December Clinical Pearl

American Heart Association Update

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At the recent American Heart Association (AHA) Annual Scientific Sessions in Orlando, FL, numerous research and clinical presentation were made regarding care of heart failure (HF) patients. The following clinical pearls are worth passing along to AAHFN members:

1. **Back to Basics: The most important assessment data comes not from sophisticated imaging or invasive testing, but from your interaction with your patients.**

The single most important marker of intravascular volume is jugular venous pressure. Data from the ESCAPE trial showed that estimated hemodynamics from history and physical examination (H & P) reflect invasive measurements and predict outcomes in advanced HF. The H & P allowed accurate estimation of right atrial pressure and reasonable discrimination as to whether left-sided filling pressures were elevated or not.\(^1\) Another sensitive indicator of hemodynamic status was the “warm/cold – dry/wet” categorization, in which clinicians estimate cardiac output by classifying patients’ circulation as “warm” or “cold” and their volume based on JVD as “dry” or “wet”. Those who fall into the combined category of “cold and wet” have the poorest prognosis.\(^2\)

2. **Non-invasive monitoring can be useful in determining which HF patient will benefit from revascularization**

Revascularization in patients with HF improves survival only when patients have viable, or hibernating, myocardium.\(^3\) Hibernating myocardium can be identified by positron emission tomography (PET), contrast enhanced magnetic resonance imaging (MRI) or single-photon emission computed tomography imaging (SPECT). For those with moderate left ventricular (LV) dysfunction, all imaging modalities are efficacious. For those with severe LV dysfunction, PET and contrast-enhanced MRI are superior to SPECT and dobutamine echo.\(^4\) Randomized trials are needed to confirm these early reports.
3. The “Techno Highway” vs. the “Road Less Travelled”: Helping HF patients make end-of-life choices

Dr. Lynne Warner Stevenson noted that we are very good at helping patients choose options aimed at preserving the quantity, but not necessarily the quality, of their lives. While many patients will continue to choose life-extending care, many can make key decisions regarding the quality of both life and death. She advocated: 1) gradual transitions in our messages to patients as they move from an initial HF hospitalization, through multiple rehospitalizations, to declining prognoses, and 2) changing “Do Not Resuscitate” to “Allow Natural Death”. She advocated early introduction of hospice to supplement, not replace, connections of patient and family to the health care team.


