves the following:

• Ambulance control contacted requesting an emergency transfer of a STEMI patient to a PPCI hospital as a Code STEMI.
• Ambulance control asked for the estimated total transport time
• If the total transport time will be within 90 minutes the contact PPCI hospital advising that the STEMI patient is being transferred for a PPCI.
• Ambulance control asked if there will be an advanced paramedic on the crew.
• The referring clinician is to consider the transport time to the receiving hospital and assess whether the patient can be transferred without additional personnel.

The code STEMI data is monitored using a database called e-Heartbeat. Brendan discussed four interesting case studies which were transferred via air ambulance to Galway University Hospital. However there is one barrier to the air ambulance as it is not permitted to fly during the night. I would like to thank Brendan Cavanagh for taking the time to discuss this imperative service with us.
I would like to take this opportunity to thank INCA for awarding me a bursary to attend this excellent conference in Norway, April 4th and 5th 2014. Stavanger was a beautiful city to visit and as we were informed by a cardiologist at the conference ‘it is the 2nd safest city in the world to have a ‘heart attack after Seattle’.

The theme of this conference was ‘Heart and Mind’ which focused on the various aspects of the physical and psychological causes of heart disease. There were many studies presented on how best to manage heart disease and more importantly how to prevent this disease.

Many aspects with regard to the heart’s response to anxiety, insomnia and depression were presented with interesting findings which highlighted the fact that individuals exposed to high levels of anxiety, insomnia and depression were at a higher risk of developing heart disease. This topic was presented in detail by H. Verteeg from the Netherlands in his presentation ‘Is the mind the primary culprit in development of heart disease?

Prevention of cardiac disease was also discussed in various presentations examining lifestyle and risk factor management. Dr. Catriona Jennings, Imperial College, London presented some interesting findings from the Principal results of the Euroaspir 1V survey of Cardiovascular disease prevention and diabetes (2014). This survey investigated lifestyle and risk factor management in coronary patients following a cardiac event, across 24 countries in Europe. The patients were selected retrospectively following AMI, Ischaemia, CABG and PTCA and data collected included measurement of waist and weight, blood pressure, lipid profile, creatinine, glucose, urine albumin ratio and current smoking status. These patients were interviewed and above data collected between 6 months and 3 years post their cardiac event with the mean interview time 1.35 years post event.

Almost 8000 patients participated in this study over the 24 countries with an average of 300 patients per country. The findings with regard to lifestyle were poor with one half of those smoking at the time of their event still smoking and a further two thirds reporting an inactive lifestyle. Even more alarming, a third of those patients at time of interview were obese with over half centrally obese. Dr. Jennings also stated that despite high prescribing rates for cardio-protective medications, only one half and one third respectively are achieving their goal for blood pressure and total cholesterol.

This study also revealed poor access to prevention and rehabilitation programs in certain countries for this patient population. Less than half of this patient group were advised to attend cardiac rehab and only one in four actually attend the cardiac rehab program. These findings further highlight the need for professional multidisciplinary expertise to achieve their lifestyle and risk factor goals.

Ireland was one of the European countries taking part in this study and we were rated in the middle range for smoking and obesity scores yet scored well with regard to cardiac rehabilitation referral and attendance.
The European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions (CCNAP) and the Norwegian Society of Cardiovascular Nurses gave a very warm welcome to all at this year's EuroHeartCare conference in Stavanger Norway. It was a wonderful opportunity to meet experts and colleagues from all around the world enhancing our knowledge and skills in cardiovascular care. Our host city Stavanger and the surrounding area which is considered a little jewel of Norway was very picturesque and a pleasure to visit.

Although the theme of the conference was focused on the heart and mind, there were many posters and presentations that showed how patient management is becoming more and more technologically focused and I will give a short synopsis of some of this work.

Gundersen, G.H et al. from Levanger Hospital, Norway delivered a moderated poster on a randomised controlled study with a cross-over design, evaluating the quality and clinical influence of including pocket size ultrasound in a nurse led outpatient heart failure clinic for monitoring fluid volume status. The purpose of the study was to assess the pleural cavity and the inferior vena cava by ultrasound to review its suitability for detecting heart failure decompensation as well as hypovolemia.

Sixty two patients were randomly selected and the nurse performed the pocket size ultrasound examination of the pleural cavity and inferior vena cava as an adjunct to the clinical examination. For quality control a reference echocardiograph examination was performed by the cardiologist to collaborate and validate the examination. The measurements correlated. The same patients were then reviewed by both nurses and cardiologists as per routine care without the use of the ultrasound or knowledge of these test results.

Their study found that the volume status of 27 of the 62 patients differed significantly with ultrasound picking up more pleural effusions that routine examination. They concluded that the nurse at an outpatient clinic was able to perform high quality focused ultrasound examinations of the pleural cavity and the inferior vena cava and that including a pocket size ultrasound in a nurse led heart failure clinic could improve diagnostics and treatment beyond standard clinical care.

Another interesting poster presentation related to the Mechanical Heart – at a heart failure clinic.

K Korneliussen from a hospital in Vestfold, Tonsberg, Norway presented a literature review of the responsibility of heart failure nurses regarding the follow up of patients at clinics with Left Ventricular Assists Device’s (LVAD). It was noted that the number of patients with advanced heart failure is increasing; this includes patients who are awaiting transplant and those who are not responding to medical management and are being followed up at the heart failure clinic.

The literature review indicated that there were very few studies noting the responsibility of the nurse at the heart failure clinic but several studies noting the need for specific clinics and follow-up for this group of people. As there is a large risk of complications and psychological challenges connected to living with an LVAD additional studies are needed to determine the level of expertise and interpersonal organising skills required by the heart failure nurse to deal with these patients.
Hagglund et al. from Stockholm evaluated the effects of a tablet computer connected to a patient-scale to monitor self-care for patients with an emphasis on self-administered education and knowledge building compliance and Health Related Quality of life (HRQoL). Seventy-two patients were randomised at 3 heart failure clinics receiving either standard information or the addition of a tablet computer connected to a patient scale. The results showed after 3 months that the patients with the tablet computer had increased knowledge of heart failure, adherence to therapy, improved HRQoL and decreased hospitalisation. They concluded that an easy navigated tablet together with a patient scale and useful information has the potential to be a valuable tool in the self-care of heart failure patients.

This was also in keeping with another study carried out by Klomstra et al. from Sweden who reviewed the appropriateness of educational websites for patients with cardiomyopathy, acute coronary syndrome and arrhythmia. They found that the internet as a source of medical information can be both beneficial and dangerous and sometimes it was hard to compete with “Dr Google”. Following a review of many different sites they found that the internet is increasingly becoming a very powerful source of information and communication for patients with heart disease with evidence of increasing usage especially with younger patients.

They found that many of the sites seemed to be effective with some sites including video animations, support tools, and patient video’s which were very beneficial. They also noted that some e-health interventions appear and change so quickly that patients and caregivers may use interventions that lack evidence of efficacy. Because of this they felt that nurses need to be aware of the web sites available and that perhaps modern patient education will include a ‘prescribing a website’?

**INCA 17th Annual Scientific Conference,**

**Dublin, April 2014:**

**Keynote Address: Dr. Siobhan O’Halloran Chief Nursing Officer,**

**Department of Health**

Scribe: Dr Rita Smith, Lecturer, School of Nursing Midwifery & Health Systems, University College Dublin.

Dr. Siobhan O’Halloran presented a very interesting paper on ‘The Twenty First Century Challenges for Nursing and Midwifery in Health Reform’. The Health Service Executive (HSE) is responsible for providing Health and Personal Social Services for everyone living in the Republic of Ireland. The objective of the HSE is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.

Dr. O’Halloran reiterated that health leaders including nurses and midwives have the most important and most difficult job in Ireland. She addressed the many common and inter-related issues and challenges in practice. Some include access and wait times for care, quality and safety issues and primary health reform. She considered the issues associated with demographics – not only of our clients and patients, but also of our workforce – growth of the population, aging, urbanization, and new patterns of work-life balance among healthcare professionals, all of which have profound implications for service delivery. The significant challenges in relation to Chronic Disease Management (CDM) were discussed and the reality that CDM is consuming up to 70% of the healthcare budget. Another issue raised was
health determinants – health leaders today are not only supposed to provide health services; they are supposed to impact the socio, economic and other determinants of population health status. The constant arrival of new communication and information technology tools new drugs and medical devices coming on the market all the time, along with new and expensive diagnostic equipment.

Dr O’Halloran reinforced that 2014 will be extremely challenging for the HSE given the dual challenge of reducing patient costs while at the same time improving patient outcomes where safety is paramount. She suggests that the Government’s Health Reform Plan is fundamentally changing our service for the better and that the changes are right for the system, right for staff and, most importantly, right for patients and all service users.

Dr O’Halloran reassured us that the essentials of nursing, a commitment to quality and excellence in patient care have remained constant over time. The critical questions for the nursing profession are how do we build in the rewards and the leadership opportunities that will attract and retain quality individuals in nursing? How do we prepare our graduates so that they are better able to construct long-term careers in nursing? How do we create a workplace that is intellectually challenging and emotionally satisfying for professional nurses?

Dr O’Halloran challenged our group to consider what roles can nursing assume to drive reform and address the increasing demand for safe high quality and effective healthcare services? She suggests we need a steadfast commitment to patient care, improved safety, quality and outcomes. We need clinicians who practice from health promotion, disease prevention, co-ordination of care to cure and to palliative care when cure is not possible. Clinicians who are confident that through their: adaptive capacity; close proximity to patients; and scientific understanding of care can drive health reform from the bedside to the boardroom.

As the chief nursing officer, Dr O’Halloran reassured us that she is committed to providing leadership with others to ensure nursing and midwifery are centre stage in policy making. She is committed to creating and maintaining an environment that supports nurses and is keen to foster a professional practice environment, where evidenced-based nursing practice is used, and professional development is encouraged and nurses are empowered to make decisions that affect their practice. Dr. O’Halloran indicated that the appointment of a Chief Nursing Officer in the Department of Health allows nursing to take part in the debates that influence health policy and can also provide a clear understanding of the knowledge embedded in nursing practice.

Dr O’Halloran proposes values-based leadership approach to help balance innovation with risk, to think long term but deliver results, decentralise yet control, and maintain staff morale and teamwork while making tough service and workforce decisions. Values-based leadership will also ensure that we tackle inequalities, drive preventive healthcare and ensure that people receive safe effective person-centred care from capable, caring and competent professionals. She suggests that nurse leaders are transformational and our core approach is defined by our patient focus. The importance of nursing expertise must be known so that our hospitals become known as the place where one goes to receive excellent nursing care. Her definition of ‘excellent’ is doing the right thing for patients all of the time with the three values that underpin nursing and midwifery — caring, compassion and competence.

Dr O’Halloran certainly provided lots of food for thought for the cardiovascular nursing group in this keynote address at our conference. We would like to express our sincere gratitude for this address and we wish her well in her post.
The family member talk was given by Seaghan Kearney, an out of hospital cardiac arrest survivor. Seaghan has an ICD insitu and he gave an inspiring and amusing talk about his experience and how the ICD affects his lifestyle. He admitted that he had some adjustments to make initially but he now he lives as normal a life as possible.

Seaghan is a schoolteacher who was 30 minutes into a five-a-side game when he went into cardiac arrest and collapsed. Luckily, those around him were quick to react and the club had a defibrillator, which they had received as a donation after Tyrone footballer Cormac McAnallen passed away in 2004. Seaghan revealed how lucky he was because clinically he was dead and he suggested a lot of events conspired to save him.

He was admitted to intensive care, the doctors were worried about brain damage because of a lack of oxygen but the only side-effect he suffered was short-term memory loss. He had an implantable cardioverter-defibrillator (ICD) inserted. Seaghan was in hospital for two and a half weeks, and his recovery was helped by the support he received from his friends, family and members of the GAA community. As a result of what happened, he had to give up competitive sport -- he can exercise but has to stay within certain parameters. While recovering he decided to do some work in raising awareness of Sudden Cardiac Death. He is part of a team who has come up with a campaign centred on the acronym 'ACT'. 'A' is to ensure that the defibrillator is accessible, 'C' is to make sure it is charged and 'T' is so that people are trained how to use it.

We are very grateful to Seaghan for sharing his story with us and for raising awareness about Sudden Cardiac Death.

Helen Danaher, Clinical Pharmacist in the Mater University Hospital presented a paper on New Oral Anti-Coagulant (NOAC) and New Anti-Platelet therapies to promote an understanding of their use in clinical practice. The topic of New Oral Anti-Coagulant (NOAC) and New Anti-Platelet therapies can cause confusion amongst health care professionals. We have to learn how to use these drugs effectively and safely in clinical practice. “Many unresolved questions on how to optimally use these drugs in specific clinical situations remain” Heidbuchel et al. (2013).

New Oral Anti-Coagulant (NOAC)

New Oral Anti-Coagulants are used as an alternative to Vitamin K antagonists (VKA). They require no monitoring and have fewer food and drug interactions. They have a shorter plasma half-life than warfarin and clinical trials have shown an improved efficacy/safety ratio.

When starting NOAC therapy a risk/benefit analysis is required and consideration must be given to co-medications and drug interactions. The drugs are contra-indicated for patients with a prosthetic/metal valve and a protein pump Inhibitor may reduce the risk of GI bleed. There is a cost implication therefore a new HSE application is required for prescribing these drugs. Medication compliance with the drug is imperative without exception. There is no known antidote to these drugs and renal function should be monitored. Examples of NOAC are Apixaban (Eliquis®) and Rivaroxaban (Xarelto®), both Factor Xa inhibitors and Dabigatran (Pradaxa®); a Direct Thrombin inhibitor.

Initial studies on Factor Xa inhibitors had shown efficacy in prevention of venous thromboembolism (VTE) post-orthopaedic surgery. Furthermore, efficacy in preventing stroke in Atrial Fibrillation has been indicated along with a reduced/comparable bleeding risks compared to warfarin or injectable anticoagulants.

Dabigatran (Pradaxa®)

The second drug discussed was Dabigatran (Pradaxa®) which works by blocking the substance thrombin which is involved in clot formation. The recommended dose is 150mg twice daily. Caution is needed with interacting drugs and there is a need to monitor for renal impairment. Factors increasing Dabigatran plasma levels are age 75 years or over and low body weight of 50kg or less.

In cases of renal impairment Dabigatran dosage should be reduced to 110mg BD, tailored to creatinine clearance. This drug is contra-indicated in prosthetic heart valves. Side effects include an increased risk of bruising/bleeding. Stomach ache or indigestion (a PPI may need to be prescribed). Avoid Anti-inflammatory medication (Aspirin / Ibuprofen / Diclofenac), and caution needs to be taken with SSRI drugs. If there is a missed dose: it can be taken if 6 hours prior to scheduled dose e.g. if prescribed for 8am/8pm, the missed morning dose can be taken before 2pm with a need to therefore monitor aPTT.

New Anti-Platelet Agents

New Anti – Platelet agents have a faster onset than their counterparts. There is an increased potency; this can induce some bleeding problems. There can be drug interactions and side effects.
Which Anti-platelet agents should be prescribed?

Clotidogrel is a safe and effective drug, it has a slow onset and offset with substantial variability in response. Clotidogrel is metabolised partly by CYP2C19 to active metabolite. Caution needs to be taken with drugs that inhibit CYP2C19. These include Omeprazole and Esomeprazole, Voriconazole, Fluconazole, Ciprofloxacin, Carbamazepine. Prasugrel has no major interactions.

Ticagrelor reduces CV death, MI, Stroke and all cause death without increased bleeding risk and increased dyspnoea. Ticagrelor is contraindicated with Ketoconazole, Clarithromycin, Nefazodone, Ritonavir, And Atazanavir. Co-administration may lead to a substantial increase in exposure to Ticagrelor.

Prasugrel is a potent agent; it is consistent with a rapid response. It has been proven to reduce CV death, MI, Stroke. It has an increased bleeding risk and it is contraindicated in previous TIA or stroke. It also has weight and age restrictions.

Moreover NOAC and Anti-platelets drugs were examined in sport and are not recommended for contact sport due to increased risk of bleeding. To reiterate, the topic of New Oral Anti-Coagulant (NOAC) and New Anti-Platelet therapies can cause confusion amongst health care professionals. We have to learn how to use these drugs effectively and safely in clinical practice. We would like to thank Helen for her comprehensive presentation on this group of drugs.

Risk Factors and Cholesterol

Presented by: Mary Kerins, Clinical Nurse Manager 2, Cardiac Rehabilitation Manager, St James Hospital

Scribe: Gillian Berry, Hypertension Nurse Specialist, Croi, West Of Ireland Cardiac Foundation

Mary Kerins presented on cardiac risk factors with a focus on cholesterol.

Ireland’s focus:

There has been a rapid reduction in the number of deaths from cardiovascular disease in Ireland over last 3 decades: due to improvements in treatment uptake and changes in levels of the main risk factors.

Coronary Heart Disease (CHD) mortality rates fell by 68% in men and by 69% in women between the year 1985 and 2006.

Approximately 40% (38% in men; 45% in women) of the CHD mortality decline could be attributed to improvements in treatment uptake. Around 48% of the CHD mortality decline was attributable to risk factor improvements. This reduction in CVD mortality in the Irish population has resulted in the re-classification of Ireland as a low risk country in the European Society of Cardiology’s risk estimation system – SCORE.

In contrast negative trends in diabetes and obesity levels generated an estimated 17% additional CHD deaths and are of significant concern.

We know that Increased Plasma Cholesterol and LDL Cholesterol are among the main risk factors for CHD while High triglycerides and low HDL are independent risk factors for CHD. It has been proven that Statin therapy has a beneficial effect on atherosclerotic CVD outcomes. Brown & Jennings (2014).
Risk Factors:
Risk Factors for Heart Disease comprise of Unmodifiable risks and modifiable risks, those we cannot and more importantly can change. Age, Gender, Family History and Race come under the category of unmodifiable risk factors. The Modifiable risk factors are Smoking, Hypertension, High Cholesterol, Over Weight, Stress, Diabetes, High Alcohol intake, the significance of Gout and Depression was highlighted.

Guides and tools:
ESC Guidelines and tools were discussed such as the essential messages prevention guidelines (2012) and the ESC pocket guidelines on dyslipidemia. Furthermore the CVD in practice can be accessed via www.cvdpractice.ie

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<th>Risk factor</th>
<th>Implementation</th>
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<tbody>
<tr>
<td>Smoking</td>
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<tr>
<td>Hypertension</td>
<td>&lt;140/90</td>
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<tr>
<td>Hyperlipidaemia</td>
<td>Total Chol = 5.0 LDL&lt;1.8 (V.H.R) &lt;28 (H.R) &lt; 3.0 (others)</td>
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<tr>
<td>Overweight</td>
<td>Optimal BMI 20.25kg/m2 but -20 not protective</td>
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<tr>
<td>Lack of Exercise</td>
<td>30 minutes most days of the week</td>
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<td>Stress</td>
<td>Manage / psychological therapy</td>
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<tr>
<td>Diabetes</td>
<td>&lt;140/80 HbA1c &lt;7.0% Statins</td>
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<tr>
<td>Alcohol</td>
<td>&lt;17 SD (men) &lt;11 SD (w)</td>
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The 2013 Arterial hypertension guidelines suggest the target BP of 140/85mmHg for a diabetic on anti- hypertensive.

Focusing on Cholesterol:
It is now known that LDL is considered “bad” cholesterol. There are two main routes by which cholesterol can rise to dangerous levels. These are genetic pre-disposition and Lifestyle and diet. The major contributors is lack of exercise and eating high fat/ high cholesterol containing foods. These foods when taken in excess increase LDL levels as there is more cholesterol than is needed. When they have enough they stop the cell receiving them from the blood by decrease the LDL receptors.

Hypercholesterolemia is an inherited condition where serum cholesterol is 2-3 times higher than the normal level. People with this condition are deficient in LDL receptors and cells are unable to remove LDL cholesterol from the blood. As LDL levels rise, plaques may deposit in the artery walls. These may become large and cause a significant narrowing. If this ruptures and a blood clot is formed risking a heart attack.

Help life style change adherence:
• Develop good alliance with the patient.
• Ensure patient understanding of lifestyle effects on CVD.
• Explore potential barriers.
• Ensure change is realistic and encouraging.
• Reinforce patients efforts to change.
• Follow up.
Other recommendations from the guidelines were explored in great detail such as initiation of statin therapy, medication compliance and dietary advice. Intervention strategies as a function of CVD risk and LDL-C level.

Take home message:
On a final note the Key Message is Increased plasma cholesterol and LDL Cholesterol are among the main risk factors for Coronary Heart Disease. High triglycerides and low HDL are independent risk factors for Coronary heart Disease and Statin therapy has a beneficial effect on atherosclerotic CVD outcomes. WWW.escardio.org/guidelines
In his introduction Dr Noel McCaffrey played an eight and a half minute video to demonstrate the Heart Smart program run by DCU Sport. The story told was mainly based on the patient’s experience. The Heart Smart program came with the highest recommendation that is the patients themselves. Heart Smart is a community based medically supervised cardiac rehabilitation program involving exercise and other elements such as educational seminars.

Heart Smart is a programme, delivered in conjunction with DCU Sport, which provides opportunities for participation in exercise classes in a safe, friendly and supportive environment. It is suitable for most people with heart disease. There is a high staff to participant ratio. Those engaged in the programme are encouraged to exercise at least twice a week at the facility and at home.

DCU Sport Heart Smart has on average 165 people attending weekly. Classes are spread to accommodate as many as possible. Heart Smart is the principal follow-on programme that patients are referred to by the cardiac rehabilitation teams in DCU’s three partner hospitals.

In relation to cardiovascular prevention programs Dr McCaffrey also spoke of the work of Croí in relation to heart and stroke prevention and rehabilitation in the West of Ireland.

Finally, DCU Sport has extended their services: Breath Smart for people with COPD and other respiratory illness, Smart Steps for people with arterial disease, Diabetes Health Steps and Move On for Cancer survivors. The overall aim is to assist people with various illnesses, to become fitter, healthier and enjoy an active lifestyle.
Dr. Joseph Galvin, Consultant Cardiologist, James Connolly and Mater University Hospital Dublin, presented a comprehensive overview of Sport and Cardiomyopathies. He opened with a defining statement ’Sport and Exercise are good for the population’ and went to outline the causes of heart disease in the older generation and the younger age groups.

Whilst intrinsic heart disease causing IHD and CAD affects mainly an older age group, Dr. Galvin went on to describe channelopathies and cardiomyopathy affecting mainly a younger age group. Dr. Galvin stated there is no national population screening program for sudden cardiac death (SCD) in the young person in Ireland. However, in Italy a National SCD screening program has been in operation since 1982, and have found 82% of their SCD’s were non-athletic and as a result of this screening program the incidence SCD has reduced from 4 in 100 to .5 in 100.

Various sports organisations have developed guidelines to raise awareness and help reduce the incidence of sudden cardiac death, FIFA, IOC and the GAA are among these organisations. The GAA have developed a questionnaire for players and if deemed at risk, their GP can forward on their ECG to Dr. Galvin in the Mater Hospital, for evaluation and further treatment if necessary. He described three areas the GP should look for on the ECG which may indicate the patient as high risk for sudden cardiac death:

- Prolong QT interval
- If Delta wave present
- If T wave inversion present

Dr. Galvin described SCD as an unexpected death that occurs within one hour of symptom onset in a person at or under the age of 35 years old, who was last seen alive and well within the preceding 12 hours. The cause of SCD in young people can sometimes be caused by CAD but it can also be caused by an unrecognised inherited cardiac condition. Hypertrophic cardiomyopathy (HCM) is the leading structural cause of SCD in young people in Ireland and Dr. Galvin discussed the pathophysiology of sudden death in HCM involving a complex arrhythmogenic substrate formed by myocyte disarray, fibrosis and calcium regulation abnormalities which predisposes the patient to fatal ventricular fibrillation. He also discussed Arrhythmogenic right ventricular cardiomyopathy (ARVC) which is characterised by fibro-fatty replacement of ventricular myocardium, usually right ventricular, resulting in ventricular dysfunction and arrhythmias. The National Italian screening program found that the most common cause of SCD is ARVC.

Dr. Galvin believes the burden of Sudden Adult Death Syndrome (SADS) which is now known as sudden arrhythmic death syndrome can be reduced by access to prompt defibrillation in the community which requires access to an automated external defibrillator (AED). He stated that AEDs must be mandatory in every sports club.

Dr. Galvin discussed access to certain sports for HCM patients and patients with ICDs. He advised that a list of sports that are advisable and not advisable for this patient group should be compiled, however for ICD group of patients, it is probably not advisable to play any contact sports. He has heard of some patient’s though using American football type shoulder pads to protect their ICD device when playing contact sports.

Dr. Galvin stressed the importance of a national screening program to identify those individuals at risk and minimise the incidence of SCD and also the screening of families with suspected or known genetic cardiac abnormalities.
Dr. Ross Murphy, Consultant Cardiologist, St. James Hospital, Dublin discussed the genetic link to sudden cardiac death (SCD) and highlighted the fact that there is no gene therapy in Ireland for SCD at present. There is a national genetics screening centre in Our Lady’s Children Hospital, Crumlin, Dublin, but no funding available for cardiac genetics.

Dr. Murphy described a study by O’Keefe et al., (2004) ‘Cardiovascular disease resulting from a diet and lifestyle at odds with our Palaeolithic genome: how to become a 21st-century hunter-gatherer’ which suggests from accumulating evidence that the mismatch between our modern diet and lifestyle and our Palaeolithic genome is playing a substantial role in the ongoing epidemics of obesity, hypertension, diabetes, and atherosclerotic cardiovascular disease which further highlights the importance of cholesterol screening.

Coronary artery disease screening in Ireland is also not as effective as it should be as patient’s present either dead or infarcted. With regard to Hypertrophic Cardiomyopathy (HCM), Dr. Murphy stated that 1:500 cases are unexplained hypertrophy with MRI testing as key to diagnosis as 50% of cases are missed on cardiac echo. Standard testing includes ECG, Echo and Cardiac MRI.

Dr. Murphy described channelopathies as a cause of sudden cardiac death in a previous healthy young person with no structural abnormality and findings at post mortem suggests an ion channelopathy such as LQTS or Brugada syndrome. Triggers for LQT can include such drugs as antihistamines, SSRI’s, Methadone and antibiotics Erythromycin and Clarithromycin.

In 1992 Pedro and Josef Brugada, brothers from Catalonia Spain presented the first description of the Brugada Syndrome, an inheritable arrhythmia syndrome associated with sodium channel mutations which poses an inherent risk of SCD due to episodes of polymorphic ventricular arrhythmias. Torsades de Points is a similar polymorphic ventricular arrhythmia, which was originally described in 1966 by Dessertenne in a French medical journal, when he observed this cardiac rhythm disorder in an 80-year-old female patient with complete intermittent atrioventricular block.

Dr. Murphy advises that management of patients with channelopathies should include use of betablockers, avoidance of sports and implantable defibrillator. In conclusion, Dr. Murphy also echoed Dr. Galvin’s sentiment regarding a national screening programme to identify those individuals at risk for SCD and also the screening of families with suspected or known cardiac anomalies.
Cecelia never fails to deliver fascinating case studies and presented a case study relating to a 33 year old female who has a history of stage two Hodgkin’s Lymphoma diagnosed in 1999. As part of her treatment she received radiotherapy to her neck and chest. The disease reoccurred in 2003 and she had a further course of radiotherapy to her lower thorax and upper abdomen. She also had a past medical history of depression and hypothyroidism.

The patient had recurrent admissions with fatigue, abdominal distension, pleural effusions, abnormal LFTs and dyspnoea and was diagnosed with acute decompensating heart failure. In 2011 she had a CT thorax which showed diffuse pericardial thickening. Pleural effusions were transudate which was treated with a VATS procedure. Over the past three years there has been a decline in her functional status. On examination she had dyspnoea on moderate exertion, increased fatigue levels and was severely disabled with heart failure symptoms.

The echocardiogram showed a reasonable left ventricular ejection fraction, the mitral valve opened well and there was no evidence of mitral regurgitation. The aortic valve showed mild aortic regurgitation and no aortic stenosis. There was a septal bounce present with acute decompensating heart failure.

The coronary angiogram showed diffuse non-obstructive coronary artery disease and biopsies were taken. A chest X-ray showed minimal volume loss in the left lung and the heart size was normal.

Cecelia highlighted why it is imperative to make the diagnosis and distinctions between constrictive and restrictive heart failure. Both conditions are common and are associated with significant morbidity and mortality. Restriction is rarely treatable or curable. Constriction may be improvable or curable by surgery. There are a number of reasons where constriction can be caused. These can be idiopathic 33%, post pericarditis 18%, post-surgical 16%, post radiation 14%, rheumatic in origin 6% and due to infection.

In restrictive dysfunction abnormal diastolic function can be prevalent, a rigid ventricular wall with impaired ventricular filling, an increased wall thickness on echocardiography is common; pulmonary artery pressures are more likely to be elevated. This patient’s diagnosis was constrictive restrictive cardiomyopathy. The treatment options available were medical management, pericardial stripping or a heart transplant. At the cardiothoracic conference a decision was made for weekly to fortnightly follow up with a plan for a heart transplant and psychological support as and when required.

I would like to thank Cecelia preparing and delivering an interesting case study.
Bronagh presented a case study on an elderly lady who lived alone and had severe heart failure. Bronagh and her team improve the quality of life for patients with heart failure in south Dublin and part of Wicklow. They do this through expert multidisciplinary advice, education and support for patients from diagnosis until end of life.

Bronagh works very closely with Professor Ken McDonald and Dr. Rory O’Hanlon, consultant cardiologists who specialise in heart failure. The project provides a multidisciplinary approach to heart failure management to ensure that patients are on maximum tolerated evidence-based medical therapy according to their individual needs. The team also empower patients to embrace self-care principles of heart failure management with strong support services for patients and family. The patient had good support from her daughter who was also involved in her care.

As part of the Community Heart Failure Project, Bronagh works in the community and visits patients in their own home. The patient had had a number of hospital admissions in the past with heart failure and no longer wished to be re-admitted to hospital. Bronagh had built up a therapeutic relationship with her and as a registered nurse prescriber was able to titrate medication according to her patient’s needs. This service provides expert care and symptom management in the comfort of a patient’s own home and offers patients the specialist care and compassion that they require. Sadly, this lady died peacefully in her own home but was granted the dignity of making an informed decision of where she wanted to spend the final days of her life.

We would like to thank Bronagh for taking the time to present to us on such an imperative service which she provides.
The 2012 guidelines are now in use for two years but we are reminded that guidelines are of little use unless implemented and that a good implementation strategy needs to be in place. The implementation of the European Guidelines on CVD Prevention is the responsibility of the Cardiovascular Prevention Implementation Committee (PIC) of the ESC. Its duty is to bridge the gap amid science and practice for secondary and primary prevention in hospital and general practice.

The Council of Cardiovascular Nurses and Allied professionals (CCNAP) is also very committed to implementing the guidelines by promoting, brainstorming and developing a tool kit and questionnaire. We at INCA are also committed to work with CCNAP and play our part in the implementation. Therefore Gabrielle Mc Kee and I have taken on the lead in developing a questionnaire to assess professional’s attitudes and awareness of the 2012 guidelines. This will be available as a survey monkey and hard copy in the near future and will be available to all cardiovascular nurses. It will be presented at EuroHeart Care in Dubrovnik 2015. The theme of Euroheart Care will be “Guidelines”.

We as nurses are good at implementing guidelines. Donna Fitzsimons (President CCNAP) told us this when she spoke on Guideline implementation at EuroPrevent 2012. The Guidelines advise that the CVD Risk Factors can be managed by behavioural strategies and by drug treatment. Evidence has shown that cognitive- behavioral methods are necessary components to target lifestyle changes. Cardiovascular nurses are in an ideal position to endorse this. The 2012 Guidelines can be easily accessed at:
http://www.escardio.org/GUIDELINES-SURVEYS/Pages/welcome.aspx
Winners of 2014 INCA Educational Bursaries

The INCA committee are delighted to announce the winners of the 2014 Educational Bursaries. We look forward to reading the recipients accounts of how they used the bursary to enhance their practice.

- Patricia Hall  
  Clinical Research Nurse Falls and Blackout Clinic, SJH
- Pat Kerrigan  
  Clinical Nurse Specialist Heart Failure, SJH
- Loreena Hill  
  PHD student (Heart Failure Nurse) Ulster University
- Deirdre McGuone  
  Clinical Nurse Specialist Chest Pain, SJH

Are you interested in applying for a bursary? Further details about the educational bursaries can be found on www.incanursing.ie

CVD Prevention in Practice

The Irish Heart Foundation launched the new cardiovascular disease (CVD) Prevention in Practice website on Friday 6th June at the Hilton Kilmainham. This website is a support tool for Healthcare Professionals to assist in the management of people who may be at risk of CVD. Guidelines are pointless unless implemented, so the site has a focus on practical aspects of using the latest European Guidelines on the Prevention of CVD in Clinical Practice, published in 2012. Although Ireland is now regarded as a ‘low risk’ country, CVD remains the leading cause of death.

Professor Ian Graham, Chair of the Irish Heart Foundation’s Council on CVD prevention and member of the European Guidelines has recorded a short video explaining the latest guidelines and why these are important for General Practitioners treating patients with cardiovascular disease. Dr John Cox, General Practitioner and ICGP Council member shares his experience on how to use the ‘Heartscore’ tool. This is a simple visual aid which can be used to calculate individual patient risk. It is also useful in helping patients understand their own personal ‘risk score’ and what they can do to improve their cardiovascular health.

The launch was attended by a number of INCA members and was well supported by Nurses in practice. For further information regarding this very useful website, please visit http://www.cvdpreventioninpractice.ie/

UPCOMING EVENTS & DATES FOR YOUR DIARY

NATIONAL MEETINGS

- Irish Cardiac Society Nurses Day in association with Irish Nurses Cardiovascular Association (INCA) Thursday 16th October 2014, Sheraton Hotel, Athlone, Co Westmeath.  
  This event is FREE FOR NURSES TO ATTEND. Register with secretary@incanursing.ie

For more information on European meetings please log on to www.escardio.org

Any submissions or suggestions for the newsletter? Please submit to Dr Rita Smith Newsletter Editor C/O Admin@incanursing.ie
IRISH NURSES CARDIOVASCULAR ASSOCIATION IN ASSOCIATION WITH THE IRISH CARDIAC SOCIETY

PRESENTS

Mind Your Heart
THE CYCLE OF CARE

16th October 2014
The Sheraton Hotel, Athlone, Co. Westmeath
Time: 10am-3:30pm

TOPICS:
Cardiovascular Targets and CVD Risk Reduction
Development of ACS App
Acute Coronary Syndrome
Behavioural Change
Overview of CCNAP
Implementing the 2012 Prevention Guidelines
Hypertension
Cardiac Rehabilitation

Poster and abstracts welcome.

Book your place: secretary@incanursing.ie  Admission: Free
https://www.facebook.com/www.inca.ie