Heart Failure: Old Questions, Insufficient Answers

Gaietà Permanyer Miralda

Servicio de Cardiología. Hospital General Universitari Vall d'Hebron. Barcelona. España.

Studies analyzing compliance with guidelines for clinical practice in numerous syndromes and diseases have proliferated, in a praiseworthy attempt to calibrate the distance that separates theoretical recommendations from the reality of care. Heart failure is not exceptional. In the present number of the journal, García Castelo et al.[1] report the results of the INCARGAL study, in which they evaluate the differences in the treatment of the syndrome depending on the department to which the patient is admitted (cardiology or internal medicine and geriatrics) in 14 hospitals of the Community of Galicia.[1] The interest of the study lies not only in its contribution to a critical understanding of care in Spain, which is still unsatisfactory, but also in its contribution to the debate that has been aired in the pages of this journal[2-5] regarding the specialty or department that is most suitable for the adequate treatment of heart failure.

The findings of the study are similar to those of other studies[6-8] with respect to trends in the use of diagnostic and therapeutic resources in general, as well as the differences observed in the profile of the patients and patterns of treatment in cardiology and internal medicine departments. A first comment, somewhat marginal, refers to the relative similarity between the findings of different studies (in relation to the most relevant variables), despite the serious limitation of the absence of satisfactory diagnostic criteria for the syndrome that have been developed by consensus. The absence of criteria continues to be an important problem for research and clinical practice, despite the efforts of scientific associations to force the introduction of criteria of this type. If a consensus is reached in the future regarding sensitive, specific, and easily applicable diagnostic criteria for heart failure, without doubt our knowledge of the characteristics of the syndrome will gain in precision. However, it does not seem likely that our fundamental ideas about forms of presentation, evolution, prognosis, and actual patterns of treatment in real life will change substantially.

Once again, in the study by García Castelo et al. it is confirmed that, within the framework of results that can be improved overall, the patients admitted to internal medicine wards are usually of advanced age and more frequently have certain associated diseases (chronic respiratory disease, dementia) than patients admitted to cardiology wards. Likewise, the rate of use of complementary studies, like cardiac echocardiography or catheterization, or treatments, such as beta-blockers, was also significantly more frequent in cardiology wards, although the authors do not provide rates of use. This type of information has been used to argue that it would be useful if the persons in charge of the treatment of patients were to be cardiologists. Is this deduction logically valid? The rationale does not seem entirely convincing. The question of who should treat heart failure is complex, and most of relevant debates have clearly discussed this,[2-5] but a synthesis of the considerations involved does not seem to be inopportune in the light of the study by García Castelo et al. What they really suggest, as do other similar studies, is that the treatment of patients with heart failure is defective in many ways, but less defective among cardiologists for the specific type of patients that they treat. It cannot be deduced from these findings that the solution for the problem must unavoidably be to generalize cardiological care to all patients with heart failure. These studies indicate that the cardiological context is probably where there is generally more awareness of the optimal treatment for heart failure and a greater facility to put it into practice. This does not mean that the knowledge necessary for its treatment is specialized. Information relative to pharmacological advances has been made known in cardiological communication media and general training programs. Application of this information is within the reach of well-prepared doctors, regardless of their specialization. Certainly, cardiologists must play a relevant role in the treatment of heart failure, although it varies in accordance with the needs of patients. Their opinion often can be important, even essential depending on the case, in specific moments in the course of the disease. These funda-

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Correspondence: Dr. G. Permanyer Miralda.
Servicio de Cardiología. Hospital General Universitari Vall d'Hebron.
Pg. Vall d'Hebron, 119-129. 08035 Barcelona. España.

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mental moments, to my understanding, are firstly, at the time of the initial diagnosis, when judgment is passed, based on the information from the examinations, on the causal heart disease and possibility of specific treatment (valve replacement, coronary bypass, etc.), as well as the characteristics of ventricular function. The second moment is when the need for non-pharmacological treatment options is considered (transplantation, pacing, etc.). Finally, cardiologists are occasionally needed in situations in which the interpretation of the cardiac rhythm and its treatment can be complex (e.g., slow rhythms due to the use of beta blockers). On the other hand, the general problems of the patient, who is often elderly and has serious associated diseases, require care that cannot necessarily be provided better by cardiologists than other professionals. For example, in a recent study of patients hospitalized for heart failure,[6] we confirmed that almost 25% of the mortality at 18 months was attributable to non-cardiac diseases, which illustrates the complexity of the general population with heart failure, above and beyond their cardiological conditions. In fact, it is often the cardiologist who in clinical practice has patients with heart failure for which other specialists must often be consulted or the patient referred to them for adequate assessment and treatment. Fundamentally, aside from the moments when decisions like those mentioned, in which a cardiologist´s expertise is fundamental, the essential elements of the treatment of heart failure are tenacity, therapeutic willpower, compassion, patience, and the imaginative use of the resources at hand to treat a patient with a chronic condition that barely responds to treatment and who often feels desperate. The qualities (and professional qualification) required for this task are outside the scope of traditional medical specialties.

Although clinical trials on heart failure are still very insufficient with regard to the recommendations applicable to older persons or patients with severe comorbidity, in principle it is assumed (for the purpose of audits or the analysis of clinical activity) that these patients are candidates for the same measures as the populations of clinical trials. Nevertheless, abstention from certain examinations and treatments in certain patients of advanced age with a poor prognosis, who are treated by internists and geriatricians, may sometimes reflect a more individualized approach, or the application of clinical wisdom, rather than the insufficiency of available information or its insufficient application. This consideration does not deny, far from it, the possibility that, at all levels, there is still a degree of information, awareness or insufficient will to use certain examinations or treatments, or scant structural and organizational facilities for carrying them out.

What is the solution to the problem? I do not believe that it lies nowadays in laying an exclusive claim on heart failure as specific to any medical specialty that now exists. In my judgment, the knowledge currently available suggests that the treatment of heart failure has important limitations in all conventional areas of health care as it is structured in developed societies. The perception of this problem has conditioned the conception and development of new care modalities or alternatives in recent years, and the creation of specific hospital units for heart failure, a multidisciplinary approach to its treatment (with the increasing participation and prominence of specialized nurses), or specific educational programs.[9,10] With no intention to take the part of any of these options, whose application must be carefully adapted to each setting rather than improvised, what is clear in my opinion, informed by experience and the recent literature, it is that the treatment of patients with heart failure is a long-term undertaking requiring considerable effort and a multidisciplinary approach. Cardiologists, internists, geriatricians, family physicians, nurses, and other healthcare professionals have a role to play in improving not only the survival (which is problematic in some cases), but also the impaired well-being of patients with heart failure. Rather than a territorial dispute about the ownership of heart failure by one specialty or another, the problem is a very real one of how best to use professionals and activities in the care of these patients. I refer not only to public health care, but also to private health care. I interpret the work of García Castelo et al. as a series of findings that suggest the usefulness of remodeling conventional patterns of medical care, including its work structures, to ensure the adequate treatment of a syndrome that is producing growing impact as a public health problem. Independently of the necessary structural changes, the wish to collaborate between different types of professionals, their therapeutic will, and a judicious adaptation to the mean characteristics of each care environment will undoubtedly contribute to improving patient care.

Another aspect worthy of mention in the study of García Castelo et al. is that, like other studies of similar design, it is hospital based. Although community-based studies are certainly not lacking,[11-13] much of our knowledge of variations in the treatment of heart failure by different specialists has been obtained from hospital populations. Although this type of studies is important, it would be particularly interesting to have more knowledge of how heart failure is treated before the patient comes into contact with the hospital. Certainly, given the generally implacable course of heart failure, few patients do not require hospital care in the course of their evolution, but it is a fact that if the treatments currently available really act by delaying the clinical evolution more than resolving the disease, it would be interesting to know the patterns of administration (as well as the characteristics of the patients)

before they reach the phase, generally advanced, in which the patient requires hospital admission. Although some community-based studies disclose a prognosis almost as poor as that of hospital patients,[11] this is not always the case[12,13] and there are reasons to assume that knowledge of the patterns of care in early phases could give us a more precise idea of the benefit that insufficient action fails to obtain.

Studies like that of García Castelo et al. have contributed to the observation, widely confirmed, that the most important population of patients with heart failure differs from the patients included in clinical trials (they are older, have more comorbidity, and a worse general prognosis). With regard to this point, everyone is in agreement. What is difficult is to determine what this difference actually means in practice. We could ask if in an elderly patient with important comorbidity (e.g., chronic pulmonary disease, neurological deficit or renal insufficiency) and, especially, no important systolic dysfunction, who would certainly not have been included in a clinical trial, whether or not the same effect of a more prolonged survival would be obtained, as has been demonstrated in clinical trials with complex associations of drugs that require patient, meticulous, frequent supervision and special attention to adverse effects. Even more, we could ask if this prolongation of survival is predictably substantial and valuable in those cases. We could also ask, and the answer would be speculative in general and empirical in specific points, what the real benefit would be in terms of a gain in the quality of life from each of the therapeutic measures mentioned. Certainly, the response to all these questions, beyond individual experience and gift for observation, would demand new types of clinical trials and large studies of effectiveness. The somewhat aberrant course of current investigation in therapy for heart failure makes this increasingly necessary. These studies could overcome the dilemma frequently encountered in patients who are different from those included in traditional clinical trials, the choice between blind compliance, carried out laboriously and with little conviction, with the recommendations of guidelines for clinical practice, or more or less dangerous and debatable individual improvisations.

The work of García Castelo et al. has had the merit of again raising old questions and demonstrating that they continue to be valid in Spain. The definitive responses to these old questions continue to lie, for the most part, in the terrain of what we wish could be. Until better solutions are found, we should not fail to take advantage of the example established by alternative therapeutic initiatives in heart failure and to creatively interpret their results to achieve more effective treatment and relief of patients.

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