

Appropriate Use Criteria for Cardiopulmonary Exercise Testing in Patients With Cardiac Resynchronization Devices. Response



Crterios de uso apropiado para la ergoespirometría en el paciente portador de dispositivos de resincronización cardiaca. Respuesta

To the Editor,

We wish to thank Dr. Dominguez-Rodriguez and Dr. Abreu-Gonzalez for their interest and comments regarding our publication.

Cardiopulmonary exercise testing is a functional test of indisputable value in patients with cardiac resynchronization therapy (CRT) devices since, in addition to enabling objective evaluation of the functional response to treatment, it also provides prognostic information, an input that eventually could have therapeutic implications. Treadmill exercise testing is far more limited in the functional and prognostic assessment of patients with CRT devices and, in this respect, we are in complete agreement.

However, the objective of our study was not to carry out a strictly functional assessment, much less a prognostic evaluation, of patients receiving CRT. This study was prospectively designed to determine the number of patients who experienced a loss of pacing capture during exercise, analyze the causes, and attempt to correct them, because nearly constant pacing is considered to be essential for achieving a response to therapy.¹⁻³

The results obtained indicate that pacing capture was lost during exercise in 24% of the patients, which led to a process of clinical decision making to correct it. Thus, we concluded that treadmill exercise testing is a simple, accessible, and useful tool for follow-up of patients with CRT, and helps to guide clinical decisions related to drug therapy, device programming, and indications for atrioventricular node ablation.⁴

Given the small sample size, it is not possible to conclude from our report that exercise testing should be systematically employed

in all the patients receiving CRT. However, we firmly believe that it can be highly useful in the assessment of certain patients, such as nonresponders or those who have atrial arrhythmias as the baseline rhythm.

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Comments on the Analysis of Telephone Calls to a Heart Failure Unit: Reasons for the Call and Resource Use



Comentarios al análisis de la demanda telefónica en una unidad de insuficiencia cardiaca: motivos de consulta y utilización de recursos

To the Editor,

We read with great interest the scientific letter published by González et al¹ in *Revista Española de Cardiología*, and, after first congratulating the authors, would like to make several comments on its content.

We know that heart failure is a complex and multifactorial syndrome that affects a high percentage of patients. Moreover, the number of patients is increasing due to the progressive aging of the population. Clinical practice guidelines recommend the implementation of multidisciplinary programs as a priority.² One of the keys to the success of these programs lies in health education interventions, essentially carried out by nurses, as reflected by several studies.³ Given their high workload, physicians have less room for maneuver for dedicating more time to patients.⁴ Nurses therefore take on most of the burden of the educational process,

although without undermining the roles of other members of the team.

With regard to the published letter, we have several doubts. First, it would be interesting to know whether the nurses' telephone calls follow a predetermined structure or protocol depending on the reason for the call or whether they simply respond to the demands of the patient. Second, we would also need to know which interventions are performed by nurses, depending on the reason for the call. Finally, the number of bureaucratic questions addressed by the nurses is noteworthy and such doubts could perhaps be resolved by administrative staff.

It is our understanding that within an educational program, taking calls should be a complementary activity to other, more important interventions. In fact, telephone support has not been shown to provide a benefit and the evidence is not sufficiently solid to support recommendation in the clinical practice guidelines.²

In the figure that is published in the letter indicating the reasons for calling, we noted that patients have problems essentially with treatment. These results may suggest that the number of calls increases due to lack of a prior educational intervention on the patient' treatment plan, leading to subsequent doubts.

A substantial proportion of calls may be due to strong trust in the unit staff and their accessibility, making the patients dependent on the system. In fact, older patients call about other

noncardiologic treatments. This would appear to go against encouraging self-care, one of the initial objectives and one that has been assessed in previous studies.⁵

With regard to the multidisciplinary approach, we should not forget other levels of care and seek the involvement of primary health care professionals, who are usually the first point of contact when older patients attend the clinic for symptoms of acute heart failure.⁶ In addition, it would be a good moment to establish strong alliances with community nursing, which is also promoting goals such as self-care.

In summary, the authors are right in affirming that their results may be relevant for planning future heart failure units. In our humble opinion, it is necessary to standardize interventions through a health plan or program that overcomes the barriers between patients and their treatment.

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Comments on the Analysis of Telephone Calls to a Heart Failure Unit: Reasons for the Call and Resource Use. Response



Comentarios al análisis de la demanda telefónica en una unidad de insuficiencia cardíaca: motivos de consulta y utilización de recursos. Respuesta

To the Editor,

We read with interest the letter by Alconero-Camarero et al about our article, "Analysis of Telephone Calls to a Heart Failure Unit: Reasons for the Call and Resource Use,"¹ and we would like to make certain clarifications.

Our study merely refers to an assessment of the reasons for spontaneous telephone calls made by patients. The attention provided by telephone was not subject to a prior protocol. Likewise, the nurses' responses were not standardized (Figure) and, as was stated, depended on the type of consultation. Obviously, this activity is complementary to other more important activities undertaken by the unit (education, supervision, treatment optimization, care for cases of decompensation, etc.). In no way should this task be compared with care programs or telephone-based follow-up of patients referred to by Alconero-Camarero et al.

We do not believe that our results indicate the telephone calls can be attributed to the lack of prior educational intervention in the patient's treatment plan. They simply highlight that, among all the calls made, the main causes are related to treatment. Often, the caller was seeking a positive reinforcement, that is, confirmation of aspects dealt with in the educational intervention. In fact, although the concept of self-care includes a dimension of self-management, it is also important to know when to contact health care professionals. We also do not share their opinion that greater confidence in the staff of the unit and their accessibility, a crucial aspect of heart failure units, are in conflict with promoting self-

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care, as the authors suggest. On the contrary, it can be considered a mechanism of self-care and encourages greater vigilance on the part of the patient.

We do agree, however, that the number of bureaucratic questions answered by nurses is worthy of attention, and this was behind our comment in the article.

Finally, we are (and have provided sufficient evidence of being) staunch supporters of a multidisciplinary approach and integration of other levels of care, such as primary health care, without this being mutually exclusive with facilitating as much as possible patient access to heart failure units.

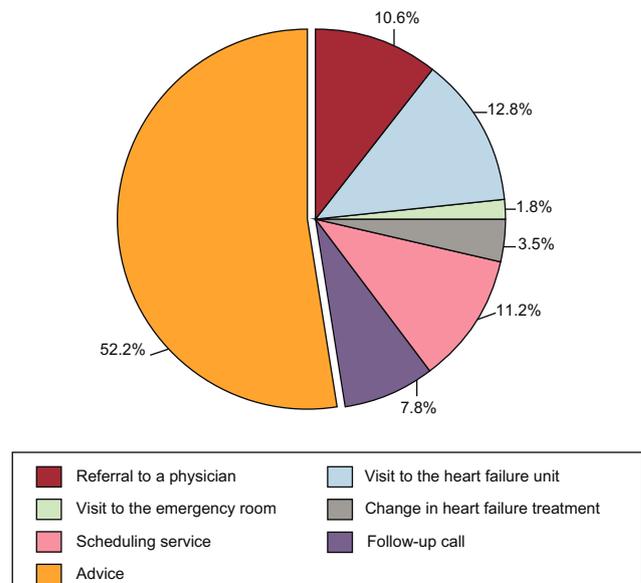


Figure. Type of response or intervention performed by nurses.