Broadening the real world of health care: what we can do for heart failure patients

I read the editorial of M. R. Cowie[1] with great interest. The figures on the prognosis of heart failure were admirably clear. Nobody can deny the grim prognosis of heart failure patients, as reported by Mosterd and colleagues in the article to which the editorial refers[2]. Cowie identifies patients who are likely to do especially badly: the very old, those with impaired renal function, diabetes and low blood pressure.

It surprised me, however, that Cowie writes that we have disappointingly little to offer these sick, old patients with serious co-morbidity.

It is generally recognized that several non-pharmacological management programmes can offer a lot to patients with advanced heart failure. These programmes often include components such as close follow-up, optimal medical treatment, intensive patient education, early attention to signs and symptoms and increased access to health care providers[3]. In several studies, these management programmes demonstrated positive patient outcomes. Both clinic and home based interventions are tested for effectiveness. Outcomes include lower readmission rates and hospital readmission days, improved quality of life and functional capacity and a survival advantage[4–5].

As Cowie states, increasingly complex poly-pharmacy is a challenge for health care providers in many European countries[6]. In a comprehensive heart failure management programme these problems are optimally addressed. Complex medication schedules are simplified if possible and patient-tailored solutions are sought to improve patient compliance, relieve distress from side-effects and avoid medication interactions. A heart failure (nurse) specialist often liaises with other specialists to co-ordinate the complex care needed for the different co-morbidities.

However, there is still a lot to be done. The results of several studies indicate that is necessary to broaden the ‘real health care world’ with a multidisciplinary approach, offering the severely affected heart failure patient maximal treatment and care.

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References


A reply

Jaarsma makes the important point that comprehensive heart failure management programmes have much to offer patients with heart failure. I have run such a service for several years and I agree that this approach can optimize patient concordance with lifestyle and pharmacological management, improve patients’ and carers’ knowledge about the disease, and reduce the risk of repeat hospitalization. However, the majority of such programmes only enrol patients after they have been stabilized in hospital and are about to be discharged home. The highest risk period for death is within the first few weeks of diagnosis, especially if the heart failure occurs in the context of acute myocardial infarction[7–9].

Elderly patients with low blood pressure and renal impairment do poorly, and indeed they may not even survive to leave hospital.

I agree with Jaarsma that management programmes for patients with heart failure need to be designed with the needs of the elderly in mind — to do otherwise would be nonsensical. The majority of patients with heart failure are elderly. In population-based studies in the developed world the average age at first presentation with heart failure is approximately 75 years[10–12].

We should be realistic about the current state of play. Even with best possible management the mortality of heart failure is high. Our patients are entitled not only to best evidence-based care, but also to realistic information about their condition and its likely impact on their life expectancy.

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References


Chronic heart failure guidelines

The update on the guidelines for the diagnosis and treatment of chronic heart failure is timely[11].
However, it is disappointing to see palliative care merited just one sentence in the guidelines. In England and Wales, palliative care for heart failure is part of the National Health Service framework for coronary heart disease. More guidance would have been welcome.

I have reservations about the advice on the use of spironolactone, as it does not reflect the use in the RALES study. The RALES study was designed to test the hypothesis that a 25 mg dose of spironolactone will decrease mortality. The dose of spironolactone was increased from 25 mg to 50 mg if there were signs and symptoms of progression of heart failure without evidence of hyperkalaemia, not if symptoms persevered as stated in the guidelines. Also the mean dose of spironolactone in RALES was 26 mg, so probably most patients were on a daily dose of 25 mg. Twenty-five milligrams was selected as serious hyperkalaemia (potassium 6 mmol. l−1 or greater) occurred with a dose of 50 mg or higher. In practice it is wise not to increase the spironolactone dose above 25 mg without compelling reasons. More attention should be paid to optimizing other medications, such as ACE inhibitors, before increasing the dose of spironolactone.

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References

Beta-blockers in chronic heart failure

I truly appreciate the recent publication ‘Guidelines for the diagnosis and treatment of chronic heart failure’. However, I do not agree with the statement on page 1544 that ‘exercise capacity usually does not improve’ with beta-blockers, since at least six clinical studies[2–7] have consistently shown an increase in exercise capacity in patients with heart failure with two different beta-blockers, metoprolol and carvedilol. According to these data, I believe that beta-blockers appear to provide a potential improvement in exercise capacity in patients with chronic heart failure.

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References


A reply

We thank Dr Shetty for correctly noticing the obvious mistake in the ESC Guidelines for diagnosis and treatment of chronic heart failure[1] in Table 18: ‘Administration and dosing considerations with spironolactone’, where the wording should have been ‘If after 1 month symptoms progress and normokalemia exists, increase to 50 mg daily’. This mistake was noticed after publication and corrected in an erratum which appeared in Eur Heart J 2001; 2217–8.

Indeed, in the RALES study progression of heart failure after 1 month occurred in a small percentage of patients[3]. At 18–24 months, only 12% of patients on active treatment received 50 mg daily, as compared to 27% in the placebo group. Thus, compelling reasons to increase the dose after 1 month’s treatment with 25 mg spironolactone were present only in a small percentage of patients with advanced heart failure. As the guidelines emphasize that patients should first be treated with optimal dosages of ACE inhibitors and beta-blocking drugs (the group which did very well in RALES) it is likely that in clinical practice, if the guidelines were followed, the percentage of patients which need the higher dose of spironolactone will be also small, as it was in RALES.

We also thank Dr Stoschitzky for his appreciation of the ESC Guidelines. However, he questions the statement about lack of improvement of exercise performance by beta-blockers and he refers to five trials[3–7]. Only two of these trials were placebo-controlled, while the other four were active comparisons between carvedilol and metoprolol. Krum et al. studied a small group of very symptomatic patients[3]. There was a slight but significant improvement in the 6 min walk test compared to placebo. In the other placebo-controlled trial, Metra and co-workers found no effect from carvedilol on peak exercise duration in 20 patients from each group. However, they found a marked and significant improvement in submaximal bicycle exercise[4]. Kukin et al. showed a small but significant increase in peak VO2 with both carvedilol and metoprolol in 67 patients[5]. In a larger trial, Metra et al. found an increase in the 6 min walk test with both carvedilol and metoprolol while metoprolol but not carvedilol increased peak VO2 slightly[6]. Sanderson et al. found a significant but small increase in the 6 min walk test with both carvedilol and metoprolol, but once again no difference and no placebo group[7].