

# 62<sup>o</sup> CONGRESSO NAZIONALE SICCC

21-22 DICEMBRE 2017  
Firenze - 2 dicembre

INVECCHIAMENTO: SCEGLI

PROGRAMMA PRELIMINARE

**ADERENZA ALLE LINEE GUIDA NELLA GESTIONE DEL PAZIENTE**

**ANZIANO CON SCOMPENSO CARDIACO ACUTO:**

**DATI REAL-WORLD DAL REGISTRO **ATHENA**.**

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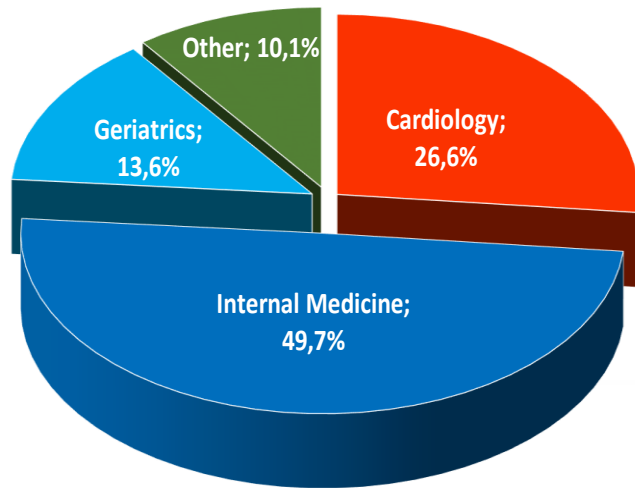
**Azienda  
Ospedaliero  
Universitaria  
Careggi**



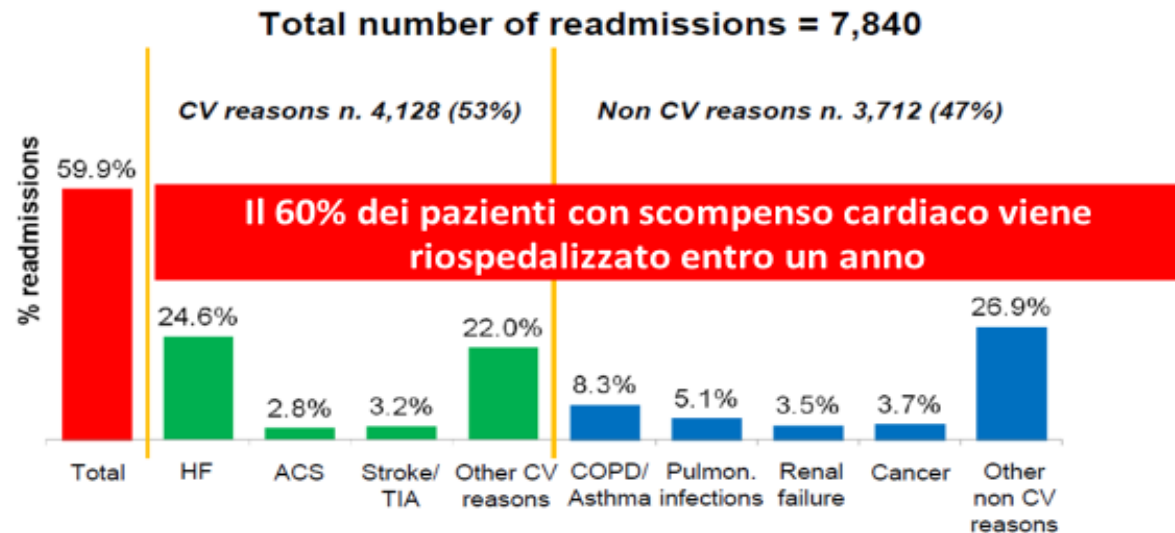
 **SOCIETÀ ITALIANA  
DI GERONTOLOGIA  
E GERIATRIA**

# The real-world evidence of heart failure: findings from 41 413 patients of the ARNO database

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Età media 78y

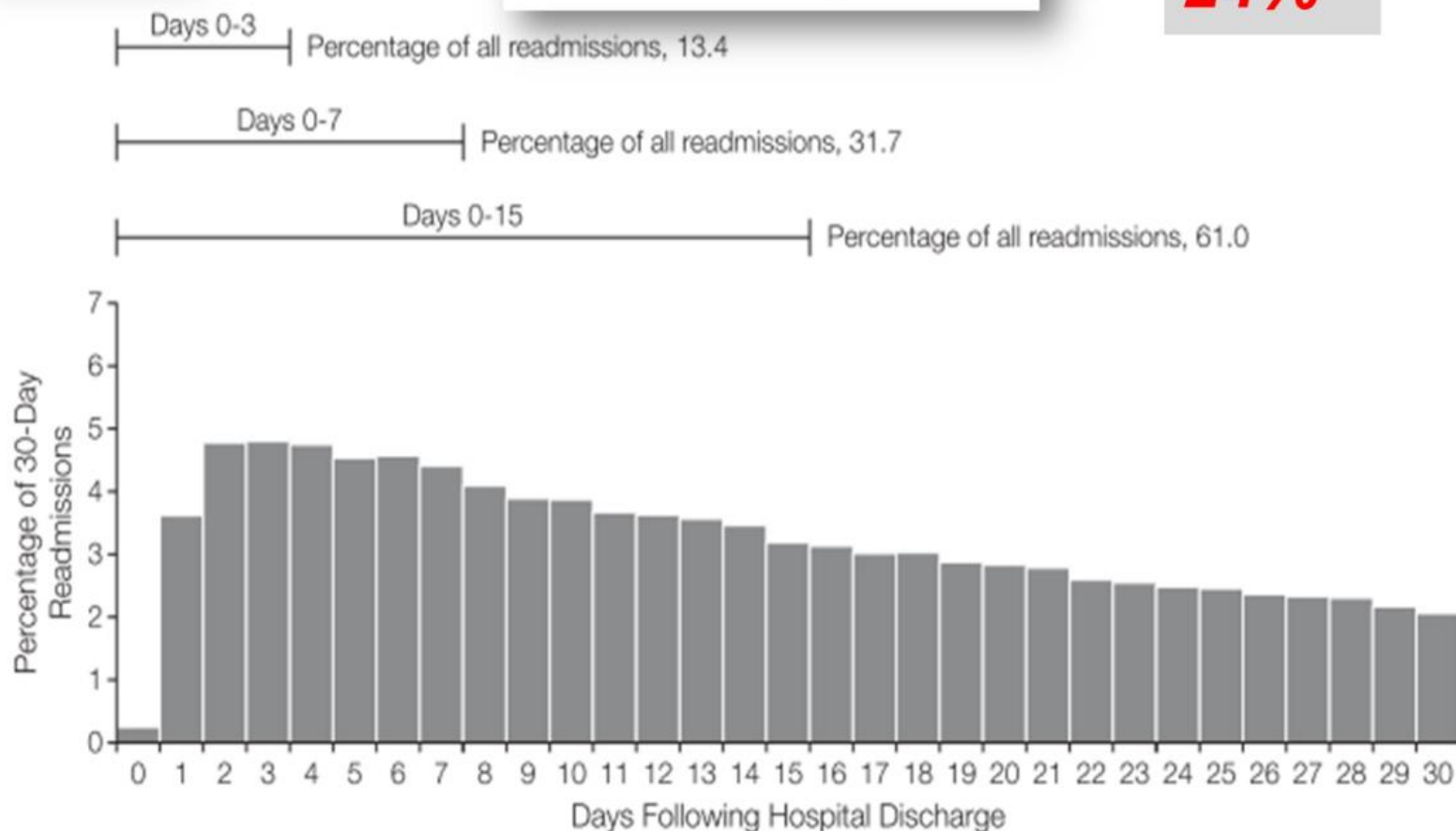




# Diagnoses and Timing of 30-Day Readmissions After Hospitalization for Heart Failure, Acute Myocardial Infarction, or Pneumonia

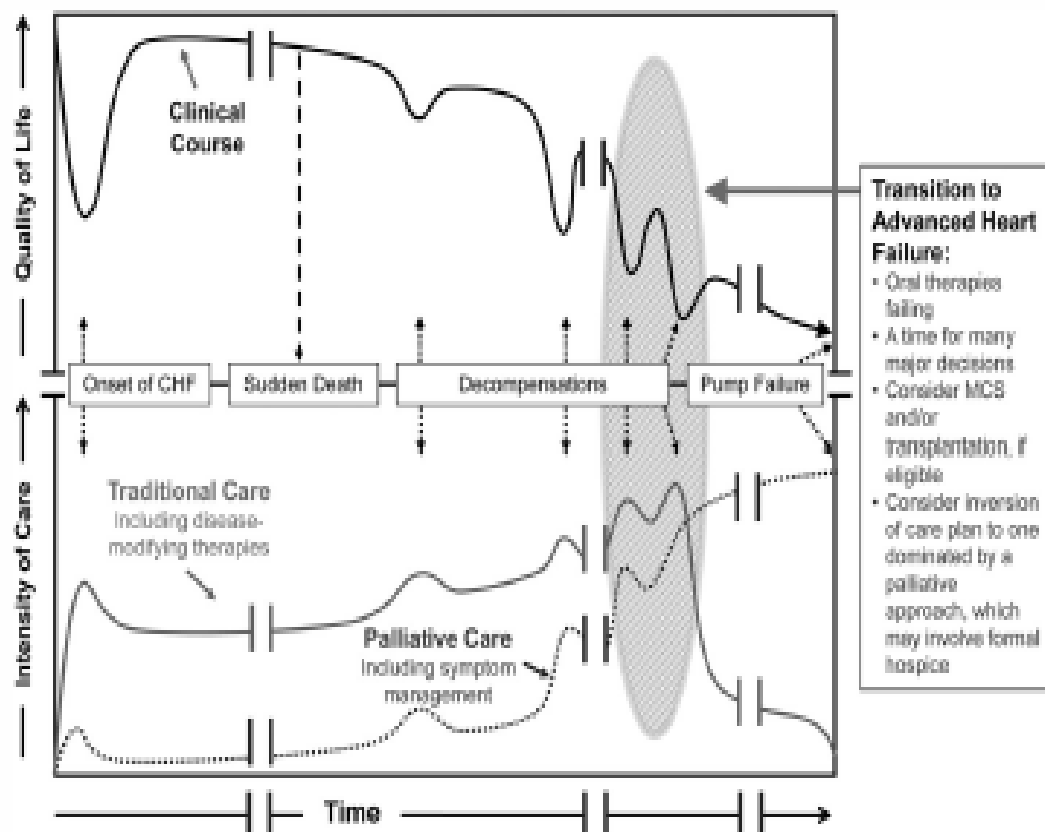
Heart failure hospitalization

24%



# Influence of Previous Heart Failure Hospitalization on Cardiovascular Events in Patients With Reduced and Preserved Ejection Fraction

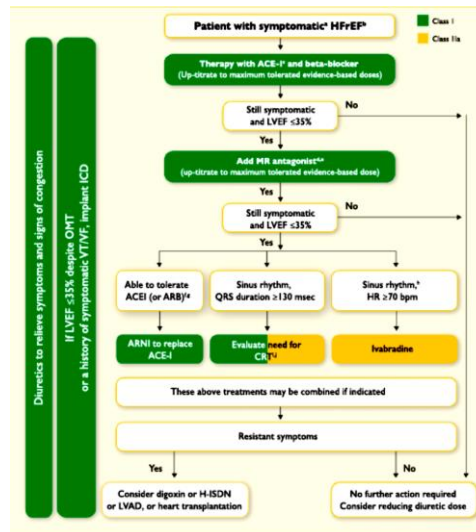
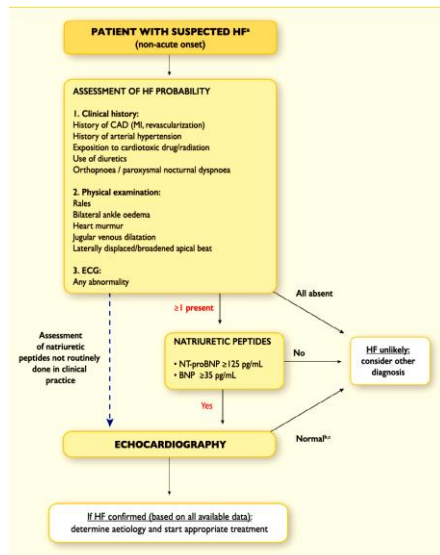
Natalie A. Bello, MD; Brian Claggett, PhD; Akshay S. Desai, MD, MPH; John J.V. McMurray, MD; Christopher B. Granger, MD; Salim Yusuf, DPhil; Karl Swedberg, MD, PhD; Marc A. Pfeffer, MD, PhD; Scott D. Solomon, MD





# 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

## The Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC)



### Recommendations to prevent or delay the development of overt heart failure or prevent death before the onset of symptoms

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>	Ref <sup>c</sup>
Treatment of hypertension is recommended to prevent or delay the onset of HF and prolong life.	I	A	126, 129, 150, 151
Treatment with statins is recommended in patients with or at high-risk of CAD whether or not they have LV systolic dysfunction, in order to prevent or delay the onset of HF and prolong life.	I	A	137–140, 152
Counselling and treatment for smoking cessation and alcohol intake reduction is recommended for people who smoke or who consume excess alcohol in order to prevent or delay the onset of HF.	I	C	131–134
Treating other risk factors of HF (e.g. obesity, dysglycaemia) should be considered in order to prevent or delay the onset of HF.	IIa	C	130, 141, 153–155
Empagliflozin should be considered in patients with type 2 diabetes in order to prevent or delay the onset of HF and prolong life.	IIa	B	130
ACE-I is recommended in patients with asymptomatic LV systolic dysfunction and a history of myocardial infarction in order to prevent or delay the onset of HF and prolong life.	I	A	5, 144, 145
ACE-I is recommended in patients with asymptomatic LV systolic dysfunction without a history of myocardial infarction, in order to prevent or delay the onset of HF.	I	B	5
ACE-I should be considered in patients with stable CAD even if they do not have LV systolic dysfunction, in order to prevent or delay the onset of HF.	IIa	A	142
Beta-blocker is recommended in patients with asymptomatic LV systolic dysfunction and a history of myocardial infarction, in order to prevent or delay the onset of HF or prolong life.	I	B	146
ICD is recommended in patients: <ul style="list-style-type: none"> <li>a) with asymptomatic LV systolic dysfunction (LVEF ≤30%) of ischaemic origin, who are at least 40 days after acute myocardial infarction,</li> <li>b) with asymptomatic non-ischaemic dilated cardiomyopathy (LVEF ≤30%), who receive OMT therapy,</li> </ul> in order to prevent sudden death and prolong life.	I	B	149, 156–158

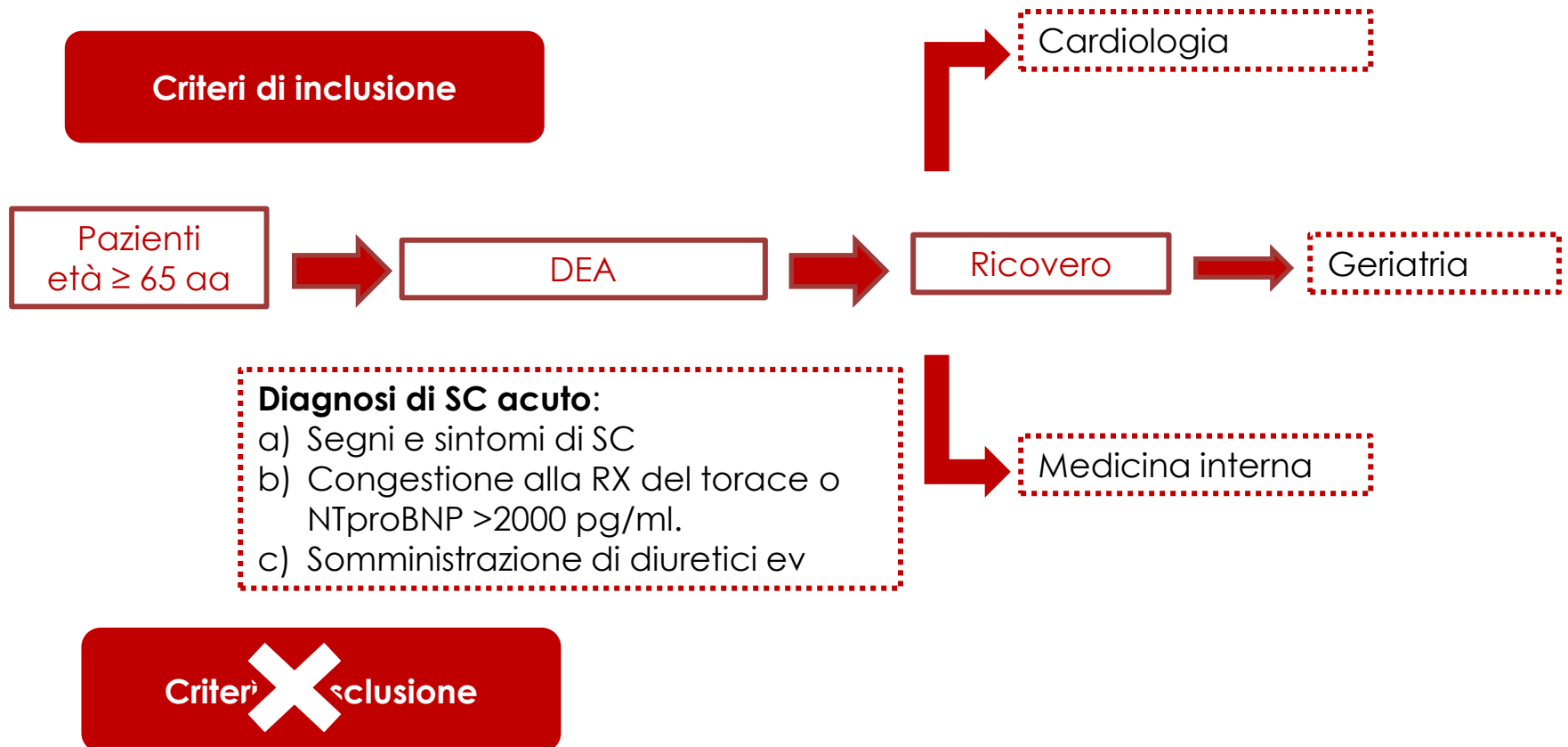
# Scopo dello studio

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- 📍 Descrivere le caratteristiche **gestionali e terapeutiche** di una casistica di “mondo reale” di anziani ricoverati per scompenso cardiaco acuto in diversi setting assistenziali.
- 📍 Valutare il livello di aderenza alle Linee Guida ESC del 2016 in diversi setting assistenziali.

# Metodi

Abbiamo analizzato **pazienti anziani (età  $\geq 65$  anni) ricoverati al Dipartimento di Emergenza e Accettazione** di un ospedale di secondo livello con diagnosi di scompenso cardiaco acuto nel periodo tra 01.12.2014 e 01.12.2015 e arruolati nel Registro **ATHENA (AcuTe Heart failure in advANced Age)**.



# Disegno dello studio II

**DEA**

**Modalità di accesso, codice di urgenza,  
Parametri vitali  
Esami laboratoristici**

**Trasferimento in  
reparto**

**Dati anamnestici (fattori di rischio, eziologia SC..)  
Parametri vitali ed esame obiettivo (ing e dim)  
Esami di laboratorio (ing e dim)  
Esami strumentali: ECG ed ecocardiografia  
Scale di valutazione: Barthel (autonomia), MUST  
(malnutrizione), Charlson (comorbidità).  
Trattamenti farmacologici (ing e dim)**

**Outcome**

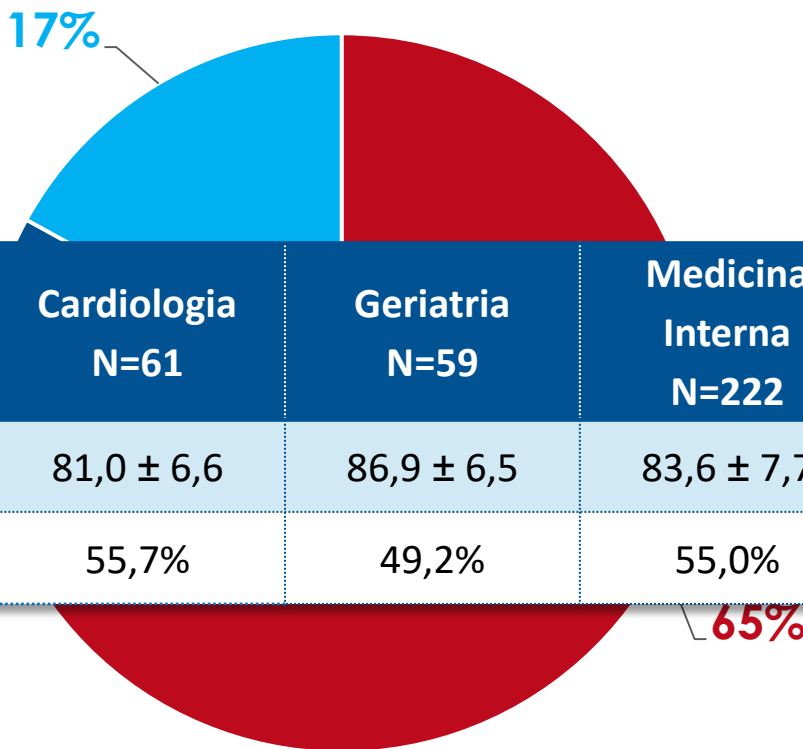
**Eventi avversi  
Mortalità  
Durata ospedalizzazione**

**Dimi domicilio vs RSA  
Prog. FU**

# RISULTATI I

## Popolazione dello studio

La popolazione dello studio è costituita da **342 pazienti**.



	Totale N=342	Cardiologia N=61	Geriatria N=59	Medicina Interna N=222	P Value
Età (anni)	83,7±7,5	81,0 ± 6,6	86,9 ± 6,5	83,6 ± 7,7	<b>0,001</b>
Femmine	54,1%	55,7%	49,2%	55,0%	0,700

■ Medicina interna ■ Cardiologia ■ Geriatria

# RISULTATI I

## Inquadramento in Pronto Soccorso



### Recommendations regarding applied diagnostic measurements

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>	Ref <sup>c</sup>
Upon presentation a measurement of plasma natriuretic peptide level (BNP, NT-proBNP or MR-proANP) is recommended in all patients with acute dyspnoea and suspected AHF to help in the differentiation of AHF from non-cardiac causes of acute dyspnoea.	I	A	531–534
At admission in all patients presenting with suspected AHF, the following diagnostic tests are recommended:			
a. 12-lead ECG;	I	C	
b. chest X-ray to assess signs of pulmonary congestion and detect other cardiac or non-cardiac diseases that may cause or contribute to the patient's symptoms;	I	C	
c. the following laboratory assessments in the blood: cardiac troponins, BUN (or urea), creatinine, electrolytes (sodium, potassium), glucose, complete blood count, liver function tests and TSH.	I	C	
Echocardiography is recommended immediately in haemodynamically unstable AHF patients and within 48 hours when cardiac structure and function are either not known or may have changed since previous studies.	I	C	

**NT-proBNP**  
n=263; 77.8%

**ecocolorDoppler**  
n=84; 24.9%

**Uno dei due**  
n=279; 82.5%

# RISULTATI II

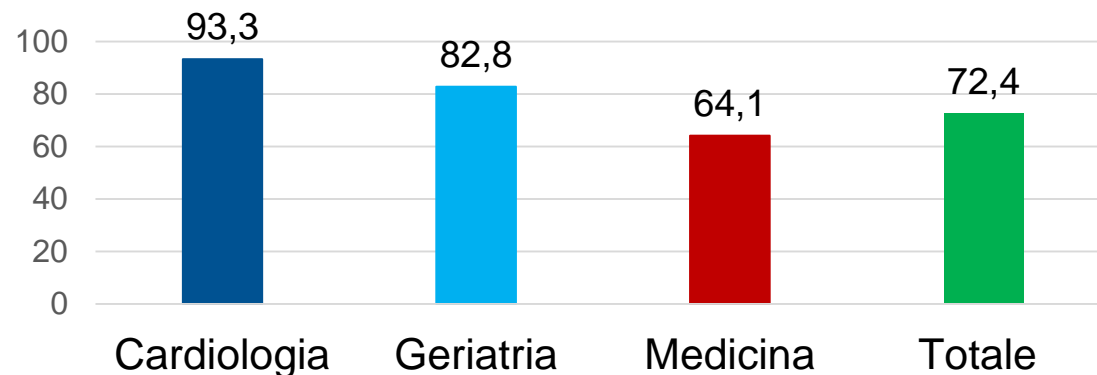
## Aderenza alle linee guida



### Recommendations for cardiac imaging in patients with suspected or established heart failure

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>	Ref <sup>c</sup>
TTE is recommended for the assessment of myocardial structure and function in subjects with suspected HF in order to establish a diagnosis of either HFrEF, HFmrEF or HFpEF.	I	C	
TTE is recommended to assess LVEF in order to identify patients with HF who would be suitable for evidence-based pharmacological and device (ICD, CRT) treatment recommended for HFrEF.	I	C	
TTE is recommended for the assessment of valve disease, right ventricular function and pulmonary arterial pressure in patients with an already established diagnosis of either HFrEF, HFmrEF or HFpEF in order to identify those suitable for correction of valve disease.	I	C	
TTE is recommended for the assessment of myocardial structure and function in subjects to be exposed to treatment which potentially can damage myocardium (e.g. chemotherapy).	I	C	

### ecocolorDoppler cardiaco



# RISULTATI III

## Aderenza alle linee guida

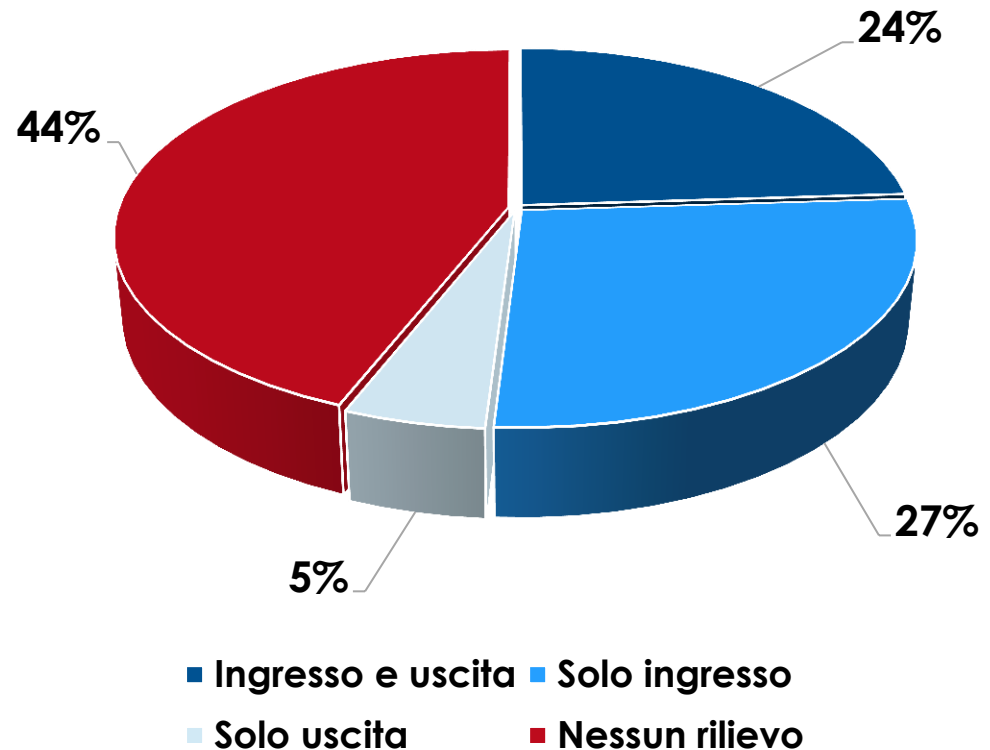


### 12.5 Monitoring of clinical status of patients hospitalized due to acute heart failure

Recommendations regarding monitoring of clinical status of patients hospitalized due to acute heart failure

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
Standard non-invasive monitoring of heart rate, rhythm, respiratory rate, oxygen saturation and blood pressure is recommended.	I	C
It is recommended that patients should be weighed daily and have an accurate fluid balance chart completed.	I	C
It is recommended to evaluate signs and symptoms relevant to HF (e.g. dyspnoea, pulmonary rales, peripheral oedema, weight) daily to assess correction of fluid overload.	I	C

Rilievo del peso al ricovero e alla dimissione



75 pts  
HFrEF

# RISULTATI V

## Aderenza alle linee guida



Pharmacological treatments indicated in patients with symptomatic (NYHA Class II-IV) heart failure with reduced ejection fraction

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>	Ref <sup>c</sup>
An ACE-I <sup>d</sup> is recommended, in addition to a beta-blocker, for symptomatic patients with HFrEF to reduce the risk of HF hospitalization and death.	I	A	2, 163-165

ACE-I/ARB  
n=44; 58.6%

A beta-blocker is recommended, in addition an ACE-I <sup>d</sup> , for patients with stable, symptomatic HFrEF to reduce the risk of HF hospitalization and death.	I	A	167-173
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BB  
n=58; 77.3%

An MRA is recommended for patients with HFrEF, who remain symptomatic despite treatment with an ACE-I <sup>d</sup> and a beta-blocker, to reduce the risk of HF hospitalization and death.	I	A	174, 175
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MRA  
n=37; 49.3%

# RISULTATI IV

## Aderenza alle linee guida



16.2%

### 12.6 Criteria for discharge from hospital and follow-up in high-risk period

Patients admitted with AHF are medically fit for discharge<sup>552</sup>

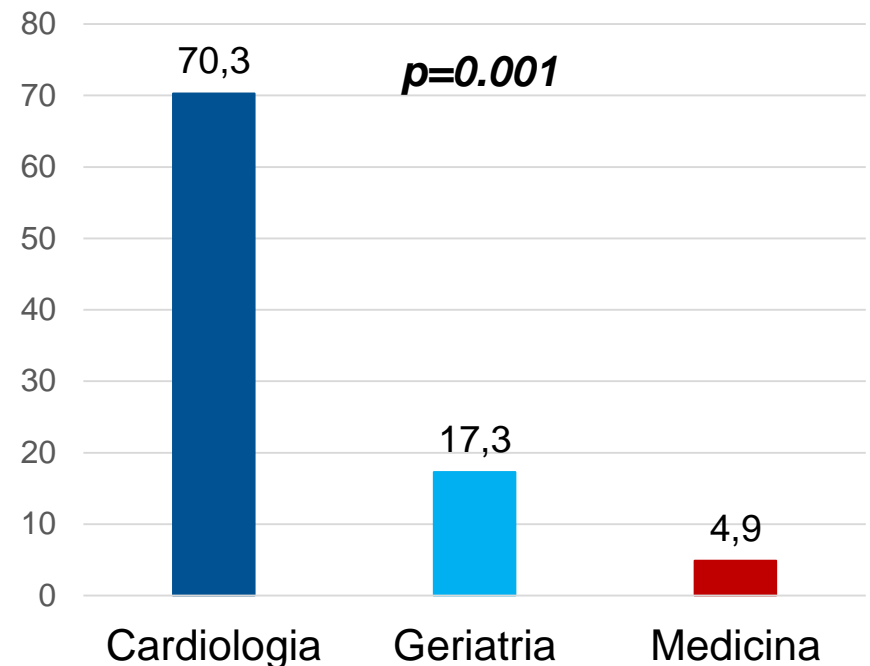
- when haemodynamically stable, euvolaemic, established on evidence-based oral medication and with stable renal function for at least 24 hours before discharge;
- once provided with tailored education and advice about self-care.

Patients should preferably be

- enrolled in a disease management programme; follow-up plans must be in place prior to discharge and clearly communicated to the primary care team;
- reviewed by their general practitioner within 1 week of discharge;
- seen by the hospital cardiology team within 2 weeks of discharge if feasible.

Patients with chronic HF should be followed up within a multiprofessional HF service. Pre- and post-discharge management should follow the standards of care of the HFA.<sup>540,591,592</sup>

### Programmazione FU alla dimissione



# Conclusioni

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- 📍 Nei pazienti anziani ricoverati per SC acuto si osserva una scarsa aderenza alle LG internazionali, in particolare nei pazienti ricoverati in reparti non cardiologici.
- 📍 Questo vale non soltanto per la terapia farmacologica anche laddove esistano forti raccomandazioni, ma anche per l'inquadramento clinico e la gestione del paziente sia in fase ospedaliera che al momento della dimissione.
- 📍 Molto occorre fare per implementare l'aderenza nei nostri ospedali, al fine di ridurre le riospedalizzazioni per SC, che sono determinanti prognostici particolarmente importanti nel paziente scompensato anziano.

# **ATHENA (AcuTe Heart failure in advaNced Age)**

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