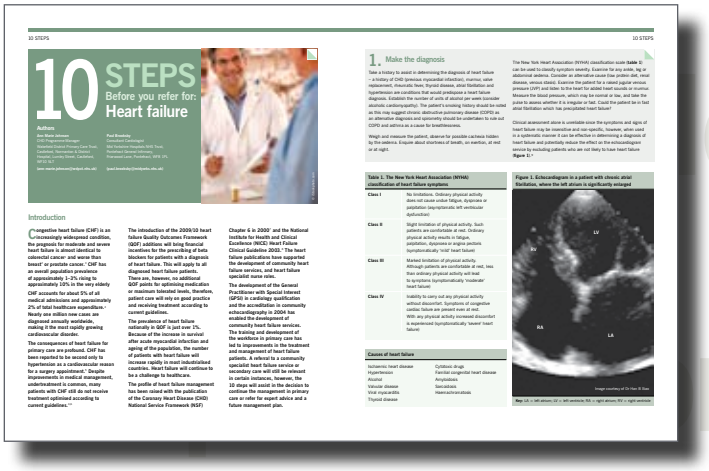
Correspondence

10 steps before you refer for heart failure



Dear Sirs

I was very interested to read this recent article (*Br J Cardiol* 2009;**16**:30–5). While I found the article a useful, well-researched and accurate guide to the medical treatment of heart failure in primary care, I was disappointed.

In my opinion this was a missed opportunity to highlight often forgotten, readily available, life-saving therapy that is clearly indicated for many patients: device therapy. The strong suggestion from the title that these '10 steps' should be attempted before referral to specialist services may actually increase the number of patients who are under treated and left at unnecessary risk.

There is detail given regarding the New York Heart Association (NYHA) classification system but no reference to the importance of NYHA class on treatment. A comment that those who are more symptomatic may benefit from additional medical therapy and device therapy would have been useful.

The only reference to device therapy in the paper states "Only if .... the echocardiogram identifies advanced disease, possibly requiring device therapy, should the patient be referred for specialist care". In fact, any patient with an ejection fraction <35% on echocardiogram, shortness of breath on mild exertion despite medical therapy, and a QRS duration >120ms on electrocardiogram should be considered for a biventricular pacemaker. Many of these patients are otherwise well managed in a primary care setting and this information is sitting in their notes.

The suggestion that a patient should be offered palliative care without specialist assessment is of particular concern. NYHA class IV patients with a QRS duration of >120ms should be offered therapy that improves not only their symptoms and quality of life (a biventricular pacemaker could result in improvement to NYHA class II in a significant number of patients) but also their mortality.

Even when commenting on the risk of sudden cardiac death in the section on palliative care, there is no reference to implantable cardioverter defibrillators (ICDs). National Institute for Health and Clinical Excellence (NICE) guidelines suggest that patients with a history of myocardial infarction, severe left ventricular impairment and a broad QRS should be offered an ICD, even if their symptoms are mild and their medical therapy not yet optimised.

I am keen, for the sake of our patients, to support the management of heart failure in primary care. However, this can only be encouraged when guidance is comprehensive. Perhaps a follow-up paper considering the important role of device therapy in heart failure would ensure that your readers are more fully informed.

Yours faithfully

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The authors' response

We agree with the points Dr Seed raises and welcome her enthusiasm and commitment to raising awareness of this very important area of heart failure management.

The article was written with the aim of managing the basics of heart failure in primary care. It quoted both the NICE Guidance for cardiac resynchronisation therapy and for implantable cardioverter defibrillators both in the text and in the references. Major space restrictions meant we were unable to expand on this and a number of other important areas, such as digoxin, the role of the practice nurse in primary care, education, training, advanced heart failure therapies and an algorithm we have developed for use in primary care showing an established pathway for diagnosis and management of heart failure.

We agree that an article dedicated to device therapy would be excellent and highlight all the areas that you feel have been neglected in the '10 steps heart failure article'.

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Antibiotic prophylaxis against infective endocarditis: new guidelines, new controversy?

Dear Sirs,

We found the editorial by Bogle and Bajpai (*Br J Cardiol* 2008;**15**:279–80) interesting, particularly highlighting the conflict in the management of at-risk patients between cardiologists and dentists. We would like to flag this with a survey performed by us; one month after the National Institute for Health and Clinical Excellence (NICE) guidelines for antibiotic prophylaxis were published. This survey was conducted to assess the change in practice among the cardiologists and cardiac surgeons throughout the country following the latest NICE guidelines. A structured questionnaire was sent by post to randomly selected consultant cardiologists (n=120) and cardiac surgeons (n=60) throughout the UK. The main questions asked were whether they were recommending antibiotic prophylaxis for at-risk patients before the guidelines and whether they would change their practice according to NICE guidelines.

The response rate was 50.8% (61 of 120) and 46.7% (28 of 60) from the cardiologists and cardiac surgeons, respectively. All cardiologists and cardiac surgeons were routinely recommending prophylaxis for infective endocarditis (IE) prior to NICE guidelines. Of the cardiologists, 49.2% replied that they would not change their practice according to NICE guidelines and 4.9% had not decided about this at the time of reply. Of the cardiac surgeons, 82.1% did not agree to change their practice according to NICE guidelines.

Our study results may not be surprising, as this survey was from a group of healthcare professionals who deal with these patients and directly observe the impact of this often life-threatening condition. This might be the same reason why the British Cardiovascular Society (BCS) issued a statement on 27th April 2008 on their website endorsing the NICE guidance, but at the same time recognising the difficulties arising with dealing with this and to support those who continue to recommend antibiotic prophylaxis in selected circumstances. It should be recognised that, even though there is a lack of clear evidence for giving antibiotic prophylaxis, equally, the evidence to disapprove antibiotic prophylaxis is not based on gold-standard, prospective, randomised controlled trials on a large cohort of patients.

This is going to be a difficult time for patients who are at risk of endocarditis. On one hand their cardiologists and cardiac surgeons would continue to recommend antibiotic prophylaxis, while on the other, their dentists may not be willing to prescribe them. We feel there should be consensus among dentists, cardiologists and cardiac surgeons, at least at a regional level, to decide on how best to manage this contentious issue.

Yours faithfully,

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