

British Society for Heart Failure 13th Annual Autumn Meeting

The major issue discussed at the 2010 Annual Meeting of the British Society for Heart Failure (BSH) was the new National Institute for Clinical Excellence (NICE) guideline on management of chronic heart failure and how best to implement its recommendations in primary and secondary care.

The guideline, issued in August last year, is a partial update of the original 2003 guideline. One of the major changes relates to diagnosis. It is now recommended that in patients with suspected heart failure general practitioners (GPs) should measure plasma B-type natriuretic peptides (BNP or N-terminal proBNP), with referral for echocardiography depending on results of this test. (The exception is patients with previous myocardial infarction who are at particularly high risk and should go straight to echocardiography).

Abdallah Al-Mohammad (Sheffield), who was clinical adviser for the NICE guideline, said that the guideline had simplified, but not compromised, diagnosis. "The diagnostic algorithm is based on clinical and cost-effectiveness evidence, as well as pragmatic clinical opinion," he said.

Allan Struthers (Dundee) explained that natriuretic peptide measurement was a good rule-out test for heart failure but a poor rule-in test. Specificity was poor because levels could be increased by pathologies other than heart failure, including left ventricular hypertrophy, myocardial ischaemia, pulmonary embolism, renal failure and chronic obstructive pulmonary disease (COPD). He emphasised that levels were raised in both heart failure with left ventricular systolic dysfunction and in preserved ejection fraction.

Prof Struthers drew attention to the fact that natriuretic peptide levels were reduced by obesity and by drug therapy, such as diuretics and angiotensin converting enzyme (ACE) inhibitors, which patients might already be taking for some other indication.

The conference heard that only 24% of a recent sample of 150 GPs had access to natriuretic peptide testing. But it was suggested that availability should improve now that the test is recommended in national guidance.

One controversial issue relating to the NICE guideline that was aired at the conference is when to refer patients to a

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Dr Theresa McDonagh.

specialist. NICE says that 'specialist assessment' is needed to confirm an initial heart failure diagnosis.

Dr Al-Mohammad said that this meant a face-to-face consultation with a consultant physician, not a GP with a special interest in heart failure. Theresa McDonagh (London), chair of the British Society for Heart Failure (BSH), agreed that consultants must see new patients and patients admitted to hospital. These were the patients at highest risk. The consultant needed to determine the aetiology of the patient's heart failure and initiate a management plan. But consultants did not need to see patients for routine follow-up.

Dr McDonagh also reported the latest data from the national heart failure audit, which covers the care of patients with an unscheduled admission to hospital with heart failure. The new data show that patients admitted to specialist care are more likely to be discharged on evidence-based drug therapy and more likely to have specialist heart failure follow-up, compared with patients treated on a general ward, and that both these factors are associated with

better survival. In light of these data, the BSH hopes to get funding for a feasibility study of heart failure units, similar to the current arrangement for stroke units.

Simon Woldman (London) suggested that for secondary care the challenge of the NICE guideline would be ensuring enough consultant appointments to see all new patients. "This should be possible with some reorganisation of services," he said.

On treatment, NICE emphasises that all patients with heart failure due to left ventricular systolic dysfunction should receive both ACE inhibitor and beta blocker therapy. Suzanna Hardman (London) said that there were many 'historical' reasons for not using beta blockers in heart failure but that the drugs could safely be used in the elderly, and in patients with peripheral vascular disease, diabetes, erectile dysfunction and COPD (unless there was clear reversibility).

In an update on telemonitoring, Martin Cowie (London) said that many physiological features could now be remotely monitored, either with stand-alone systems or implanted systems.

There was increasing evidence of the benefit of remote monitoring and this technology would become important for selected patients with heart failure within the next 5-to-10 years. However, the evidence base was not yet robust and it was not clear, for example, what was the best combination of variables to monitor or the best method of displaying the data for appropriate decision-making.

Another major topic discussed was patients' unmet needs, which included cardiac rehabilitation (which still has low use in patients with heart failure), advance care planning and end-of-life care. Jim Beattie (Birmingham) said that one of the important challenges in end-of-life care was the issue of when to deactivate a patient's implantable cardioverter defibrillator (ICD). Cardiologists must not forget to discuss this, and they had to accept the patient's decision. ●

Visit www.bsh.org.uk for further information about the society, this meeting and future conferences.

