Talking about matters of the heart

David Haslam

Author

David Haslam
Chair, National Institute for Health and Care Excellence

10 Spring Gardens, London, SW1A 2BU

Correspondence to:
Professor D Haslam
(nice@nice.org.uk)

Key words

anticoagulation, atrial fibrillation, e-patient, NICE guidance, patient empowerment, stroke

doi: 10.5837/bjc.2014.020

Br J Cardiol 2014;**21**:89–90

Today's patient is potentially very different compared with only just a few years ago. So much has changed there is even a new word to describe them, the 'e-patient'. The 'e' can stand for one of many things, equipped, enabled, empowered, engaged or even electronic to cover the internet-savvy approach taken by these patients. Increasing numbers of patients are ever more knowledgeable than in the past and are keen to take control of their own health as much as they can. Many walk in to your consulting room no longer just up to speed on what could be wrong with them, but also with strong opinions on the latest treatments.

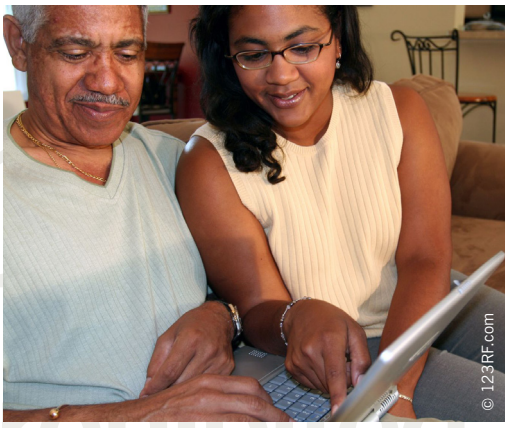
Yet, not all today's physicians are keeping step with this new world. All too often adopting new ways of talking to patients or prescribing new technologies and medicines is left by the wayside in favour of keeping to tried and tested habits.

Treating a common heart disorder

Take the case with atrial fibrillation (AF), which affects around 800,000 people in the UK. Anticoagulation to reduce the risk of stroke is an essential part of AF management but according to the Department of Health many patients are not always appropriately anticoagulated.[1] Since 2012, the National Institute for Health and Care Excellence (NICE) has approved a number of new generation anticoagulants to manage AF. Yet, if you look at recent data from the Health and Social Care Information Centre, the reality is that uptake of these treatments is not as high as it might be.[2]

So what is going on here? There can be no question of safety, efficacy or cost. NICE has found that dabigatran, rivaroxaban and apixaban are both clinically and cost-effective at preventing strokes and should be made available to patients within their licensed indications.

In primary care, which is under so much pressure at the present time, new advice is often seen as generating much more work. The 2002 Reassessing European Attitudes about Cardiovascular Treatment (REACT) study revealed that over a fifth of primary care physicians find heart disease guidelines difficult to implement in their practice and, as such, not useful.[3] This sentiment was echoed by the British Medical Association who, in commenting on the draft AF guideline, described the recommendations as



"complex" and felt that most GPs would no longer be comfortable managing AF in primary care.

People with AF have the right to be involved in discussions and make informed decisions about their treatment and care with their healthcare team. We cannot ignore the fact that GPs see the majority of people with AF. We need to ensure GPs are supported to respond to their needs beyond diagnosis. An exhaustive discussion with patients about the risks and benefits of their new treatment is something that should be happening as standard to ensure the best level of care. To support these discussions, NICE has produced its first Patient Decision Aid to be used alongside the AF guidance.

The decision aid allows people with AF to weigh up possible benefits and harms of available treatment options, helping them make specific, personal choices about their treatment and have better discussions with their physician. In turn physicians have access to a user guide that outlines the sources of information in the decision aid and provides useful tips on how to present this to the patient, helping them better handle these conversations.

NICE worked closely with experts and patients to create a tool that will help support the physician–patient partnership and, ultimately, ensure the most appropriate treatments are prescribed.

Fulfilling recommendations

Implementing NICE guidance goes beyond the patient and physician interaction. We need to make sure local authorities have the frameworks in place to provide access to what the recommendations advise. The NICE Implementation Collaborative (NIC) was set up

to provide this support and they have issued a report to highlight the steps needed to improve access to anticoagulants to prevent strokes in people with AF. The NIC report summarises key aspects of the new guidance around the use of the new generation anticoagulants and recommends ways in which local practices can be adapted to deliver high-quality treatment for people with AF. This includes setting up agreed protocols across primary and secondary care for initiation of novel anticoagulants. Or considering a managed introduction of drugs in clinics or practices, with patient groups who would see the most benefit started on therapy first.

There is no expectation that every GP, in every practice, will be an expert in the area of anticoagulation for AF. The NIC report highlights the need for local leadership, suggesting 'champions' within each practice – this could be a GP, nurse or pharmacist – who have expertise in the area and can take the lead in driving improvements forward.

We are taking novel approaches to improving uptake of guidelines and prescribing of treatments approved by NICE. Health professionals cannot do it alone – in fact this is the mind-set of the e-patient movement – and we recognise that. Giving patients the right information to empower their discussions, and providing local authorities with support to deliver NICE recommendations, can help physicians achieve proper management of AF. If we achieve this, we could go a long way towards preventing 7,000 strokes and saving over 2,000 lives in England every year

Conflict of interest

DH is Chair of the National Institute for Health and Care Excellence.

References

1. Department of Health. Cardiovascular Disease Outcomes Strategy. Improving outcomes for people with, or at risk of, cardiovascular disease. London: DoH, March 2013. Available from: https://www.gov.uk/government/publications/improving-cardiovascular-disease-outcomes-strategy

2. Health and Social Care Information Centre. Use of NICE appraised medicines in the NHS in England – 2012, experimental statistics. Leeds: Health and Social Care Information Centre, January 2014. Available from: http://www.hscic.gov.uk/catalogue/PUB13413

3. Hobbs FDR, Erhardt L. Acceptance of guidelines recommendations and perceived implementation of coronary heart disease prevention among primary care physicians in five European countries: the Reassessing European Attitudes about Cardiovascular Treatment (REACT) survey. *Fam Pract* 2002;**19**:596–604. http://dx.doi.org/10.1093/fampra/19.6.596

Correspondence

Gender and outcome from acute myocardial infarction and secondary stroke

From Drs Ivy Shiue and Krasimira Hristova

In Sweden, a recent study has reported that mortality after acute myocardial infarction (MI) complicated by ischaemic stroke has decreased for both men and women between 1998 and 2008, and the authors concluded that evidence-based therapies seemed to explain the reduction of mortality post-MI. However, the proportions in females have actually increased over the last decade, from 38.2% to 42.1% in non-fatal stroke events and from 46.4% to 50.1% in all stroke events, including both fatal and non-fatal. Were those therapies better for men only? On the other hand, some concerns on the adherence to evidence-based pharmacotherapy and long-term mortality after acute MI could be of interest.

In Canada, among statin users, compared with their high-adherence counterparts, the risk of mortality was greatest for low adherers (deaths in 261/1071 [24%] *vs.* 2310/14,345 [16%]; adjusted hazard ratio 1.25; 95% CI 1.09–1.42; p=0.001) and was intermediary for intermediate adherers (deaths in 472/2407 [20%]; adjusted hazard ratio 1.12; 95% CI 1.01–1.25; p=0.03). A similar but less pronounced dose-response-type adherence-mortality association was also observed for beta blockers, although mortality was not associated with adherence to calcium channel blockers. *The full version of this letter with references is available online...*

Professor Jagdish Sharma responds

Women admitted with acute MI (AMI) have a higher burden of risk factors, tend to be older and have pre-morbid disability. In addition, they have a spectrum of risk factors unique to female gender, which may not only predispose them to more severe AMI, but may also lead to an attenuated response to interventions. In a study by Zhang et al., women had a lower level of acute intervention and this may be an explanation of their higher mortality, in addition to any gender-related hormonal factors. Less intervention in females has been shown to be associated with poor outcome, but not if they receive equal interventions, which is associated with adjusted mortality similar to men. Thus, women have an equal response to intervention and the higher mortality in the Zhang et al. study may simply be explained by fewer interventions being offered to women. A German study has revealed higher mortality in younger women as compared with men following AMI, possibly due to their higher prevalence of diabetes and cardiac failure and less inpatient intervention.

Patients developing acute stroke (AS) after AMI have a higher mortality, 36.5% versus 18.3% in the Brammås study. A number of non-neurological variables predict stroke mortality. Cardiovascular factors of atrial fibrillation, but more significantly, the presence of cardiac failure is highly predictive of mortality following AS. Interestingly, the patients dying after AMI, with or without AS, in the Brammås study had a much higher prevalence of congestive cardiac failure (CCF) and were, thus, on diuretics. The full version of this response is available online...

BJC ONLINE Visit www.bjcardio.co.uk for the full text of these letters