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Dear Colleagues,

Happy New Year to all INCA members and I hope you all had a wonderful Christmas.

This year brings lots of interesting things to the INCA calendar.

INCA is offering educational bursaries again this year but with a difference. We are offering three educational bursaries to go to a conference of your choice or course (up to €1000) and five bursaries to attend Europrevent in Dublin in May (up to €500). You will receive more information about this later.

The Travelling Fellowship sponsored by MSD is also on offer again this year, and we thank MSD for their continued kind and generous sponsorship over the years.

An international working group is looking at staffing levels in CCU’s under the lead of Scott McLelland, England. Gabrielle McKee and Eric Reyes are the INCA representatives on this group. There are no evidence-based guidelines specific to cardiovascular nurse staffing, although there is some evidence suggesting that nurse staffing levels, skill mix and practice work environment are associated with improved patient outcomes. The aim of this study is to bring together key nurse scientists, clinicians and managers to identify, debate and reach a consensus upon which to base recommendations. This is to be published as a scientific statement sponsored by CCNAP and partner national societies.

Other Councils/Associations with INCA representative include The National Council on Blood Pressure (Geraldine Lynch) and The Heartbeat Initiative (Acute Coronary Syndrome strategy) (Kate O’Donovan).

**EUROPrevent May 3rd to 5th.**

Ireland Day is on Thursday 3rd which includes a Nurse’s session organized by INCA (I am the INCA representative on this committee) and IACR. EUROPrevent is a big international meeting with many with many renowned guest speakers present. It will be held in the new convention centre on the Quays, Dublin.

Our Annual Scientific Meeting will be held in Tullamore again this year. Your feedback from last year’s event was very positive regarding this location and venue. We will keep you updated.

I would urge you all to contact us with any comments and suggestions for the Association, after all this is your Association and we value all of our members. We will also be looking for nominations for new committee members in the Spring.

The Autumn Evening Meeting was held in the Alexander Hotel on the 10th of November and we were delighted to have internationally renowned Prof Debra Moser as our Guest speaker.

I would encourage you all to renew your membership in January. We ask graciously that you renew on line or by cheque as this makes the treasurer’s job much easier.

Lastly I would like to thank the hard working INCA committee whose support and enthusiasm has been invaluable to me in my role as president. This association has stayed strong and grown from strength to strength over the years thanks to the input of its various committees.

Kindest regards to you all,

MARY KERINS
**A Reminder**

**INCA membership renewal**

You can renew your membership by logging on to www.incanursing.ie. INCA uses PayPal for transactions which is a secure and safe method. We look forward to your continued support and thank you for your support in 2011.

The cost of being a member has been reduced from €40 to €30 and membership can be easily renewed via www.incanursing.ie

**Benefits of membership include:**

- Free quarterly newsletter 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

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**INCA COMMITTEE 2012-2013**

**Executive Committee**

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Heart Failure Nurses Representative  
Cecelia Tracey  
Chest Pain Nurses Representative  
Geraldine Lynch  
Ex Officio: Kate O’Donovan
Report – 11th CCNAP Annual Spring Meeting on Cardiovascular Nursing April 2011

Francis O’Brien, Assistant Professor, School of Nursing & Midwifery, Trinity College.

Introduction

I applied to the Irish Nurses Cardiovascular Association for an educational bursary to defray the cost of conference attendance. It was this bursary that facilitated my trip to the 11th Annual Spring Meeting on Cardiovascular Nursing which was held in Brussels on April 1st and 2nd this year. Over 400 international delegates attended the conference over the two days. The meeting was officially opened by Dr. Kaat Siebens, Chair of the Council on Cardiovascular Nursing (CCNAP) and Dr. Philip Moons, Chair of the Belgian Working Group for Cardiovascular Nursing. Professor Panos Vardas, President of the European Heart Rhythm Association (EHRA) reminded delegates of the importance of nurse education and how cardiovascular medicine relies upon the efforts of nurses to successfully serve patients. The aim of this report is to provide you with an insight into some of the sessions I attended at this congress. I have also included information on my contribution to the conference.

Session 1: Do patients with atrial fibrillation benefit from exercise training?

This session by L. Vanhees focused on the exercise tolerance, training and risks in those suffering from atrial fibrillation. The causes of atrial fibrillation include: advancing age, hypertension, alcohol consumption, metabolic syndrome, stress and anger, obesity, sleep apnoea and heart disease, particularly heart failure. The cardiac patient with atrial fibrillation differs from those with sinus rhythm in that stroke volume is affected. In atrial fibrillation, the variation in R-R interval causes a variation in diastolic filling, thereby reducing cardiac output and exercise capacity. Therefore, special consideration is warranted where patients present with heart failure combined with atrial fibrillation. Studies have shown that for this group, oxygen volume is significantly lowered, which further impacts exercise tolerance. The implication of this is a large oxygen deficit, even with sub-maximal exercise.

Researchers have compared patients who have atrial fibrillation and those in sinus rhythm and found that those with atrial fibrillation have increased heart rates at rest and at peak values and lower workload capacity. Patients in sinus rhythm with a previous history of atrial fibrillation also have reduced exercise capacity. While the benefits of exercise are well recognised, exercise in atrial fibrillation must be placed in context. Few studies have examined the impact of exercise training in atrial fibrillation. Training has been shown to increase exercise tolerance, yet there are few guidelines provided for healthcare providers in this area. This is significant as the complications of exercise training include stroke or TIA and ventricular arrhythmias, including cardiac arrest. Those on anticoagulants should avoid contact sports as the risk of haemorrhage is increased. While exercise training in atrial fibrillation is possible, safety precautions should be taken in light of the known risks. From a nursing perspective, cardiac rehabilitation should focus on the reduction of risk factors for the development of atrial fibrillation and patients should be made aware of the need for precautions with training. Delegates were referred to Heidbuchel et al. (2006) “Recommendations for participation in leisure-time physical activity and competitive sports in patients with arrhythmias and potentially arrhythmogenic conditions. Part 1: Supraventricular arrhythmias and pacemakers”. European Journal of Cardiovascular Prevention and rehabilitation.
Session 2: Knowledge of acute coronary syndrome symptoms: An Irish population survey (moderated poster)

This study provided baseline data from an Irish randomised controlled trial in which I am involved. This study will be familiar to some nurses who work in the area of cardiology, as the data were collected from five of the major academic teaching hospitals in Dublin.

The purpose of this study was to identify whether patients who were diagnosed with acute coronary syndrome (ACS) had the ability to decipher which symptoms were associated with a heart attack. Patients (N=1,947) who had recently been diagnosed with an acute coronary syndrome were presented with a list of twenty-one symptoms and were asked to correctly identify those symptoms that could be representative of a heart attack.

Consistent with the literature, knowledge of ACS symptoms such as chest pain, arm pain and shortness of breath appeared to be well recognised among this Irish population. However, almost half of those surveyed did not recognise jaw pain, neck pain, heartburn, or nausea as heart attack symptoms. Failure to recognise ACS symptoms and correctly attribute them to a cardiac cause can result in minimisation of the seriousness of the event. As symptom presentation cannot be pre-determined, the entire spectrum of potential heart symptoms should be included in cardiovascular education protocols.

Session 3: Hybrid procedures: where the surgeon meets the interventionalist

This presentation by Dr. Budts provided a humorous slant to the familiar dilemma regarding which therapeutic option is superior in the management of patients with coronary heart disease; coronary artery bypass grafting or percutaneous coronary intervention. The sparring that often takes place between cardiologists and surgeons in clinical practice is encountered by nurses and generally concludes in an agreement that greater collaboration is required. It was on this word collaboration that the above session focused.

Dr. Budts presented information about hybrid procedures, which began in the 1990s. This is a combination of catheter-based therapy and traditional surgical intervention where surgeons and interventionalists use a combination of tools available from the cath lab and the operating theatre. The first trial on hybrid coronary intervention conducted by the National Heart, Lung and Blood institute has defined those patients who are most eligible for hybrid Coronary Revascularisation. Hybrid procedures are used for valve surgery, atrial fibrillation procedures, coronary and carotid artery disease, coronary revascularisation, congenital heart disease and trans-catheter valve procedures. Indications for its use, patient suitability and standardisation are on-going. As patients present with increasingly complex cardiac conditions, hybrid therapy is becoming a popular treatment option. Patients who are considered to be “high risk” benefit from this tailored combined approach. Hybrid procedures are not widely used at present. However, as their use gains further momentum, the differences in opinions regarding the best treatment option will be lessened. According to Dr. Budts, there is an absolute need for cooperation between the surgeon and the interventionalist. While Dr. Budts did not refer to the implications of hybrid procedures for nurses, the need for skilled training for those who work in the Hybrid operating room and for those caring for patients afterwards cannot be overlooked.

Delegates who attend receive a complimentary monthly copy of the European Journal of Cardiovascular Nursing for one year. The journal provides information on cardiology based issues with a focus on research and organisational activities. I would like to thank INCA for the opportunity to attend this conference. Nursing conferences offer opportunities for new information, experience and, of course, enjoyment.
Introduction

It was with delight when I learned of my successful application for the educational bursary through the Irish Nurses Cardiovascular Association. The conference I attended was the 11th Annual Spring Meeting on Cardiovascular Nursing (ESC nursing), which was held in Brussels, Belgium and took place over a two day period (April 1st and 2nd). I nominated this conference as I was presenting a moderated poster relating to my area of research and the bursary facilitated this. There were sessions on arrhythmias, implantable cardioverter defibrillators, heart failure and valve disorders and their management. Some of the information gleaned at these sessions was of value and will be incorporated into my teaching sessions. This paper will outline my experience of attending the conference and some of the sessions I attended.

Challenges in arrhythmia management for the 21st century

This keynote session was presented by Professor Vardas who highlighted the importance of the ESC Guidelines for the Management of Atrial Fibrillation (2010) in practice. Nurses working in the area of cardiology are frequently challenged with caring for patients with arrhythmias. These challenges will increase in the future as the prevalence of arrhythmias continues to rise. Professor Vardas suggested that this increase in the presence of arrhythmias is most likely due to the increasing life-span of the general population. At present approximately 400,000 people are affected by arrhythmias each year. Atrial fibrillation is one of the most commonly seen arrhythmias. The condition is managed using anti-thrombotic therapy, the treatment of associated diseases and ventricular rate control. Additional management may on occasion include the need for cardioversion, antiarrhythmics and ablation therapy. All treatments are aimed at minimising symptoms and preventing complications. Nurses working in the area of cardiology should familiarise themselves with the guidelines and understand the significance of arrhythmias and their potential dangers.

Professor Vardas referred also to the risks associated with ventricular arrhythmias, and in particular, ventricular tachyarrhythmia, which causes electrical disturbances. The management of these is concerned with primary and secondary prevention. It was interesting to note the variation in secondary prevention measures between ESC member countries. Some of these do not cover the costs of cardiac device implantation for secondary prevention.

Mitra clip – management of mitral valve regurgitation when surgery is not an option.

Mitral regurgitation symptoms can be treated with medical therapy or cardiac resynchronisation. Until recently, where symptoms persisted or failed to respond to these measures, surgery was the only alternative treatment on offer. However, surgery is not always an option for patients, particularly for those with severe secondary mitral regurgitation. This presentation by cardiologist Jan Van der Heyden focused on patient outcomes following the management of mitral valve regurgitation using Mitraclip therapy where surgery was not feasible. The evolution of the implantable Mitraclip offers an alternative treatment for patients with significant mitral regurgitation for whom surgery was not an option. It is for this sub-group of patients that Mitraclip therapy has been predominantly used.
Dr. Van der Heyden explained that the Mitraclip is a catheter-based system which consists of a guide catheter and a clip delivery system. There are two arms with grippers attached to each arm on the clip. The clip is introduced into the left atrium using the trans-femoral venous route and a trans-septal puncture. The mitral leaflets are captured and held in place using these grippers and clip arms. When the regurgitation level is sufficiently reduced, the clip is deployed. The procedure which is carried out under general anaesthetic is monitored using fluoroscopy and echocardiography. It is considered successful if at least one clip is correctly implanted. From a nursing perspective, vigilant post-procedure haemodynamic monitoring is essential, as there is an alteration in pre-load and after-load. Dr. Van der Heyden concluded that from their study (N=50), Mitraclip implantation is feasible and effective in patients from whom surgery would not be an option. At 6 months post procedure, 81% of successful Mitraclip implantation patients had improved by at least one NYHA functional class. However, overall survival rates were influenced by NYHA functional class.

It was anticipated that these findings by O’Donnell et al. (2006) would have given rise to behavioural changes among the Irish population and that pre-hospital delay times would have reduced since then. This study looked at current pre-hospital delay times and found that median delay time in this sample was 3.5 hours (25th percentile = 1.5, 75th percentile = 14.8 hours). A gender comparison in this study revealed that women delayed for 4.2 hours while men delayed by 3.3 hours. These pre-hospital delay times are longer than those reported by O’Donnell et al. (2006) five years previously. Delay time by ACS diagnosis revealed that those who were diagnosed with an ST elevation MI delayed less than those diagnosed with a non-ST elevation MI.

Attendance at the 11th Annual Spring Meeting on Cardiovascular Nursing provided me with an opportunity to learn, teach and think. I would like to thank INCA for the opportunity to attend the conference and to share my information and experience with the readers.

Irish pre-hospital delay times in acute coronary syndrome: an on-going dilemma.

This presentation was in the form of a moderated poster, which I presented. This study measured baseline pre-hospital delay times among patients diagnosed with acute coronary syndrome in Ireland and compared them with baseline equivalents recorded five years previously. Pre-hospital delay time was interpreted as the time from acute symptom onset until arrival at the emergency department. Researchers have reported European pre-hospital delay times between 2 and 4 hours. In 2006 median pre-hospital delay times of 3.1 and 1.8 hours were reported for women and men respectively in Dublin (O’Donnell et al. 2006). The revelation that there was an excessively long pre-hospital delay time by women in Ireland received much media coverage at that time.
I would like to take the opportunity to thank INCA for their sponsorship allowing me to attend the 2011 ESC Heart failure conference in Gothenburg, Sweden. Observing the conference programme, the following areas which were of particular interest to me; palliative care in heart failure, iron use in heart failure, sleep apnoea, mitral clip, (HFPEF) heart failure with preserved ejection fraction, new biomarkers and tele-monitoring. I have summarised information from some of these areas. The conference was a little disappointing due to the lack of new ground breaking trials; nonetheless there was a plethora of other interesting presentations. I particularly enjoyed the interactive sessions in which case studies were presented and you got to vote on treatment options etc. Ireland was also well represented in the poster session.

Here is a summary of some the topics I found particularly interesting:

Eplerenone has been shown to reduce atrial fibrillation (AF). The aldosterone antagonist, eplerenone (Inspra) was shown to significantly reduce the development of new onset AF and flutter in patients with class II heart failure shown by a sub analysis of the EMPHASIS HF (Eplerenone in mild patients hospitalisation and survival study in heart failure): trial. The analysis of this trial also indicated that the beneficial effects of Eplerenone in reducing major CV events in patients were similar with and without AF at the start of the study. This analysis strengthens the case for the use of Eplerenone in this setting because in addition to reducing mortality, it also reduces the incidences of AF. AF is a condition which both increases morbidity and complicates the care of patients with heart failure. The EMPHASIS HF study demonstrated that Eplerenone when compared with the placebo, produced a 37% reduction in the primary end point of the composite of death from cardiovascular causes or hospitalization reduction in cardiovascular death, and a 42% reduction in hospitalisation for heart failure for patients with class II heart failure. The EMPHASIS–HF trial involved 2737 patients from 278 centres with ejection fractions ≤35% and set out to address this hypothesis in patients with mild heart failure.

Another presentation I attended was about NGAL, a renal biomarker. It is hypothesised that measuring NGAL levels in addition to creatinine measurement, may allow earlier intervention and timely treatment decisions for patients with acute kidney injury (AKI). AKI is a common complication and is associated with poor prognosis. What is NGAL? Neutrophil Gelatinase Lipocalin, of NGAL is a 25 KDA iron transporting protein. Under normal conditions NGAL is detected at very low levels in the kidney. However NGAL levels increase significantly after AKI and can be detected in blood or plasma. NGAL concentrations increase 10-100 fold during the 2 hours that follow tubular injury, whereas creatinine does not rise until 24 to 72 hours after the initial renal insult. Measuring NGAL in addition to serum creatinine at ICU admission has the potential to assess for and treat AKI at an earlier stage. AKI can occur long before a loss in renal function is observed by creatinine elevations. A biomarker such as NGAL that rises early, indicates real time renal injury, provides information that is
additive to creatinine may be beneficial for early diagnosis and allow more timely, actionable health care decisions. This research was discussed at a satellite symposium organised by Alere and they listed three studies to show how NGAL aided in early identification of AKI and disease severity assessment. This test can be done by rapid point of care testing. Other point of care biomarkers such as BNP and additionally, the application of tele-monitoring were also discussed.

A new research study called The HOME (Heart failure Outpatient Monitoring Evaluation) study in which Prof. Ken McDonald (SVUH) is a principal investigator was also outlined.

While discussing the TIM-HF study, Dr. H.J. Dargie (Glasgow, GB) discussed statistics which were of particular interest to me. Quoting from the NHS information centre 2010 he said that in the UK an audit conducted by the Health Care Commission highlighted that many patients admitted to acute hospitals are not managed fully in accordance with evidence based guidelines. Factors such as access to specialist wards and services may impact on access to key treatments. Forty-six % of the patients in the study were managed on a cardiac ward and 42% on general medical wards. The key finding of this report was that patient’s admitted to cardiology wards have a 20% lower mortality rate than those admitted to a general medical unit underlying the need to develop specialist in-patient services for heart failure patients. In the study the one year mortality was 32% but results were significantly better for those who had access to specialist heart failure care, with a 23% mortality rate. I found these statistics particularly relevant and useful as working as a CNM on a Cardiology ward I have to continually make a case for prioritising the admission of cardiac patients.

Another session I went to was titled “Improving the lives of patients with chronic heart failure (CHF): iron matters”. Prof Swedberg gave the opening introduction and quoted from trials that anaemia is a common co-morbidity in patients with chronic heart failure and is associated with worsening long term outcomes. Of potential importance is the observation that Iron deficiency can also reduce exercise capacity. Additionally, more recent data by Jankowska et al EHJ 2010, has shown that iron deficiency in CHF is independently associated with increased mortality, irrespective of the presence of anaemia and the severity of the disease. In Patients with CHF Jankowska et al also showed that in CHF, iron deficiency, irrespective of anaemic status, is associated with elevated levels of natriuretic peptide, poorer functional status, reduced exercise capacity and impaired quality of life. Prof Pontikowski discussed that recent data have established that iron deficiency is also prevalent in CHF patient without anaemia. Furthermore, it appears that the underlying pathophysiology in CHF facilitated the development of both absolute (depleted Iron stores in the body) and functional iron deficiency (impaired iron availability despite preserved stores).

The FAIR-HF Study, (The Ferric Carboxymaltose Assessment in patients with Iron deficiency and chronic heart failure) 459 iron deficient CHF patients with class II or III, with and without anaemia, demonstrated that, compared to placebo, the administration of IV ferric carboxymaltose therapy (FCM) for 24 weeks improved CHF symptoms, physical performance and quality of life. Additionally treatment with I.V. FCM was associated with a significant improvement in renal function, as evidenced by an increase towards a lower rate of hospitalisation compared with placebo.

Nursing topics at the conference included information on devices and palliative care. The potential impact of in appropriate ICD shocks on morbidity and mortality was described by Dr. Camm (London, GB) as follows:

- Causing myocardial injury, resulting in deteriorating of myocardial function, increased anxiety and depression
• AF the major cause of inappropriate shocks and is associated, with increased mortality
• Provocation of an arrhythmia by an inappropriate shock of any kind. Another factor responsible for both inappropriate shock and increased mortality, smoking/increased sympathetic stimulation etc.

There is also increased negative perception of ICD such as reduced battery life, increased economic burden due to additional health care costs. ICD patients can accept 4 shocks without a clinical deterioration in quality of life (Sears et al 2009).

One statement of interest that Dr. Camm made is that many people die in bed but we should not conclude that it was the bed that killed them. Many people die after an ICD shock but we should not conclude that it was the shock the killed them (McMahon Stephen 1995).

‘The importance of psychosocial support for the ICD patient’ was a presentation I attended, delivered by psychologist S. Kikkonenbourg Berg (DK). She explained the importance of assessing psychological symptoms in patients with an ICD. She quoted a study by Dunbar et al (PACE 2009) which said that patients with an ICD experienced anxiety in 36% of cases and depression in 23% of cases. She gave examples of emotional triggering of ICD - emotional stress leading to electrical stability causing a shock in which termination can be more difficult. She said there was increased incidents of ventricular life threatening arrhythmias in ICD patient’s observed after 9/11 and this phenomenon was also seen in Florida (JACC Vol. 44 2004). There is an apparent increase in VT on Mondays and in morning hours; anger or anxiety can also trigger fatal arrhythmia. Phantom shocks (sensation of shock in absence of therapy) can also occur but more likely in people who suffer from stress, depression or anxiety.

Barbara Riegel a nursing guru from the USA spoke about the importance of giving accurate information to a patient who is undergoing ICD insertion. Points she outlined that should to be addressed in planning for an ICD intervention with a patient include the following
• Incision and the procedure
• Explaining the rational for the ICD
• Ensuring informed consent
• Reiterating the perception of security
• Prevent device regret
• Explaining the difference between heart attack and cardiac arrest
• Potential protection value of ICD
• Practical issues, eg. driving limiting arm movements
• Physical and sexual activity
• Electromagnetic interference
• ICD shock events
• Device recalls
• End of life

The following were identified as correlates of low patient acceptance of the device
• Psychological acceptance
• Older age
• Patient concerns
• Disease severity

Correlates to higher patient acceptance of the ICD were as follows
• Presence of a partner
• Attitudes to technology
• Culture of the patient
• Communication from doctor

Ms Riegel advised care deliverers to focus on the following positive aspects of risk
• Having heart failure increases risk threatening arrhythmia (Sears et al 2009)
• Any treatment has pro and cons
• ICD is superior to medication in saving lives
Use positive communication
• Most people tolerate ICD’s well

Emphasise the positive influence on quality of life
• ICD therapy including shocks may be uncomfortable not painful
• Explain ICD patients experience a quality of
life comparable to that of other cardiac patients (Sears et al 2009)

**Respect for end of life**

- Device deactivation should be discussed prior to implantation and as the end of life nears

The following interesting figures relating to ICD therapy were presented. In a nationwide study of 734 physicians, 59% of them had <3 experiences discussing deactivation of ICD’s with patients and/or families (Hauptman et al 2008). A survey done of hospices in USA found that <10% had a policy regarding device deactivation of ICDs >50% had at least one patient that had been shocked (Goldstein et al 2010). Few families are approached about device deactivation. Only one in four families report discussing device deactivation. Twenty-seven out of 100 patients received a shock in the month prior to death. One third of patients with an ICD received a shock in the last few minutes of life (Allen et al, AHA statement in process).

This talk linked up with another presentation I attended relating to ethics in palliative care in patients with end stage heart failure. Dr. Beattie (UK) discussed every day ethical scenarios. Some examples of the scenarios he discussed I have described:

**A competent patient with an active ICD requests deactivation**

- Examine rationality of request
- Explore alternatives e.g. anti-arrhythmic therapy
- Exclude depression
- Accept

**Dying patient/distress: lacks decision making capacity-ICD active**

- Exclude any reversible elements that may impair functional capacity
- Seek guidance from carer on any previous declared policy
- Independent review by health care professional
- The best interest principle should apply

There is an ICD users group web site http://icdusergroup.com

For your interest there is also a position statement from the palliative care workshop of the heart failure association of the ESC that you can assess on their web site.

I would like to conclude by encouraging all members of INCA to apply for this bursary as it is a great way to travel and also to enjoy the educational experience of attending a conference.
I would like to thank the INCA for their bursary allowing me to attend the ESC Congress 2011 in Paris in August. An overwhelming 33,000 delegates attended this congress from all over the world.

There were so many interesting topic areas that it was difficult to attend all the sessions that would benefit my clinical practice. This congress covered all areas of cardiology such as, epidemiology, prevention, intervention, arrhythmias, valvular disease, diabetes, stroke, surgery and nursing among others. For the purpose of this summary, I will give an overview of the sessions on sleep apnoea, women and heart disease, smoking cessation and laughter and the heart.

**Obstructive Sleep Apnoea:** WT MacNicholas, UCD, Dublin commenced by identifying sleep apnoea as a risk factor for heart disease. It is defined as recurring apnoea (>5/hour) during sleep usually due to obstruction of the oropharynx. The symptoms include chronic fatigue, chronic headache, snoring (in 90% of cases), decreased sex drive. It is associated with daytime symptoms, particularly sleepiness and is one of the most prevalent chronic respiratory disorders. Most commonly found in men aged 40-59 years. There is evidence linking sleep apnoea to hypertension, stroke, cardiac arrhythmias, coronary artery disease and cardiovascular mortality. Sleep apnoea is prevalent in 50% of people with hypertension; 33% of patients with cardiovascular disease; 50% of patients with atrial fibrillation. Alarmingly, it is present in 70% of patients with stroke or TIA and sleep apnoea diagnosed after a stroke predicts worse functional outcome and is associated with greater mortality. Nocturnal arrhythmias, such as atrial fibrillation, AV block, non-sustained ventricular tachycardia occur in up to 50% of patients with sleep apnoea. It can predispose to the development of atrial fibrillation and increase the risk of sudden cardiac death. It is diagnosed by clinical assessment using the Epworth Sleepiness scale or Berlin Questionnaire and objective sleep monitoring. The gold standard for diagnosis remains the poly-somnography but it is expensive. The mode of diagnosis is a major area for current research comparing home versus lab assessment. The treatments are CPAP, decreasing weight, postural changes when sleeping and avoiding alcohol. CPAP is tolerated by 70% of patients and is found to be very effective but there is a lack of research due to the impossibility of giving placebo CPAP. Levy, France identified that the challenge is the growing prevalence due to the obesity epidemic and the logistics of assessing all suspected cases.

**Gender issue: Are women different?**

This session covered the topics of gender gap in cardiovascular risk factors, morbidity and mortality, whether under treatment of women influences outcome and treatment effects between men and women.

Dr. Diego Vanuzzo from Italy started the session by pointing out that cardiovascular disease is the leading cause of death in women in Europe, causing 54% of deaths compared to 43% in men. In 2008, the life expectancy in Europe was 82.4 years among women versus 76.4 among men. Italian data show that this major gap in life expectancy is due to CVD and cancer and importantly, that up to the age of 74, 62% of the difference is amenable to primary prevention. Several studies have found that smoking is a stronger risk factor in women than men. Dr Diego stated that life expectancy with disability is longer in European women than men.

Dr Sofia Sederholm Lawesson from Sweden presented the results of a study which reviewed...
the treatment of all STEMI patients in ICU between 1998-2000 and 2004-2006 to assess their treatment according to evidence based guidelines recommendations. This showed that there was a gender difference with respect to treatment and outcome in the first phase (1998-2000) which had not changed by the second phase (2004-2006). For example, 63.1% of women and 70.9% of men received reperfusion therapy. She stated that they had assumed with the shift towards primary PCI in the treatment of STEMI the gender difference would have diminished by the second phase but they were surprised when they actually found the opposite. It was also found that although the overall use of coronary angiography, beta blockers, ACE Inhibitors/ARB’s and statins had all increased from the earlier to later periods, the gender differences in their use still persisted. The in-hospital female mortality rate was higher than the male rate in both time periods. An explanation for the gender differences has also proved elusive, despite multivariate and age adjustments to the data. Dr Lawesson stated that the overall higher age of female STEMI patients will make a difference to treatment and outcome but it couldn’t explain all our results.

Dr Susanna Sans Menendez from Spain reviewed the evidence regarding whether undertreatment of women influences the outcome after cardiovascular disease. Studies have shown that women receive fewer cardiac procedures after myocardial infarction than men, and survival is poorer. In acute coronary syndromes, the Crusade study found that a smaller proportion of women than men received medical treatment within 24 hours and women also received less discharge medical treatment. As a result, short term fatal outcomes are more frequent in women. Part of the adverse outcomes are due to under-treatment compared to men. Dr Sans concluded that barriers that contribute to treatment differences in women, as well the influence of other clinical characteristics on differences in treatment patterns and outcomes among women and men require further investigation.

Laughter and the Heart

Professor Michael Miller, Preventive Cardiology, University of Maryland, Baltimore presented an interesting talk on how positive emotions can help protect the heart. He explained that laughter exerts its beneficial effects through the release of endorphins by the brain, which activates receptors on the endothelium which in turn lead to the release of nitric oxide. Nitric Oxide dilates the blood vessels, reduces inflammation, cholesterol deposition and clotting. He states that the type of laughter that protects the heart is not just a simple chuckle but mirthful laughter which is more of a deep belly laugh that brings tears to your eyes and this laughter needs to last for about 15 seconds. He describes a study on a group of 150 patients who had suffered an MI where laughter was looked at as an active player and studied the impact that positive emotions had on vascular reactivity. Using ultrasound, they measured the diameter of the brachial artery in 20 non-smoking healthy men and women who on one day watched clips of comedy films, while on another day watched the stressful opening sequence of Saving Private Ryan. The results showed that blood flow was enhanced by 22% in the group watching the funny film, but decreased by 35% in those watching the stressful film. Miller commented that the magnitude of the effects seen in the study were similar to the effects of exercise or taking a statin. There is a need for more research to examine the long term effects of laughter on cardiovascular health. In conclusion, Miller says he prescribes humour for all his patients.

As I work in Primary Prevention which includes smoking cessation, I attended a session on: Strategies for smoking cessation: policy and practice. Sidney Smith, WHO President, opened the session by stating that smoking kills 15,000 people per day worldwide, adding that second-hand smoke kills another 1000. The WHO Framework Convention on Tobacco Control (FCTC) is the most important initiative in tobacco control worldwide, reaching out to 87% of the global population. He pointed out
that the UK provides the most successful services for smoking cessation through the NHS. Ireland was marked as a high achiever and is the fourth strongest country in smoking cessation.

Dr Kornelia Kotseva and Dr David Wood from the UK presented the smoking data from the EUROASPIRE and the EUROACTION demonstration projects. EUROASPIRE showed that 17% still smoked one year after a coronary event and this rate was higher in the younger age groups. Below the age of 50, it was found that 27.8% and an alarming 88.6% of those who smoked before the coronary event still smoked one year later. In the EUROACTION project, no significant beneficial effect of the program on smoking cessation could be shown in either the high risk group or among the coronary patients. This was the reasoning behind the development of the EUROACTION PLUS trial. The aim of this was to determine if high medical risk smokers and their partners in a nurse-led family-based preventive programme (EUROACTION) with an intensive smoking intervention focus including an optional use of Varenicline (Champix) could achieve greater smoking abstinence. The subjects were randomised into either the intervention or usual care arm for the 16 week programme. Non-smoking status was validated by breath carbon monoxide testing. This resulted in a positive outcome- The nurse led EUROACTION PLUS preventive programme reduced smoking by half in high risk patients. Even the partners showed higher rates of smoking cessation: 73.1 vs 36.7%.

**Report Summary: ESC Congress Paris 27th to 31st August 2011**

Mary Kerins, Cardiac Rehabilitation, St James’s Hospital, Dublin.

Almost 30,000 people attended the ESC congress in Villepinte in Paris from August 28th to 31st; they included cardiologists, nurses, allied professionals, journalists and colleagues from industry.

The following are snippets of some of the sessions presented at the congress.

**Strategies for smoking cessation: policy and practice:**

This session on strategies for smoking cessation started with a presentation from Dr Sidney Smith (US). He stated that it is estimated that 15,000 people die every day due to active smoking and another 1000 people die due to second-hand smoke. He said that the WHO Framework Convention on Tobacco Control (FCTC) is the most important initiative in tobacco control worldwide, reaching out to 87% of the world population. In Europe, the United Kingdom (UK) provides the most successful services for smoking cessation through the National Health Service. Nevertheless, Europe appears to be lagging behind in legislation on smoke-free environments, on cigarette packaging and on picture pack warnings: There is need for improvement in government policies.

Dr Kornelia Kotseva and Dr David Wood (UK) both presented the smoking data from the EUROASPIRE III database and from the EUROACTION demonstration project. It was demonstrated that 17% still smoked one year after a coronary event. The prevalence of smoking in people under 50 was 27.8% and an astonishingly 88.6% of those who smoked before the coronary event still smoked one year later:

In the EUROACTION project, no significant beneficial effect of the program on smoking cessation was proven, among CVD patients or among those at high risk for CVD. Consequently EUROACTION PLUS trial was designed. This is a trial in general practice of a nurse-led prevention program among patients at high CVD risk and their partners, where the
optional use of the drug varenicline was used. This resulted in a positive outcome regarding smoking cessation: 51.2% had stopped smoking as compared to 18.8% in the control group. Even the partners showed higher rates of smoking cessation: 73.1 vs 36.7%. This success was due to a combination of the nurse led clinic and the programme. Patients were only included if they had agreed to stop smoking before entering the program, which resulted in 20% inclusion of the entire eligible population.

Erica Froelicher (US) demonstrated the exceptional guidance for smoking cessation programs (US surgeon general) that nowadays can be found on the Internet. There are clear step by step models for use in clinical practice. Intensive programs should consist of 4-7 sessions of 20-30 minutes lasting at least two weeks. She finished by stating that healthcare systems should be tailored to regularly recognize and intervene in cases of current smoking and that patients should be provided with personalized quit plans.

In a Nursing Symposium “let’s talk about sex” Elaine Steinke, Professor of Nursing at Wichita State University, Kansas, USA, stated that information about the resumption of sexual activity should be provided effortlessly, first in the hospital setting immediately before discharge, then during cardiac rehabilitation and finally in the primary care setting. Prof. Steinke believes that cardiologists, family doctors and nurses all have a proactive role to play in addressing patients’ sexual concerns.

A survey of 157 cardiovascular nurses questioned at the 2009 annual spring meeting on cardiovascular nursing in Dublin found that, while 87% agreed nurses had a responsibility to discuss patients’ sexual concerns, only one in ten frequently assessed their patient’s sexual health; and one in five felt they had insufficient knowledge to tackle the problem. Prof. Steinke said that it was an important issue for improving the quality of life of both patients and their partners. She also emphasised that age should not prevent an interest in having an active sex life.

An easy way to broach the subject, she suggested, was to talk about sex in the context of exercise or in conversation of cardiovascular disease in daily life.

The type of information which patients might find reassuring is on the energy requirements for sex, which have been estimated as the equivalent of 3 to 4 metabolic equivalents (METs) - which corresponds to mild-to-moderate physical activity. They might be reassured from the evidence that sexual intercourse is a low-frequency trigger for MI. In a survey of 1712 post-MI people, sex was a trigger in 1.5% of incidents compared with anger in 2.4%, heavy exertion in 4.9%, and psychological stress in 11.6%.

The information that MI patients most want to know is how soon they can safely resume their sexual relations Guidelines state that sexual intercourse can be resumed within a few weeks after an uncomplicated MI, but that longer is needed if the patient has required cardiopulmonary resuscitation or suffered hypotension, serious dysrhythmias or heart failure.

In addition patients need information about the warning signs of cardiac stress, such as chest pain, shortness of breath, rapid or irregular heart rate, dizziness, insomnia or extreme fatigue the day after sex. Healthcare providers should be told of all such signs. And it can help to advise them of the medications used in their treatment - thiazide diuretics, calcium channel blockers, beta-adrenergic blockers; vasodilators and lipid lowering agents can all affect sexual function. “Patients need to be told not to stop any drug without talking to their healthcare providers.

In conclusion, the congress provides a wealth of information in the form of symposia, oral abstracts and presentations, work-shops, debates, posters and much more. To find out additional information about the congress many of the reports and web casts can be accessed on www.escardio.org.
As usual a massive event, with on average 28,000 delegates a day and consequently the choice of presentations available to attend and listen to was a bit overwhelming. There were up to 20 concurring sessions on topics for 4½ days ranging from arrhythmias to valvular disease.

There were some interesting sessions in the prevention theme. It was indicated that in the future we might do well to consider HDL more, as HDL is very predictive of cardiovascular disease risk regardless of LDL-C. There was an interesting debate of diet versus drugs to reduce blood lipid levels. While diet alone could be enough to keep blood lipid levels to guideline level but it would need low or no dairy and meat to get the most benefit and this might lead to difficulty in adherence.

The cardiac rehabilitation symposia also had some interesting new points. While it was indicated that overall older patients are still less likely to be referred to cardiac rehabilitation it was also indicated that elderly men benefited most from rehabilitation. There was an interesting session on method of referral, indicating lots of patient related (age, co morbidities, motivation), system related (time, timing, who is responsible for referral) and professional related barriers to referral. It was surmised that to optimise referral and subsequent attendance not automatic but rather a systematic referral system that included, bedside discussion, written physician endorsement, mandatory field in case notes were factors that would improve attendance.

As we all know with the advancement of technology there has been much discussion on telemedicine especially in heart failure. There were two main sessions on this topic at the conference. There are many on-going studies in this area and there was a call for even more trails. The overview to date seems to be: that tele-monitoring should be referred to as tele-management, it should be part of a long term management approach, that it works best on a large scale, should use mobile technologies, assessment around the clock, follow-up for up to 12 months, integrated into present management and be incorporated into centres of excellence.

Fortunately the last session on the Wednesday 31st August was a highlight session where I was able to get an overview of what was considered some of the main “news” from the conference.

- The ARISTOTLE trail showed evidence that apixaban is superior to warfarin in the prevention of stroke in patients with atrial fibrillation and had less bleeding and lower mortality rates
- The PRODIGY trial, which showed that a 6 months dual antiplatelet therapy after stent drug eluding implantation was as effective as 24 months
- The EXAMINATION trial, which demonstrated a drug eluting stent were as effective as older treatments with regard to clinical endpoints but that the drug eluding stents had lower stent thrombosis and revascularization rates up to 1 year
- EUROHEART survey saw an increase in PTCI treatment for STEMI and NSTEMI but no changes in outcomes, it also indicated that there was higher mortality at weekends!
- The PURE registry found that the application of guidelines was particularly bad in low income countries where 80 % of cardiac patients received no medication at all
- STENTS versus CABG: from a death, MI and stroke point of view evidence showed that there were better benefits from surgery
- Heart failure patients with lung disease have worst prognosis
- Nurse led clinics showed a decrease in all-cause mortality by 22%
There were three new or updated ESC guidelines launched at the conference: Management of cardiovascular disease in pregnancy; Management of non-ST elevation acute coronary syndromes and Dyslipidaemias.

The conference though immense, did give attendees the opportunity to find out in particular about updates in current practice and the evidence for them but this did require careful examination of the timetable and selection of areas of interest. Overall there were 9 main topic areas each divided into 5 subsections, nursing was bundled with prevention, rehabilitation and sports as one of these subsections. Compared to other years there was only a small section of nursing research and symposia presentations, although there were some nursing presentations scattered in other areas such as prevention. The next ESC conference is in Munich ESC Congress for 25th – 28th August 2012, and there is also the Europrevent conference in Dublin in the spring, these are good opportunities to increase the dissemination of research findings from the nursing sector.

A Summary of Presentation – Irish Cardiac Society Cardiovascular Nurses Meeting Slieve Donard Hotel Newcastle Co Down. October 2011

Kate O’Donovan Post Graduate Diploma in Cardiovascular Nursing Facilitator, MMUH Dublin

The Irish Cardiac Society Cardiovascular Nurses Scientific Conference was held on Thursday 6th October in the Slieve Donard Hotel, Newcastle, Co Down. Mary Kerins President Irish Nurses Cardiovascular Association and Dr Carol Wilson President Irish Cardiac Soc jointly opened the conference. The keynote address was given by Dr Laserina O’Connor PhD, RANP, RNP in pain management from the Mater Hospital, Dublin. The focus of her presentation was on the Who’s Who in Cardiovascular Nursing: Challenges for the future. Laserina outlined how we as nurses have lost the “Art” of nursing and split the world of the clinician from that of academician. Instead the need for both to improve patient care was highlighted. With the advent of nurse specialists, advanced nurse practitioners and PhD qualifications Laserina advocated valuing each other’s contribution to the totality that is nursing and that as nurses we should work as a community in cardiovascular practice, rather than separate disciplines. The principles of this community were outlined as acting as a vehicle for collaboration; novices mix with experts, lecturers mix with practitioners and where the mentor is the expert in clinical practice.

- ASCOT follow up, still see benefits of statins even in non-cardiac deaths
- ONTARGET trial: with better adherence get better outcomes; patients with poor adherence who had a subsequent event were even worse adherers after the second event; aging, females, ethnics, low physical activity, smoking, diabetes and neuropsychiatric disorders are predictors of medication non-adherence.
- Beneficial effects of chocolate consumption shown, but little indication of dose required
- Ikaria study on a population from this Greek island where approximately 30% of the population lives to 90. Traits common in this population: good diet: fruit, vegetables, olive oil, wine, social cohesion and engagement, living with family and having a nap every day!
- There was significant discontinuation of Clopidogrel treatment after MI in primary care which was associated with adverse outcomes

For more detailed information on the conference: http://www.escardio.org
Laserina aptly concluded her keynote address by advising the audience to think with your head and your heart!

Following on from the keynote address Lucy Blennerhasset Chest Pain Nurse Specialist in St James’ Hospital Dublin gave a presentation on her experience of the nurse-prescribing pathway. This presentation provided an overview of the highlights and challenges encountered when undertaking the nurse-prescribing course. The experience goes beyond successfully completing the course where one needs to secure the support from their medical colleagues as well as establishing guidelines and policies for prescribing specific medication when then needs to be passed by local medicines board and equivalent committees. Lucy gave the audience a lot to think about in relation to nurse prescribing and its position within cardiovascular nursing.

Lucy’s presentation was followed by Sinead Teehan CNS, Interventional Cardiology, St James’ Hospital Dublin. Sinead gave an overview of her experience in achieving CNS role in the Cath Lab including site preparation, service need requirements, the need for supervised practice and the rationale to expand and evolve the role clinically to meet the needs of the cardiovascular patient in the cardiac catheterisation lab. Sinead provided an overview of her job description as CNS and what her typical day involves. Sinead concluded her presentation by highlighting the service provided in St James’ Cath Lab and how this influences her role as CNS.

Diverging from the theme of specialisation and role expansion in cardiovascular nursing, I gave a presentation on Iron Deficiency Anaemia in Heart Failure which focused on the pathophysiology, symptoms, treatment options and the specific nursing care that those suffering from iron deficiency anaemia should receive. Currently in Europe there are 15 million patients with heart failure. Of those 22 –37% will experience iron deficiency anaemia, which negatively impacts on functional capacity and quality of life. It has also been identified as an independent risk factor for hospitalisation and mortality. Causes for this form of anaemia in this specific population include poor nutrition, cardiac cachexia and malabsorption of iron from the intestine. I then went on to illustrate treatment options drawing on the findings from the FAIR HF trial, which examined the role of intravenous iron supplementation in those with heart failure. The findings from this trial demonstrated that intravenous supplementation was superior to oral supplementation where patients demonstrated an increase in their haemoglobin levels, improved ventricular function as well as a reported improvement in their quality of life and their functional capacity. I concluded the presentation by highlighting further innovations in iron deficiency anaemia such as a role for statins.

Geraldine Lynch Chest Pain Nurse Specialist, Blackrock Clinic Dublin, gave the last presentation in the morning session. Geraldine provided an overview of a young patient who presented to the chest pain clinic with a 4-week history of exertional chest pain. The focus of the presentation was the role of stress testing in risk stratifying those patients who present with chest pain. Geraldine provided the audience with the rationale for using stress tests where the goals of an early stress test include the ability to identify high-risk patients, to avoid inappropriate discharge and to rule out acute coronary syndrome. Geraldine gave an synopsis of the stress test findings and how it influenced patient care and intervention.

The morning session concluded following this presentation and was very educational and enjoyable.

The afternoon session was scribed by Dr. Gabrielle McKee, Assistant Professor, Trinity College Dublin and Geraldine Lynch, Chest Pain CNS, Blackrock Clinic, Dublin.

Expanding Cardiovascular Care

Dr Donna Fitzsimons, Vice President of CCNAP (Council on Cardiovascular Nursing and Allied
Professions) opened the afternoon with her keynote address titled Building Networks to advance Cardiovascular Nursing. Donna opened her talk by observing that although there are a great variety of roles in cardiovascular nursing each with their specialized needs but all serve to reduce the burden of CVD in Europe and how building networks was essential to advance cardiovascular nursing. In her capacity as vice chair of CCNAP she discussed how the ESC could advance this agenda through its multifaceted functions including provision of information, research guidelines, networks, fellowships links to other health bodies and linking with other societies throughout the world. It has been decided that CCNAP title is to be changed to Eurocare to better encompass the allied professionals. Many advantages of being a member in particular opportunities to contribute to education and research propose sessions etc were outlined. For example it has facilitated network development in Northern Ireland and the linking of these networks to even wider clinical networks. These networks provide support from portfolio development to ethics application, sharing work and experience, developing better quality research influencing guidelines and quality developing professionally and ultimately improving patient care.

For further information on CCNAP see: http://www.escardio.org/comunities/councils/CCNAP

Cecilia Tracy, ANP candidate from the Mater Hospital Dublin presented a lovely heart failure case study on a difficult diagnosis of a 46 year old women presenting with chest discomfort, dyspnoea and fatigue. Many signs indicated NSTEMI, she had an EF (ejection fraction) of 30%, and an angiogram that showed no significant coronary artery disease so the diagnosis was initially thought to be heart failure. An appropriate treatment plan including education, support, non-pharmacological lifestyle interventions and pharmacological interventions were put in place including attendance at the heart failure clinic. Poor resolution of symptoms followed, although the EF improved somewhat and additional symptoms presented including weight gain, irritability, cold intolerance and aches and pains in joints. Hypothyroidism was found to be the root of the problem.

Scribed By Geraldine Lynch, Chest Pain CNS, Blackrock Clinic, Dublin

Dr. Sally Doherty, School of Psychology, NUI Galway presented her study on Cardiac Health and Assessment of Relationship Management and Sexuality. This interesting Irish based study was based on the impact of cardiovascular disease on sexual relationships. Most patients felt comfortable discussing this intimate subject with their healthcare professionals. A reduction in energy levels which may be secondary to medication was also highlighted in the study. This generated discussion relating to the importance of healthcare professionals addressing sexuality with patients as part of their therapeutic relationship. It was also stressed that educating patients about the possible side effects of drugs such as beta-blockers, which can cause impotence, should be discussed. Recommendations were made to ensure that patients should be advised to inform their clinician of any possible side effects which may have a negative impact on them and their partner’s relationship.

The final speaker was Dr. Angie Browne, Medical Director of the Irish Heart Foundation. Dr. Browne delivered an excellent presentation in Primary Prevention in Hyperlipidaemia. She demonstrated that atherosclerosis can commence during our teenage years and highlighted the importance of good lipid management and advice in both patients with a low and high risk of developing cardiovascular disease. In addition she looked at statin therapy for patients with known cardiovascular disease. Dr. Browne recommended requesting a full lipid profile in order to enhance lipid management.
A very successful Autumn Evening Meeting was hosted by INCA on Thursday November 10th in the Davenport Hotel in Dublin. We are extremely grateful and would like to express our sincere thanks to MSD who very kindly sponsored the meeting.

The meeting was well attended and there was a large group of nurses present with an interest in heart failure. We were honoured and delighted to have Professor Debra Moser, University of Kentucky as a guest speaker. Professor Moser has vast experience and is very well published in cardiovascular nursing with a particular interest in heart failure management and research. We are grateful to our committee colleague Dr Gabrielle McGee who arranged the presentation. A brief synopsis of Prof Moser’s talk is now presented.

Improving Patient Outcomes by Promoting Self Care of Heart Failure: What Makes a Patient “Expert” in Self-Care?

Prof Moser focused on self-care in heart failure management with a kernel question ‘Self-Care: What is it?’ She outlined why self-care is so important in heart failure, she alluded to the concept of an expert and what this is. She reviewed ideas on what makes a self-care expert. The whole focus of her talk was better outcomes for patients and her thesis is that good self-care contributes in the prevention or early detection of health problems, leads to better overall health and quality of life, results in improved clinical outcomes and reduced healthcare costs and it is a naturalistic decision-making process.

In reality, as highlighted by Prof Moser most heart failure care is done by patients and their families at home and we need to equip them with the self-care skills to manage. Prof Moser posed the question as to why self-care is so important. She then presented research evidence to show that HF most common cause of hospitalization in Western countries. Her research is all about improving outcomes and she referenced many research studies in support. Her simple message was that a self-care expert is someone who can overcome all the obstacles to effective self-care. Prof Moser posited that the art of improving self-care requires nursing interventions to allow clients to build skill in self-care, build confidence in self-care, to overcome barriers to self-care and also requires the nurse to engage family and other informal caregivers.

Prof Moser spoke about future research and in her opinion the dynamics of self-care decision making needs further research. She proposed systematic research efforts with a sound theoretical basis, uni-dimensional studies are not helpful and studies must build on previous findings. An interdisciplinary perspective should be used and biological and psychological viewpoints need to be integrated. Her final point was that it is essential to examine not only bad self-care but also expert self-care. Prof Moser’s research is easily available online and a literature search on her work will provide valuable research to guide practice.

An expert group Scientific Statement from the American Heart Association - Promoting Self-Care in Persons With Heart Failure, (Riegel B, Moser DK et al 2009) is available online at: www.americanheart.org/downloadable/heart/125200343471520090903_slideHF_Self-Care.pdf
Oral Presentations

We are very grateful to both Michelle Lynch and Mary Kingston for presenting reports from the ESC Congress in Paris at the autumn evening meeting. Mary and Michele were the recipients of the ESC Congress Travelling Fellowship very kindly sponsored by MSD. Again we thank MSD for their continued support for this fellowship which provides an excellent opportunity for attendance at the congress. A brief synopsis of the presentations is now represented; both presentations are available on the INCA website.

Michelle Lynch CNS Emergency Cardiology Emergency Department/Chest Pain Assessment Unit St. James’s Hospital.

Michelle presented an excellent, detailed and informative paper: Updates on the ESC Guideline for NSTEMI 2011. She initially outlined all the updated or new guidelines 2011 which are available on the ESC website.

- ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST elevation
- ESC Guideline on the management of cardiovascular diseases during pregnancy
- ESC Guideline on the diagnosis and treatment of peripheral artery disease
- ESC Guideline for the management of dyslipidaemias

The focus of Michelle’s presentation was on the new NSTEMI Guidelines for 2011 which replaced the 2007 version, as this is linked to her area of practice. The main question was: what is new? In a detailed and comprehensive paper Michele discussed changes to diagnostics, changes to risk stratification, changes in medical treatments, revascularisation and the management of special populations. It is beyond the scope of this report to discuss the changes, to reference to the new guidelines and to update yourself on the changes please refer to the ESC website. Michele’s presentation can also be viewed on the INCA website.

The second oral presentation at the evening meeting from the ESC Congress was ‘Aortic Valves – What is new’ and was presented by:

Mary Kingston Advanced Nurse Practitioner in Cardiothoracic Care in St. James’s Hospital.

Mary presented an excellent and informative paper reporting the congress highlights from her area of practice. She covered many interesting points in relation to valve heart surgery. Again for the purpose of this report a brief synopsis is presented, Mary’s presentation is available on the INCA website.

Mary gave an overview of the TAVI procedure: Transcatheter Aortic Valve Implantation. This was introduced in 2002 by Alain Gribier, it is performed in patients with severe aortic stenosis considered at high risk for surgical valve replacement. The procedure has been carried out in 40,000 patients worldwide. The question was posed: ‘Can TAVI be considered an alternative option to surgery for lower risk patients? Mary presented the research to answer the question and the research results represent a first step towards a broader assessment of percutaneous techniques in populations at lower surgical risk.

Mary then discussed aortic valve repair and how valve reparability is assessed. The discussion covered the prerequisites to successful aortic
valve repair. The message from the presentation was the importance of a thorough, accurate and appropriate valve analysis to determine the mechanism of valve dysfunction. Both TOE and Cardiac CT allow for accurate valve assessment. The following points were made in relation to Aortic Valve Repair:

- Both transesophageal echocardiography and cardiac CT allow for accurate delineation of the mechanism of aortic regurgitation.
- In both type I and type II dysfunction by echocardiography or CT, the likelihood of successful and durable repair is > 90%.
- In type III dysfunction by echocardiography or CT, the likelihood of repair does not exceed 50%.
- More than 40% of attempted repairs in type III dysfunction fail within the next 4 years.

Mary Concluded that TAVI may be an option for lower risk surgical patients in the future and that the feasibility of aortic valve repair for aortic valve regurgitation should be considered.
DATES FOR YOUR DIARY

NATIONAL MEETINGS

• INCA Annual Scientific Meeting, Tullamore, Friday March 30th 2012

EUROPEAN MEETINGS

• 12th Annual CCNAP Spring Meeting on Cardiovascular Nursing Copenhagen March 16th & 17th 2012
• EuroPRevent, Dublin, Ireland 3rd to 5th May, 2012
• ESC Congress Munich, Germany August 25th-29th

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

Any submissions or suggestions for the newsletter? Please submit to Rita Smith Newsletter Editor C/O Admin@incanursing.ie