We thank Strømgard and Dahlström for highlighting the structured clinical care programmes often used in Swedish hospitals. In our discussion, we clearly point out that we do not know why the prognosis for patients hospitalised for heart failure has improved.1 We discuss different possibilities and it is very likely that improved medical treatments of hypertension, ischaemic heart disease and heart failure, which have been demonstrated in big outcome studies, is of great importance for the beneficial results. We also discuss how to provide these treatments in a clinical setting. The evidence for benefit from special care programmes of patients with heart failure is limited but it is reasonable to believe that an organised treatment regimen is favourable as this care will help to disseminate evidence-based treatments. We referred to home-based care because it shows one extreme possibility.2 More recent findings from Sweden with a limited number of patients support the value of nurse-led clinics.3 Nurse-led clinics are also recommended in the ESC guidelines.4 However, as discussed elsewhere, we do not know why structured care may be successful.5 The content of the components of structured care would be important to assess for our understanding of the importance of this type of care.

Until now, we have reason to speculate upon the importance of this care but as Strømgard and Dahlström point out, the results are not unambiguous. Accordingly, we do believe that nurse-led clinics are important. However, we do not know why this care may be beneficial and we do not know the relation between special care and the documented effects of medicines. Until then, each organisation has to find the optimal way to provide evidence-based treatments. In Sweden, nurse-led clinics in this context have now been established.

References


Anna Strømgard
Ulf Dahlström
Department of Cardiology
Linköping University Hospital
Department of Medicine and Care
Linköping University
S-581 85 Linköping, Sweden
Tel.: +46-13-227762
E-mail address:
anst@inv.liu.se (Anna Strømgard)


Many factors contribute to improved prognosis for patients with heart failure: Reply

We thank Strømgard and Dahlström for highlighting the structured clinical care programmes often used in Swedish hospitals. In our discussion, we clearly point out that we do not know why the prognosis for patients hospitalised for heart failure has improved.1 We discuss different possibilities and it is very likely that improved medical treatments of hypertension, ischaemic heart disease and heart failure, which have been demonstrated in big outcome studies, is of great importance for the beneficial results. We also discuss how to provide these treatments in a clinical setting. The evidence for benefit from special care programmes of patients with heart failure is limited but it is reasonable to believe that an organised treatment regimen is favourable as this care will help to disseminate evidence-based treatments. We referred to home-based care because it shows one extreme possibility.2 More recent findings from Sweden with a limited number of patients support the value of nurse-led clinics.3 Nurse-led clinics are also recommended in the ESC guidelines.4 However, as discussed elsewhere, we do not know why structured care may be successful.5 The content of the components of structured care would be important to assess for our understanding of the importance of this type of care.

Until now, we have reason to speculate upon the importance of this care but as Strømgard and Dahlström point out, the results are not unambiguous. Accordingly, we do believe that nurse-led clinics are important. However, we do not know why this care may be beneficial and we do not know the relation between special care and the documented effects of medicines. Until then, each organisation has to find the optimal way to provide evidence-based treatments. In Sweden, nurse-led clinics in this context have now been established.

References


5. Ekman I, Swedberg K. Home-based management of patients with chronic heart failure; focus on content not just form!. Eur Heart J 2002;23(17):1323.

Maria Schaufelberger
Annika Rosengren
Karl Swedberg
Department of Medicine
Sahlgrenska University Hospital/Ostra, S-416 85
Göteborg, Sweden
Tel.: +46-31-3434000
Fax: +46-31-259254
E-mail address:
maria.schaufelberger@hlj.gu.se
(M. Schaufelberger)

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Contrast agent nephropathy

Dear Sir

The meta-analysis in the Lancet 23 August 20031 concluded that acetylcysteine significantly reduces the risk of contrast nephropathy in patients with chronic renal insufficiency, and that the relative risk of contrast nephropathy was not related to the amount of radio contrast media given. Yet, as we see from a recent issue of the European Heart Journal, doubt seems to remain concerning both questions2-4. Is it not time to do a large multi-centre trial?

References


Peter Nicol
Christian Axelson
Department of Medicine
Köping Hospital
Glaspagatan 4, 731 81 Köping, Sweden
Tel.: +46-221-26000
Fax: +46-221-26515
E-mail address: peter.nicol@ttvastmanland.se (P. Nicol)

Contrast agent nephropathy: Reply

N-Acetylcysteine (NAC) may prevent contrast agent associated nephrotoxicity (CAN) in patients with chronic renal insufficiency by avoiding direct oxidative tissue damage and also by improving renal haemodynamics. Tepel et al.,1 first reported that NAC (600 mg orally twice daily) plus hydration is more effective than hydration alone in preventing CAN. A recent meta-analysis evaluating over 800