Conoscere e Curare il Cuore 2019

SABATO 2 MARZO

PREVENZIONE DOPO UNA SINDROME CORONARICA ACUTA. LA FILOSOFIA DEL "LESS IS MORE"

Pier Luigi Temporelli

Divisione di Cardiologia Riabilitativa
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Conflitti di interesse da dichiarare

Consulenza per Alfasigma
Letture per Menarini e Servier

Contents lists available at ScienceDirect

EBioMedicine

journal homepage: www.ebiomedicine.com

Research Article

Practice Patterns for Outpatients With Stable Coronary Artery Disease: A Case Vignette-based Survey Among French Cardiologists

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Beta-blockers
Anticoagulation

ABSTRACT

Background: Although medical management of patients with coronary artery disease (CAD) is often based on scientific guidelines, a number of everyday clinical situations are not specifically covered by recommendations or the level of evidence is low. The aim of this study was to assess practice patterns regarding routine management of patients with stable CAD.

Methods: A survey comprising six questions on two clinical scenarios regarding stable CAD management was sent to 345 cardiologists from the Nord-Pas-de-Calais Region (France). We first assessed practice patterns globally and then searched for associations with physician characteristics (age, gender, sub-specialty, and type of practice).

Findings: The response rate was 92%. Regarding management of asymptomatic CAD, 86% of the cardiologists performed routine exercise testing, before which, 69% withdrew β-blockers. After a positive exercise test, 26% immediately performed coronary angiography and 67%, further imaging tests. In the absence of left ventricular dysfunction or history of myocardial infarction, routine β-blocker prescription for stable CAD was selected by 43%. When anticoagulation was needed for atrial fibrillation, 41% initiated direct oral anticoagulants rather than vitamin-K antagonists and 50% combined aspirin with anticoagulants. For recurrent stable angina in patients with known CAD, 24% performed coronary angiography directly, 49% requested a stress test, and 27% opted for medical therapy without further diagnostic testing. Age, gender of the cardiologist, academic environment, and practice of interventional cardiology were associated with certain management patterns.

Interpretation: When not guided by high-level recommendations, practice patterns for routine clinical situations in stable CAD vary considerably. Future clinical trials should address these clinical interrogations

Case # 1

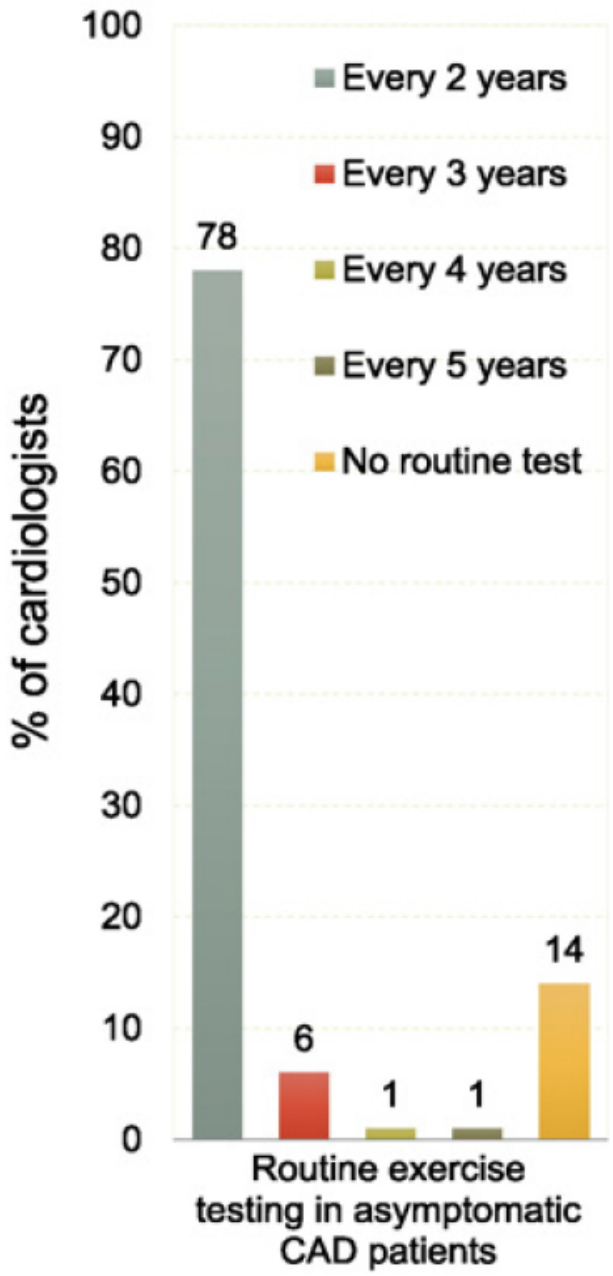
- ✓ A 62-year-old man has sustained an inferior ST segment-elevation MI. He has undergone successful primary angioplasty with implantation of a drug-eluting stent for acute occlusion of the right coronary artery.

- ✓ There were no other significant coronary lesions, and the left ventricular ejection fraction at hospital discharge was 55%. Smoking was the sole cardiovascular risk factor and was stopped at time of MI.

- ✓ Six months after MI, an exercise test was performed (80% of maximum predicted heart rate; negative).

- ✓ At present, two years post-MI, the patient is asymptomatic and is receiving optimal medical therapy for secondary prevention.

a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Every 2 years
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No routine test
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Routine exercise testing in asymptomatic CAD patients

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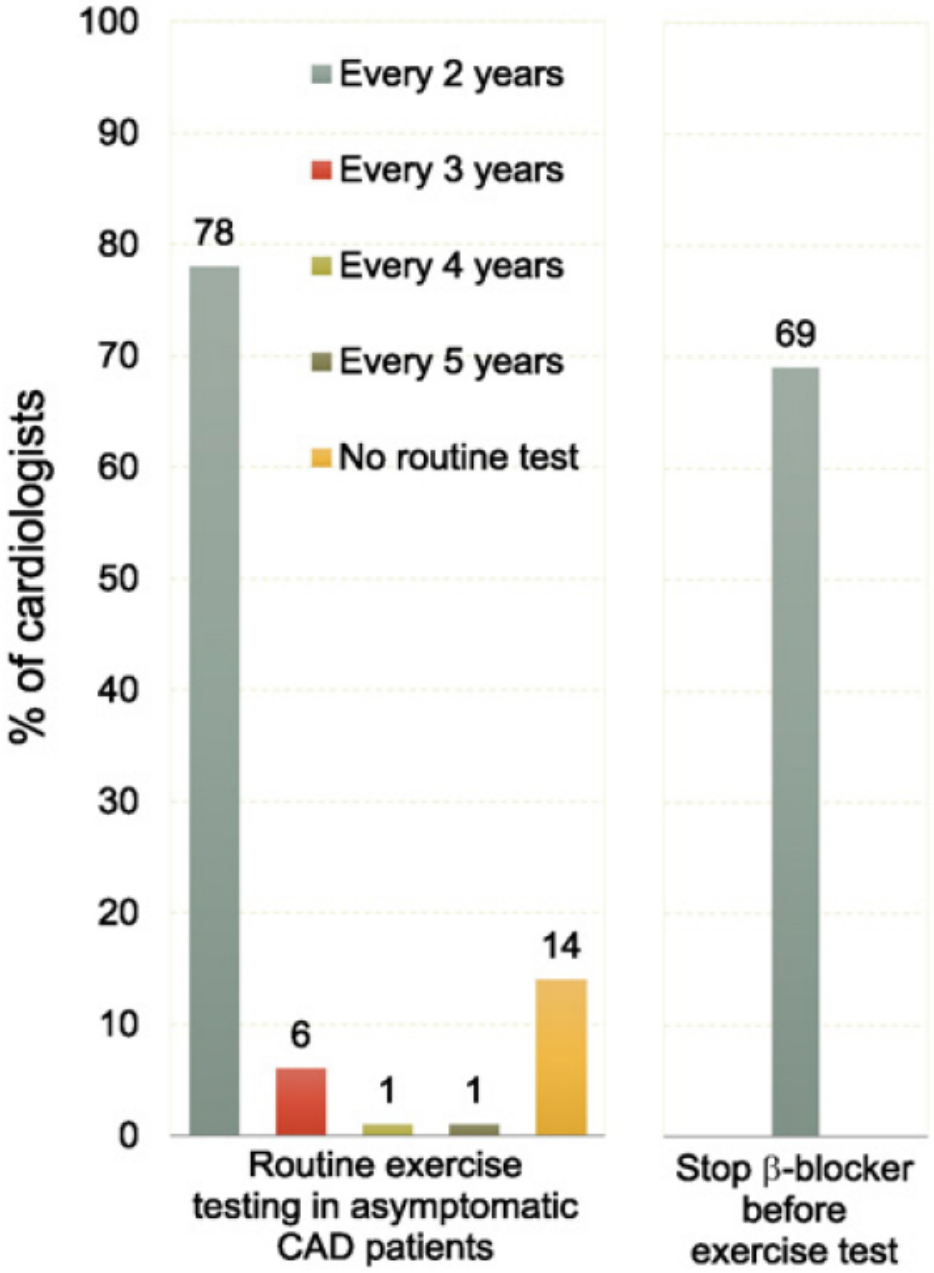
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Routine exercise testing in asymptomatic CAD patients
Stop β-blocker before exercise test

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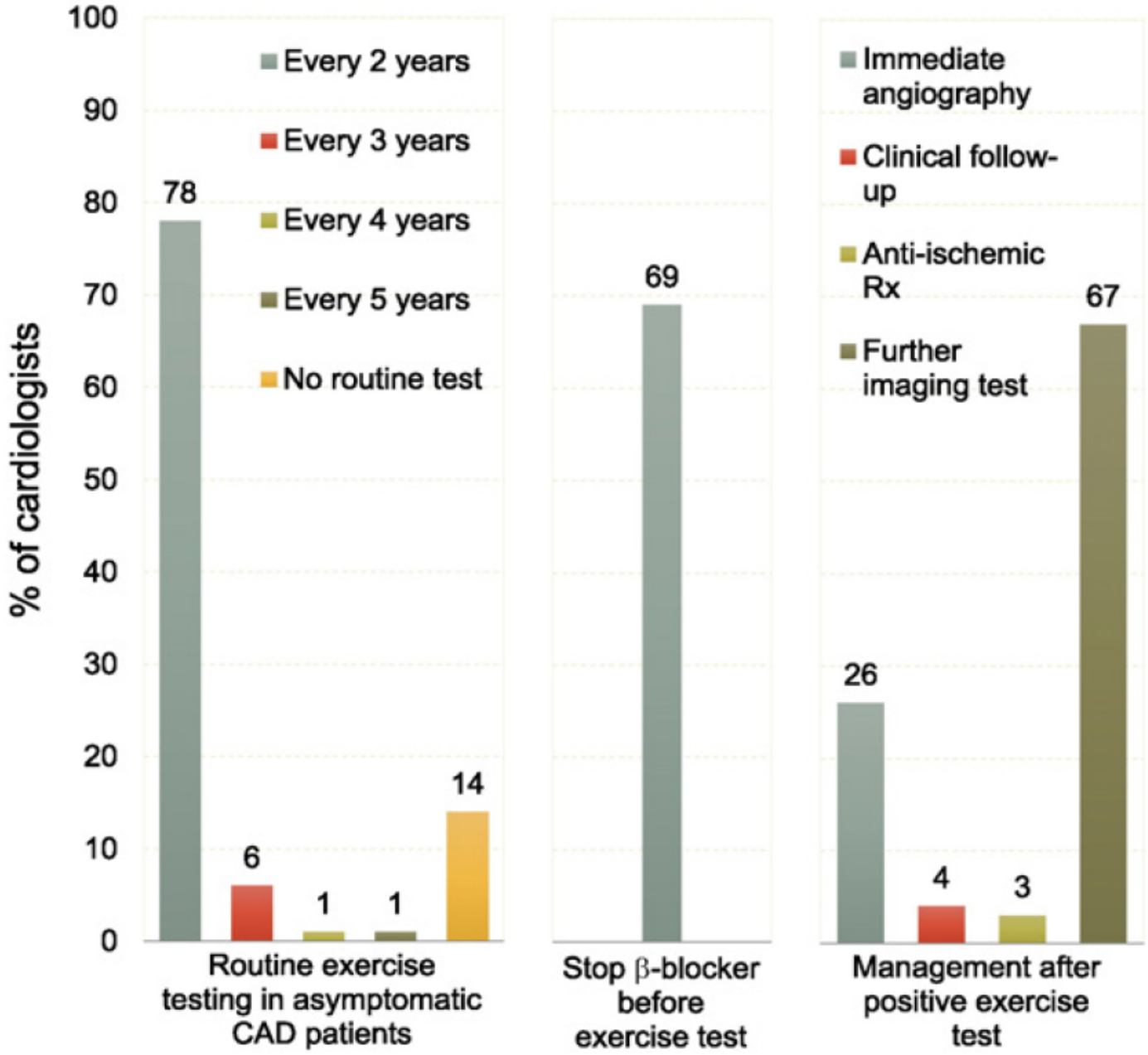
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Routine exercise testing in asymptomatic CAD patients
69
Stop β-blocker before exercise test
Immediate angiography
Clinical follow-up
Anti-ischemic Rx
Further imaging test
26
4
3
67
Management after positive exercise test

Less Is More

How Less Health Care Can Result in Better Health

Deborah Grady, MD, MPH
Rita F. Redberg, MD, MSc
Editor

ARCH INTERN MED/VOL 170 (NO. 9), MAY 10, 2010

If some medical care is good, more care is better. Right?

Unfortunately, this is often not the case.

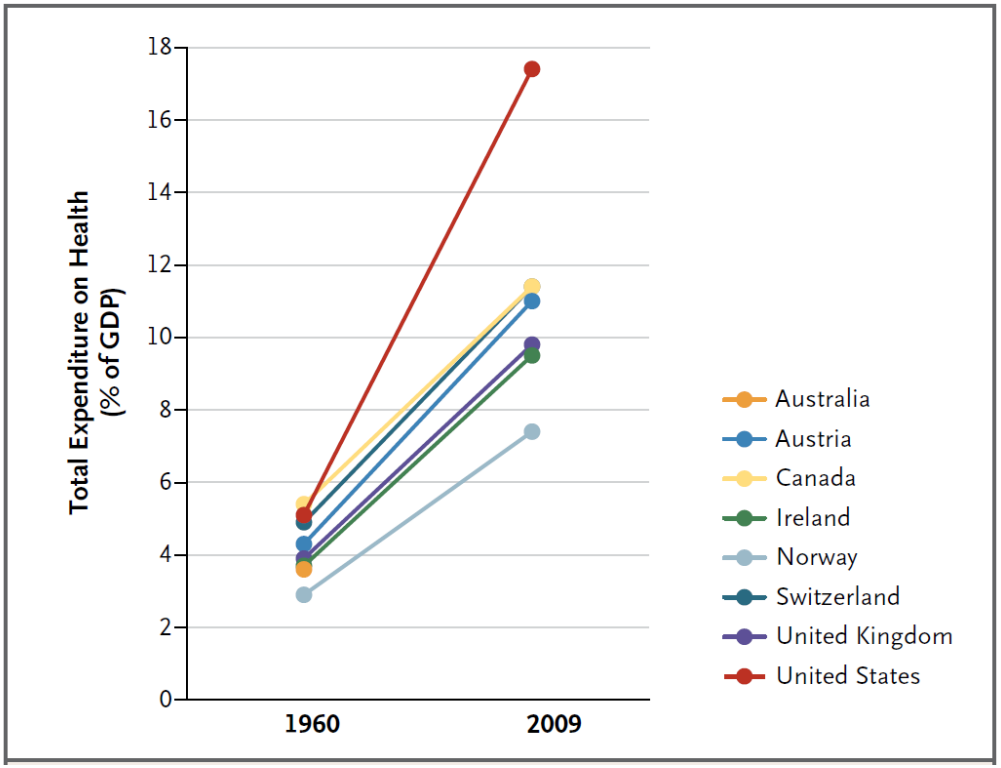
SPECIAL ARTICLE

SHATTUCK LECTURE

A Successful and Sustainable Health System — How to Get There from Here

Harvey V. Fineberg, M.D., Ph.D.

N Engl J Med 2012;366:1020-7.



Health Expenditures as a Percentage of Gross Domestic Product (GDP) in Selected OECD Countries, 1960–2009.

"By 2009, U.S. life expectancy had increased by more than 8 years, to 78.2.

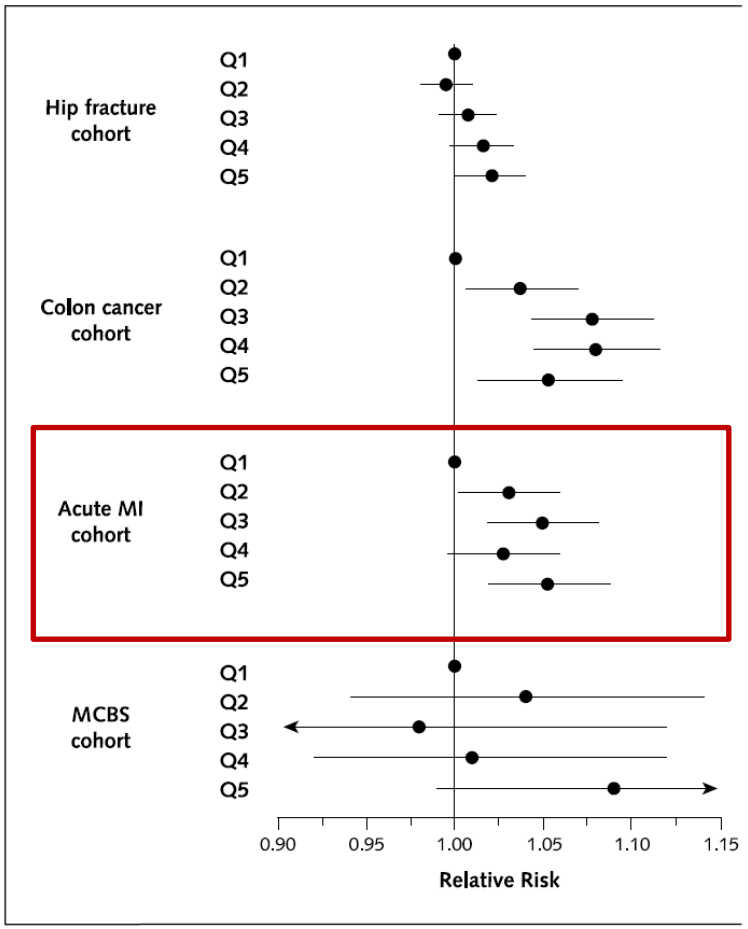
Yet this progress left us in the lowest quartile of the OECD countries: by 2009, 26 countries had longer life expectancies»

The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care

Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Thérèse A. Stukel, PhD; Daniel J. Gottlieb, MS; F.L. Lucas, PhD; and Étoile L. Pinder, MS

Ann Intern Med. 2003;138:288-298.

Figure 1. Adjusted relative risk for death during follow-up across quintiles of Medicare spending.



Conclusions: *Medicare enrollees in* ***higher-spending regions receive more care*** *than those in lower-spending regions* ***but do not have better health outcomes or satisfaction with care****.*

Efforts to reduce spending should proceed with caution, but ***policies to better manage further spending growth are warranted.***

JAMA Internal Medicine | Original Investigation | HEALTH CARE POLICY AND LAW

Variation in Physician Spending and Association With Patient Outcomes

Yusuke Tsugawa, MD, MPH, PhD; Ashish K. Jha, MD, MPH; Joseph P. Newhouse, PhD; Alan M. Zaslavsky, PhD; Anupam B. Jena, MD, PhD

Published online March 13, 2017

IMPORTANCE While the substantial variation in health care spending across regions and hospitals is well known, key clinical decisions are ultimately made by physicians. However, the degree to which spending varies across physicians and the clinical consequences of that variation are unknown.

OBJECTIVE To investigate variation in spending across physicians and its association with patient outcomes.

DESIGN, SETTING, AND PARTICIPANTS For this retrospective data analysis, we analyzed a 20% random sample of Medicare fee-for-service beneficiaries 65 years and older who were hospitalized with a nonelective medical condition and treated by a general internist between January 1, 2011, and December 31, 2014. We first quantified the proportion of variation in Medicare Part B spending attributable to hospitals, physicians, and patients. We then examined the association between physician spending and patient outcomes, adjusted for patient and physician characteristics and hospital fixed effects (effectively comparing

JAMA Internal Medicine | Original Investigation | HEALTH CARE POLICY AND LAW

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Published online March 13, 2017

CONCLUSIONS AND RELEVANCE. Health care spending varies more across individual physicians than across hospitals. However, higher physician spending is not associated with better outcomes of hospitalized patients. Our findings suggest policies targeting both physicians and hospitals may be more effective in reducing wasteful spending than policies focusing solely on hospitals.

patient and physician characteristics and hospital fixed effects (effectively comparing

Magical Thinking and Modern Medicine

The avoidable care often is related to "magical thinking"—"convictions that individuals tend to hold despite evidence that should lead to contradictory or more nuanced beliefs."

Some examples of such thinking are the beliefs that:

technology is always good,

new technology is always better than older technology,

uncertainty is intolerable.

Fineberg HV. *Avoidable Care*. http://avoidablecare.org/the-healthcare-imperative/

Pro-technology bias: il fattore umano

"Lo specialista si innamora dell'unica metodica, meglio se sofisticata, che è capace di padroneggiare e deve difenderla se vuole giustificare la sua sopravvivenza, produzione, successo e ascolto – e diventa pericoloso"

G. Baroldi, G. Ital. Cardiol, 1995; 1:242-245

The New York Times

Opinion | EDITORIAL

Do You Need That Test?

APRIL 8, 2012

If health care costs are ever to be brought under control, the nation's doctors will have to play a leading role in eliminating unnecessary treatments. By some estimates, hundreds of billions of dollars are wasted this way every year. So it is highly encouraging that nine major physicians' groups have identified 45 tests and procedures (five for each specialty) that are commonly used but have no proven benefit for many patients and sometimes cause more harm than good.

Many patients will be surprised at the tests and treatments that these expert groups now question. They include, for example, annual electrocardiograms for low-risk patients and routine chest X-rays for ambulatory patients in advance of surgery.

The doctors were prodded into action by a conscience-provoking article by Dr. Howard Brody, director of an institute that explores ethical issues in health care, published in The New England Journal of Medicine in early 2010. Dr. Brody criticized the performance of medical groups during the

RELATED COVERAGE

Doctor Panels Urge Fewer Routine Tests

RECENT COMMENTS

cb April 9, 2012
IF health care costs continue to soar, patients w
more of the financial burden??? where in the US
care costs...

Ted April 9, 2012
I have a friend who is an ER doc. Kid came in, w
indication for anything worse. Kid came back ne
hospital got sued...

Bobolinski April 9, 2012
It's in Obamacare. It's called IPAB.IPAB- Indepen

ONLINE FIRST

Choosing Wisely

Helping Physicians and Patients Make Smart Decisions About Their Care

Christine K. Cassel, MD

James A. Guest, JD

While the United States grapples with the challenge of health care costs that contribute to high rates of poor-quality care, burdens to business competitiveness, and looming government deficits, clearly there are areas in which health care spending does not add to the health of individuals and communities. The polarizing political environment makes it difficult to conduct rational public discussions about this issue, but clinicians and consumers can change the nature of this debate to the potential benefit of patients, the medical profession, and the nation. The initial focus should be on overuse of medical resources, which not only is a leading factor in the high level of spending on health care but also places patients at risk of harm. In fact, some estimates suggest that as much as 30% of all health care spending is wasted.[1]

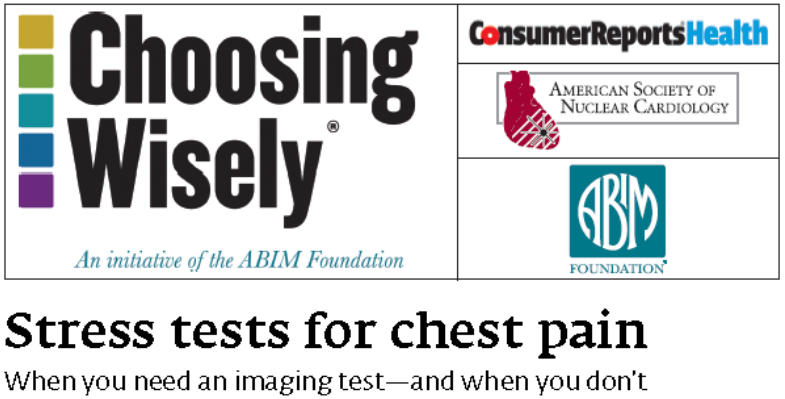
To reduce unnecessary tests and procedures, physicians will need to play a leading role—their decisions account for about 80% of health care expenditures.[2] Yet physicians do not always have the most current effectiveness data, and despite acting in good faith, they can recommend diagnostic or therapeutic interventions that are no longer considered essential. Also, research shows that physicians may need help communicating these matters to their patients. This may be ments built to enhance both comfort and personalization of medical care. Patient engagement, as 1 of the 6 major initiatives of the National Priorities Partnership of the National Quality Forum, promises more informed and involved patients as decision makers. To make good on this promise requires transparent and credible information about the relative value and risk of various medical diagnostic and therapeutic interventions.

To help reduce waste in the US health care system and promote physician and patient conversations about making wise choices about treatments, 9 medical specialty societies have joined the ABIM (American Board of Internal Medicine) Foundation and Consumer Reports in the first phase of the Choosing Wisely campaign, including the following: American Academy of Allergy, Asthma & Immunology; American Academy of Family Physicians; American College of Cardiology; American College of Physicians; American College of Radiology; American Gastroenterological Association; American Society of Clinical Oncology; American Society of Nephrology; and the American Society of Nuclear Cardiology.

As part of Choosing Wisely, each society has developed a list of 5 tests, treatments, or services that are commonly used in that specialty and for which the use should be reevaluated by patients and clinicians. Those lists were released on April 4, 2012, at a national event in Washington, DC. Additionally, other societies, consumer organizations,

Quando le indagini diagnostiche non sono appropriate nel follow-up del paziente cardiopatico cronico?

- Ecocardiografia
- ECG da sforzo
- Stress Imaging
- Angio-TC coronarica



Le cinque pratiche a rischio d'inappropriatezza di cui medici e pazienti dovrebbero parlare

Associazione Nazionale Medici Cardiologi Ospedalieri ANMCO

1	**Non richiedere ecocardiografia di controllo in pazienti con valvulopatia lieve-moderata o con disfunzione ventricolare sinistra, in assenza di nuovi sintomi, segni o eventi clinici.**
	A causa della lenta evolutività delle patologie valvolari lievi-moderate e dell'inutilità clinica di rivalutare la funzione ventricolare sinistra in pazienti clinicamente stabili, l'ecocardiografia dovrebbe essere eseguita solo in presenza di variazioni dello stato clinico.
2	**Non richiedere di routine prova elettrocardiografica da sforzo di controllo in pazienti asintomatici dopo rivascolarizzazione chirurgica o percutanea.**
	Non ci sono prove di efficacia che dimostrino la riduzione di eventi con l'esecuzione di routine di una prova da sforzo dopo rivascolarizzazione. La prova da sforzo dovrebbe essere eseguita solo per valutare rivascolarizzazioni incomplete o in presenza di variazioni dello stato clinico.
3	**Non richiedere registrazione Holter in pazienti con dolore toracico da sforzo che siano in grado di eseguire prova da sforzo, a meno che non vi sia anche il sospetto di aritmie.**
	L'Holter ha una bassa sensibilità e specificità nell'evidenziare ischemia in pazienti con dolore toracico, non potendo calibrare l'entità dello sforzo. È preferibile eseguire prima una prova da sforzo.
4	**Non richiedere test di imaging associato a test provocativo in fase di valutazione iniziale di sospetta cardiopatia ischemica.**
	Il test dovrebbe essere indicato solo in presenza di importanti fattori di rischio: diabete oltre i 40 anni, arteriopatia periferica, rischio Framingham/Cuore superiore al 20%, o in presenza di alterazioni dell'ECG di base, tali da inficiare l'interpretazione della prova da sforzo.
5	**Non richiedere prova elettrocardiografica da sforzo per screening di cardiopatia ischemica in pazienti asintomatici a basso rischio cardiovascolare.**
	In pazienti asintomatici e senza fattori di rischio, la probabilità di malattia coronarica è molto bassa, per cui l'esame aumenta il rischio di falsi positivi e di indurre ulteriori test diagnostici per escludere i dubbi sollevati dal test.

Attenzione: le informazioni sopra riportate non sostituiscono la valutazione e il giudizio del medico. Per ogni quesito relativo alle pratiche sopra individuate, con riferimento alla propria specifica situazione clinica è necessario rivolgersi al medico curante.

Giugno 2014

Gruppo di lavoro

"Fare di più non significa fare meglio"

Area Prevenzione Cardiovascolare A.N.M.C.O.

F. Fattirolli, A. Cherubini, P. Clavario, A. Frisinghelli, GF Mureddu, PL Temporelli

Procedure diagnostiche in prevenzione cardiovascolare: di che cosa possiamo fare a meno?

G Ital Cardiol 2014;15(4):253-263

Utilità degli esami strumentali nel follow-up del cardiopatico cronico.

Esame	Popolazione	Timing	Scopo	Appropriatezza
Ecocardiografia	Clinicamente stabili	Entro 6 mesi da evento	Funzione e rimodellamento VS	Utile
		Annuale	Funzione e rimodellamento VS	Non necessaria
Test ergometrico	Clinicamente stabili	Entro 2 anni dall'evento	Ischemia inducibile	Non necessario
	Asintomatici post-PCI (entro 2 anni) o post-BPAC (entro 5 anni)	Entro 2 o 5 anni	Ischemia inducibile	Non necessario
	Post-PCI (entro 2 anni) o post-BPAC (entro 5 anni) se nuovi sintomi o rivascolarizzazione incompleta	Prima di 2 o 5 anni	Ischemia inducibile	Utile
Stress imaging	Solo se ECG basale non valutabile o inadeguata capacità funzionale. Per indicazioni vedi test ergometrico			
ECG Holter	Cardiopatia ischemica cronica		Ischemia miocardica	Non necessario
	Aritmie sospette o angina vasospastica		Ischemia o aritmie	Utile
TC coronarica	Sindrome coronarica acuta/IMA		Valutazione malattia coronarica	Non indicata
	Cardiopatia ischemica cronica		Valutazione malattia coronarica	Non indicata
	Post-PCI e post-BPAC	Prima di 2 o 5 anni	Valutazione malattia coronarica	Non indicata
	Post-BPAC se sintomi	Prima di 5 anni	Verifica pervietà graft	Utile

Journal of the American College of Cardiology

Published by Elsevier Inc.

EDITORIAL COMMENT

Stress Testing After Coronary Revascularization

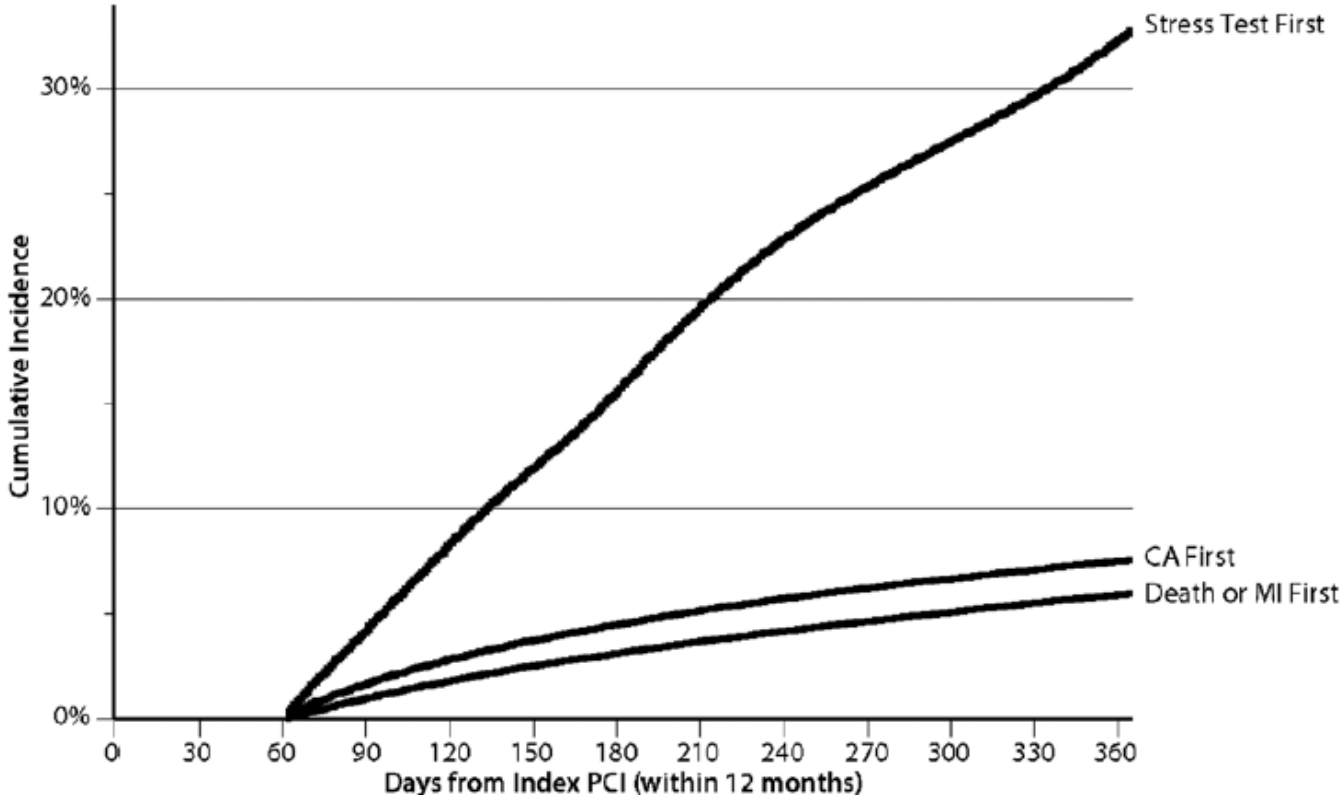
Too Much, Too Soon*

George A. Beller, MD

Charlottesville, Virginia

Patterns of Stress Testing and Diagnostic Catheterization After Coronary Stenting in 250 350 Medicare Beneficiaries

Circ Cardiovasc Imaging January 2013



Conclusions. ***Stress testing was common in older patients after PCI.*** *Paradoxically,* ***patients with higher risk features at baseline were less likely to undergo post-PCI testing***

Right Care 1

Evidence for overuse of medical services around the world

Shannon Brownlee, Kalipso Chalkidou, Jenny Doust, Adam G Elshaug, Paul Glasziou, Iona Heath, Somil Nagpal, Vikas Saini, Divya Srivastava, Kelsey Chalmers, Deborah Korenstein*

Overuse, which is defined as the provision of medical services that are more likely to cause harm than good, is a pervasive problem. Direct measurement of overuse through documentation of delivery of inappropriate services is challenging given the difficulty of defining appropriate care for patients with individual preferences and needs; overuse can also be measured indirectly through examination of unwarranted geographical variations in prevalence of procedures and care intensity. Despite the challenges, the high prevalence of overuse is well documented in high-income countries across a wide range of services and is increasingly recognised in low-income countries. Overuse of unneeded services can harm patients physically and psychologically, and can harm health systems by wasting resources and deflecting investments in both public health and social spending, which is known to contribute to health. Although harms from overuse have not been well quantified and trends have not been well described, overuse is likely to be increasing worldwide.

Published Online
January 8, 2017
http://dx.doi.org/10.1016/S0140-6736(16)32585-5

This is the first in a Series of four papers about right care

See Online/Comment
http://dx.doi.org/10.1016/S0140-6736(16)32588-0,
http://dx.doi.org/10.1016/S0140-6736(16)32570-3, and
http://dx.doi.org/10.1016/S0140-6736(16)32573-9

www.thelancet.com **Published online January 8, 2017**

Cardiovascular procedures	Italy: Rate of inappropriate PCI 22% and inappropriate coronary angiography 30%;[39] USA: Rate of inappropriate PCI 1·1% for acute indications and 11·6% for non-acute indications with variation across hospitals (6·0–16·7%);[40] Brazil: Rate of inappropriate coronary angiography 20%[41]

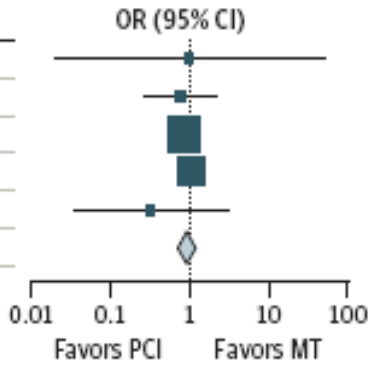
Metanalisi effetto PCI in pazienti con CAD stabile e documentazione ischemia

Stergiopoulos et al. JAMA Intern Med 2014;174:232-40

Morte

A

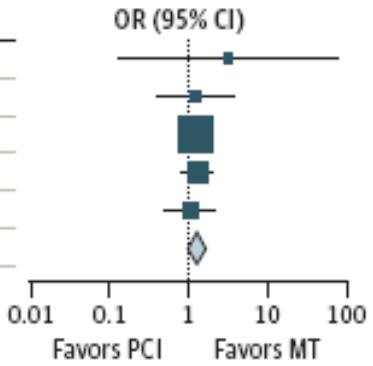
Source	OR (95% CI)	*P* Value
Hambrecht[15]	1.02 (0.02-52.43)	.99
MASS II[13]	0.76 (0.27-2.16)	.60
COURAGE[17]	0.84 (0.61-1.18)	.32
BARI 2D[14]	1.06 (0.71-1.58)	.78
FAME 2[16]	0.33 (0.03-3.16)	.33
Overall	0.90 (0.71-1.16)	.42



IMA non fatale

B

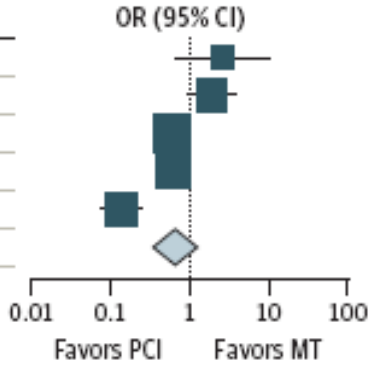
Source	OR (95% CI)	*P* Value
Hambrecht[15]	3.12 (0.12-78.45)	.49
MASS II[13]	1.24 (0.40-3.88)	.71
COURAGE[17]	1.24 (0.94-1.65)	.13
BARI 2D[14]	1.29 (0.82-2.04)	.27
FAME 2[16]	1.06 (0.51-2.22)	.88
Overall	1.24 (0.99-1.55)	.06



Revasc Unplanned

C

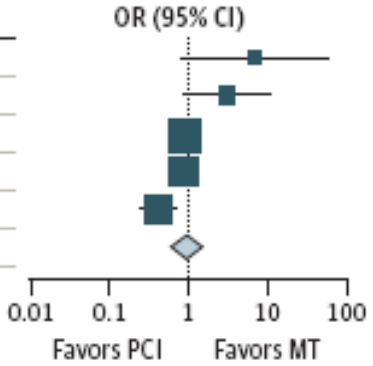
Source	OR (95% CI)	*P* Value
Hambrecht[15]	2.60 (0.63-10.71)	.18
MASS II[13]	1.84 (0.91-3.73)	.09
COURAGE[17]	0.60 (0.48-0.74)	<.001
BARI 2D[14]	0.61 (0.46-0.80)	<.001
FAME 2[16]	0.13 (0.07-0.24)	<.001
Overall	0.64 (0.35-1.17)	.14



Angina in FU

D

Source	OR (95% CI)	*P* Value
Hambrecht[15]	6.82 (0.79-58.85)	.08
MASS II[13]	3.06 (0.83-11.29)	.09
COURAGE[17]	0.91 (0.74-1.10)	.33
BARI 2D[14]	0.87 (0.59-1.28)	.47
FAME 2[16]	0.42 (0.25-0.72)	<.001
Overall	0.90 (0.57-1.44)	.67



Quindi cosa serve?

Valutare il paziente, innanzitutto !

Il follow-up strumentale del paziente stabile dopo SCA non può essere prestabilito ma dipende da **una accurata valutazione clinica**, che tenga conto di volta in volta del **profilo di rischio dopo la fase acuta**, di **eventuali variazioni del quadro clinico** nel contesto di un attento controllo dei fattori di rischio, **dell'aderenza ai trattamenti farmacologici raccomandati ed allo stile di vita appropriato**.

Association of Diet, Exercise, and Smoking Modification With Risk of Early Cardiovascular Events After Acute Coronary Syndromes

Clara K. Chow, MBBS, FRACP, PhD; Sanjit Jolly, MD, MSc, FRCPC; Purnima Rao-Melacini, MSc; Keith A.A. Fox, BSc (Hons), MB, ChB, FRCP, FESC, FMedSci; Sonia S. Anand, MD, PhD, FRCPc; Salim Yusuf, DPhil, FRCPC, FRSC

Background—Although preventive drug therapy is a priority after acute coronary syndrome, less is known about adherence to behavioral recommendations. The aim of this study was to examine the influence of adherence to behavioral recommendations in the short term on risk of cardiovascular events.

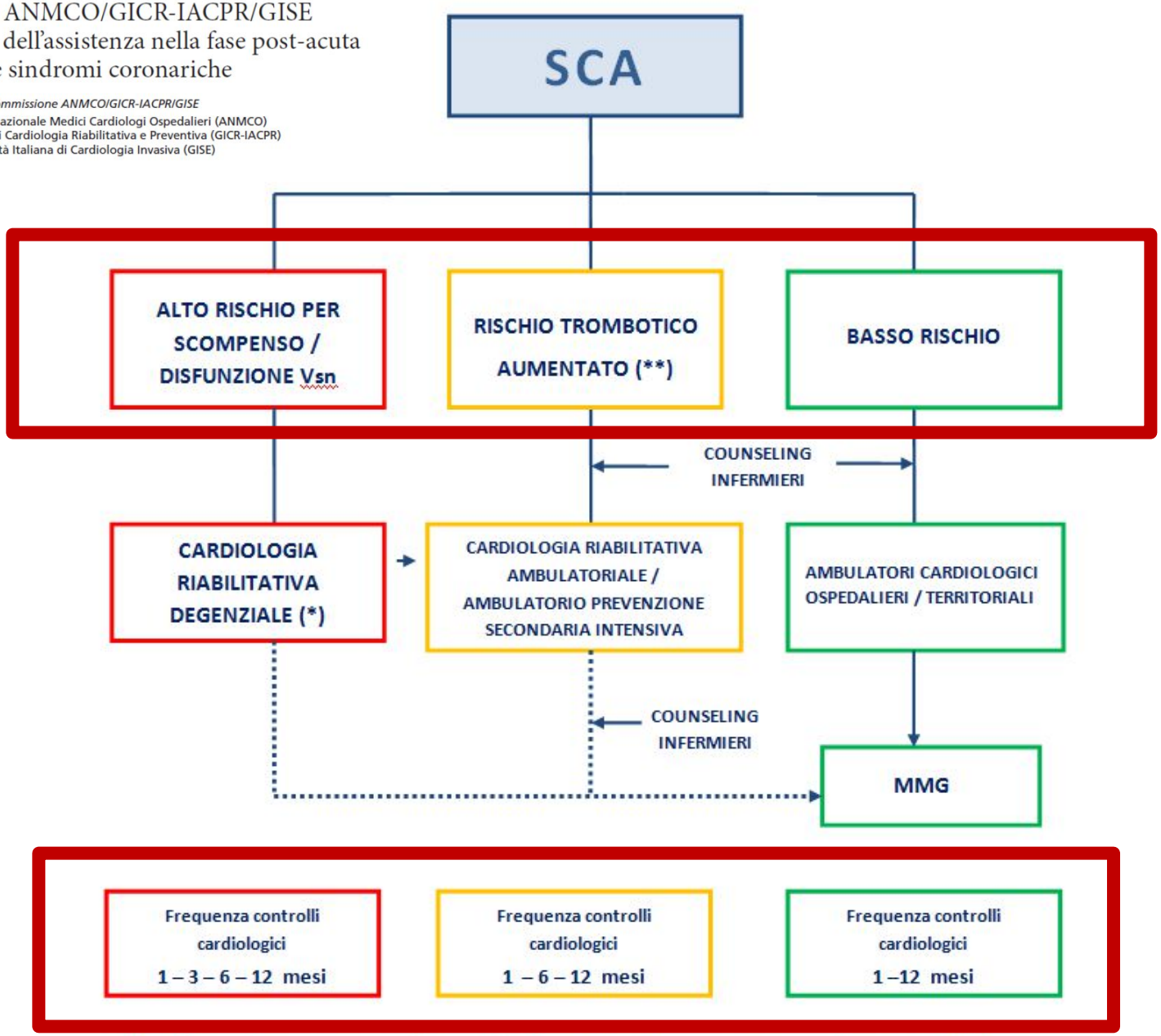
Methods and Results—The study population included 18 809 patients from 41 countries enrolled in the Organization to Assess Strategies in Acute Ischemic Syndromes (OASIS) 5 randomized clinical trial. At the 30-day follow-up, patients reported adherence to diet, physical activity, and smoking cessation. Cardiovascular events (myocardial infarction, stroke, cardiovascular death) and all-cause mortality were documented to 6 months. About one third of smokers persisted in smoking. Adherence to neither diet nor exercise recommendations was reported by 28.5%, adherence to either diet or exercise by 41.6%, and adherence to both by 29.9%. In contrast, 96.1% of subjects reported antiplatelet use, 78.9% reported statin use, and 72.4% reported angiotensin-converting enzyme/angiotensin receptor blocker use. Quitting smoking was associated with a decreased risk of myocardial infarction compared with persistent smoking (odds ratio, 0.57; 95% confidence interval, 0.36 to 0.89). Diet and exercise adherence was associated with a decreased risk of myocardial infarction compared with nonadherence (odds ratio, 0.52; 95% confidence interval, 0.4 to 0.69). Patients who reported persistent smoking and nonadherence to diet and exercise had a 3.8-fold (95% confidence interval, 2.5 to 5.9) increased risk of myocardial infarction/stroke/death compared with never smokers who modified diet and exercise.

Conclusions—Adherence to behavioral advice (diet, exercise, and smoking cessation) after acute coronary syndrome was associated with a substantially lower risk of recurrent cardiovascular events. These findings suggest that behavioral modification should be given priority similar to other preventive medications immediately after acute coronary syndrome.

Clinical Trial Registration Information—URL: http://clinicaltrials.gov/ct2/show/NCT00139815. Unique identifier: NCT00139815. (***Circulation*. 2010;121:750-758.**)

Documento ANMCO/GICR-IACPR/GISE
L'organizzazione dell'assistenza nella fase post-acuta delle sindromi coronariche

Commissione ANMCO/GICR-IACPR/GISE
Associazione Nazionale Medici Cardiologi Ospedalieri (ANMCO)
Società Italiana di Cardiologia Riabilitativa e Preventiva (GICR-IACPR)
Società Italiana di Cardiologia Invasiva (GISE)



(*) In sua assenza programma di controlli ambulatoriali con ecocardiogramma a 1-3-6-12 mesi.

(**) Il livello di rischio trombotico richiesto per l'inserimento in questo percorso va valutato in rapporto alle potenzialità organizzative del centro.

Istruzioni operative

Ipotesi di follow-up "sartoriale"

Heart failure
Left Ventricular
Dysfunction

Multivessel CAD
Left main disease
Proximal LAD
Suboptimal/
Incomplete revasc.
Diabetes

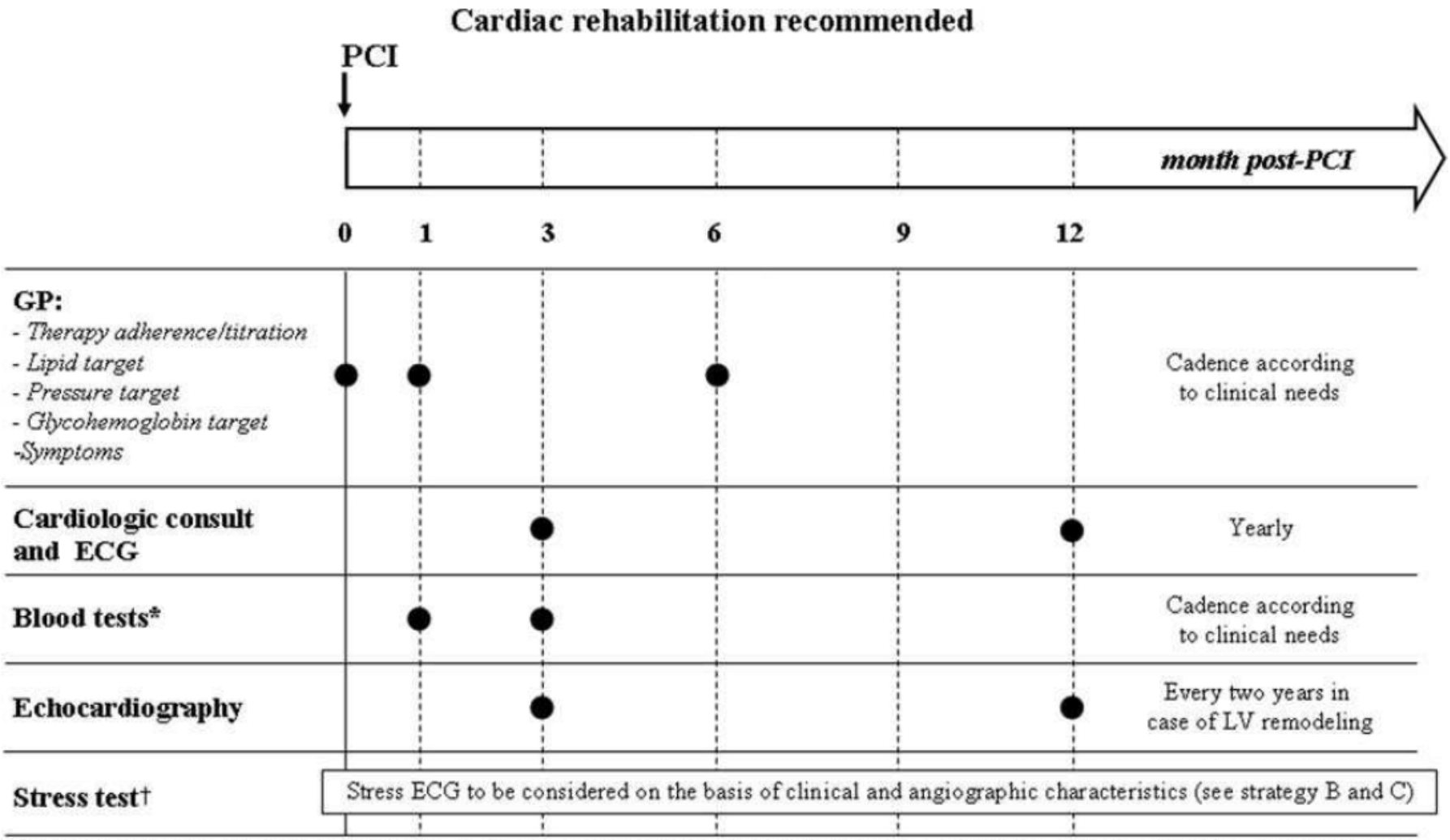
Low risk patients

Percorso A

Percorso B

Percorso C

Strategy A follow-up



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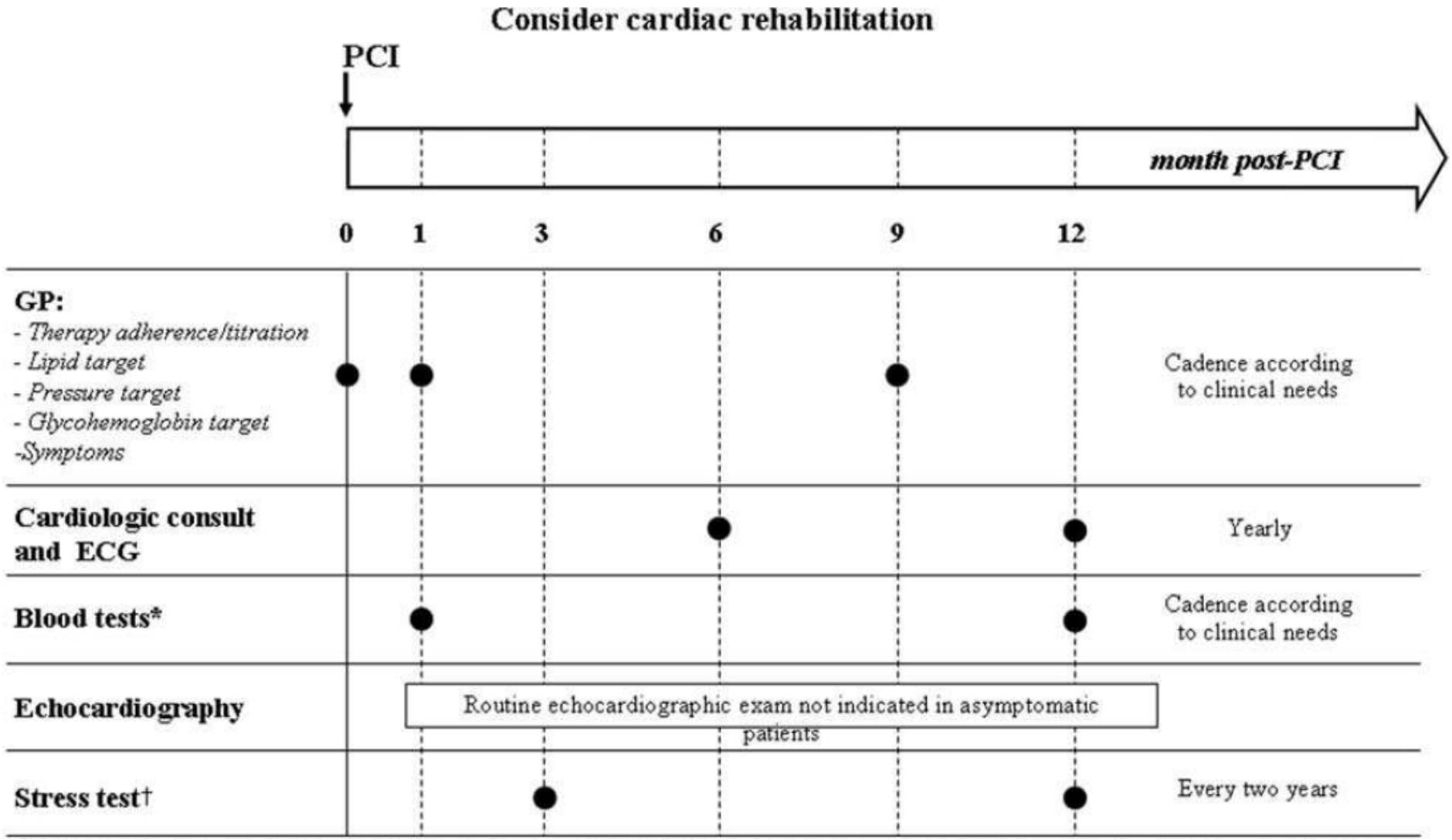
Strategy B follow-up



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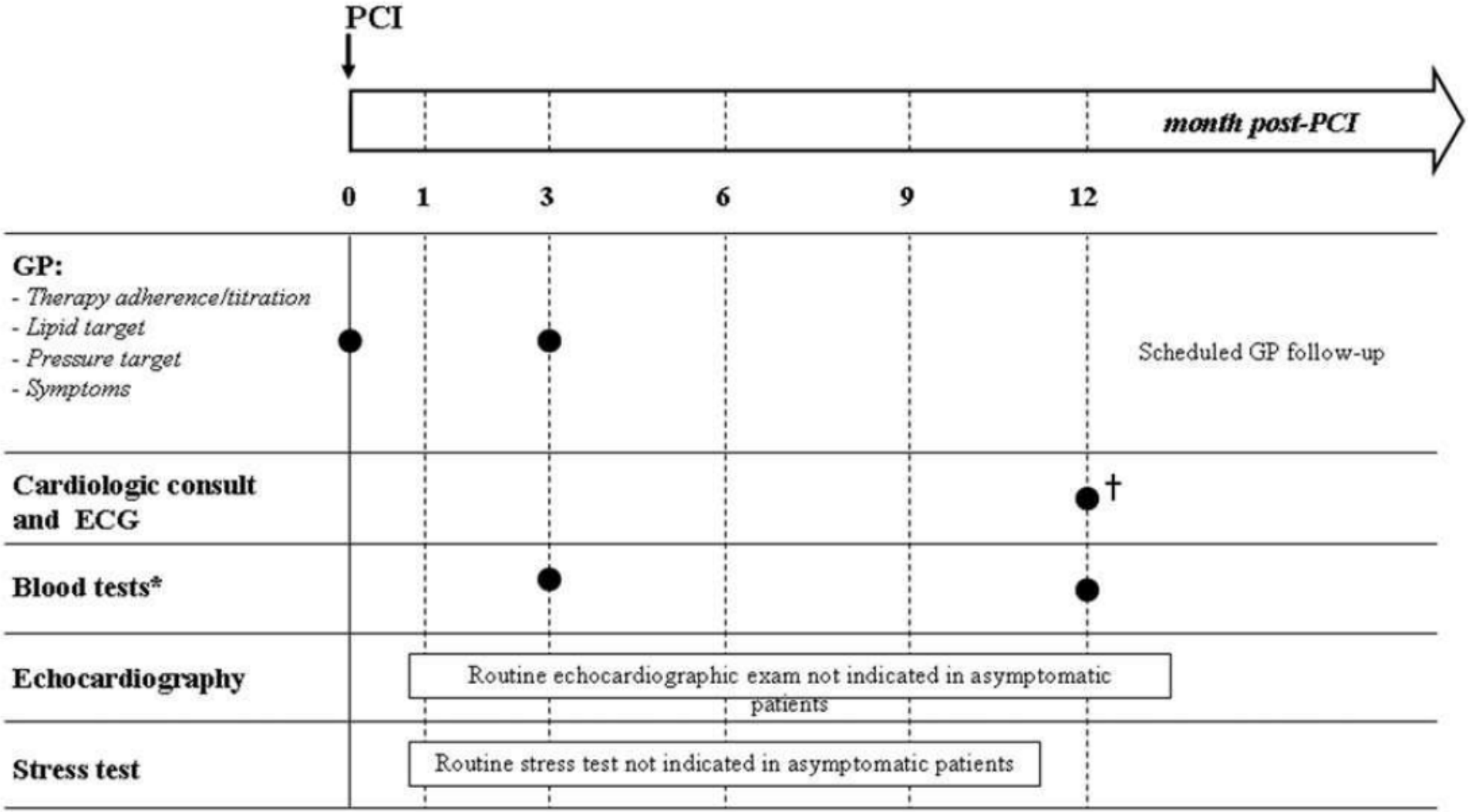
Strategy C follow-up

Routine cardiac rehabilitation not recommended



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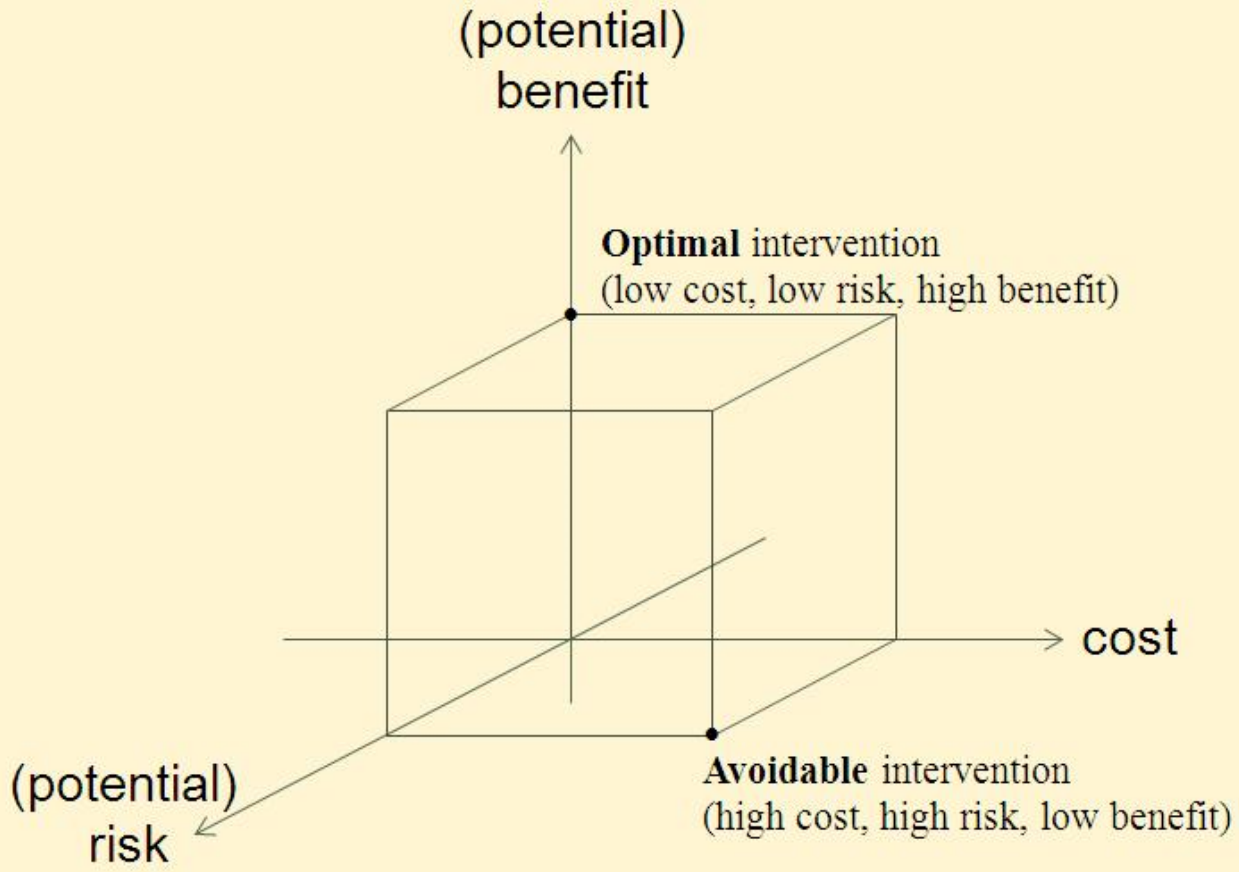
Defining Avoidable Care



Fineberg HV. *Avoidable Care: Magical Thinking and Modern Medicine*.
http://avoidablecare.org/the-healthcare-imperative/

Take Home Message

«Un nuovo tipo di pensiero è essenziale se l'umanità deve sopravvivere e muoversi verso livelli più alti»

Albert Einstein

New York Times. May 25, 1946:13