Heart failure management – a secondary care perspective

In the previous article, Dr Sarah Jarvis provides a useful perspective on the management of heart failure in primary care.[1] Recent reports from the Department of Health and the Healthcare Commission have highlighted the lack of progress in implementing evidence-based practice in heart failure. It is essential that primary and secondary care work together to improve the situation.

In her article, Dr Jarvis endorses the place of the National Institute for Clinical Excellence (NICE) guideline[4] in providing clear and specific advice about the management of chronic heart failure. She also raises the issue of poor access to the key tests in the diagnostic pathway for patients with suspected heart failure – B-type natriuretic peptide (BNP), N-terminal pro-BNP (NTproBNP) and echocardiography. More needs to be done to provide primary care physicians with the tools to identify patients with heart failure correctly and rapidly. Of course, none of the tests should be viewed in isolation – a systematic approach to diagnosis needs to be adopted, with different models working in different areas. The development of rapid access heart failure clinics, together with the expanding role of general practitioners with a special interest (GPSIs), are very likely to lead to improvement.

'The challenge is to ensure that new evidence is translated into practice as rapidly as possible'

Martin Cowie

New evidence

The NICE guideline did not consider evidence published after October 2002 and Dr Jarvis is correct to point out that since that time several new studies have been published. The NICE guideline will be updated in 2007 but in the meantime several

developments should be borne in mind:

- The evidence that angiotensin II receptor blockers (ARBs) are of value in the treatment of heart failure due to left ventricular systolic dysfunction (LVSD) is now much more secure. For chronic heart failure, the CHARM (Candesartan Heart failure – Assessment of Reduction in Mortality and morbidity) programme[5] has shown that candesartan cilexetil is highly effective in patients with LVSD when angiotensin-converting enzyme (ACE) inhibitors are not tolerated. Also, there is additional benefit if candesartan can be added to treatment with an ACE inhibitor and beta blocker. For patients with preserved systolic function, candesartan reduces the risk of hospitalisation, but not cardiovascular mortality, and it remains a key drug for the treatment of concomitant hypertension in such patients.
- The benefits of electrical therapy appear to be robust. The COMPANION (Comparison of Medical Therapy, Pacing, and Defibrillation in Heart Failure)[6] and CARE-HF (Cardiac Resynchronization-Heart Failure)[7] studies demonstrate important clinical benefit for patients with broad QRS complexes and ongoing symptoms despite optimal drug therapy from the use of atrio-biventricular pacing. COMPANION and SCD-HeFT (Sudden Cardiac Death in Heart Failure Trial)[8] also suggest that for patients in New York Heart Association (NYHA) Class II and III failure, implantable cardioverter defibrillators may reduce mortality, irrespective of the aetiology of the LVSD. NICE has yet to update its guidance on the use of such therapies but the benefits appear to be real and probably as cost-effective as many other interventions funded by the NHS. The potential implications for implanting centres are enormous.
- The rather neglected area of heart failure after myocardial infarction (see pages 205–08)[9] has also been pushed into the limelight with the results of the VALIANT (Valsartan In Acute Myocardial Infarction)[10] study and EPHESUS (Eplerenone Post-Acute Myocardial Infarction Heart Failure Efficacy and Survival Study).[11] VALIANT showed that there was nothing to be gained, other than a higher risk of side effects, by adding valsartan to captopril, although the angiotensin II receptor blocker on its own appeared to be as good as captopril on its own. EPHESUS showed an important reduction in cardiovascular risk (including sudden death) with treatment with eplerenone (an aldosterone blocker without the sexual side-effects of spironolactone) in the early period after infarction.

As ever, the challenge is to ensure that new evidence is translated into practice as rapidly as possible, so that patients gain the benefit. There are many barriers to this, not least poor communication between primary and secondary care. One of the key recommendations of the NICE guideline is that there should be a clear management plan for a patient with heart failure and this should be communicated to the patient and all health care professionals involved in that person's care. Increasing focus on heart failure in the new General Medical Services (GMS) contract, and possibly also in the new 'balanced score card' used by the Healthcare Commission, will help encourage joined-up thinking across the health sector. Each locality needs to review its approach to heart failure and how it plans to improve the service it delivers. Local champions in primary and secondary care will be key to driving up standards for diagnosis and therapy.

Conflict of interest

MC is currently in receipt of research funding from Pfizer, Takeda and Medtronic.

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