



# CARDIAC CARE

FOR NURSES, NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS and PHYSICIAN ASSISTANTS

## In This Issue

Reducing Risk to Young Athletes with CHD

Young Patients, Sports and Parent Issues

Piecing Together the Healthcare Puzzle

Discover Cardiosource

To the Cardiac Care Team

From Beth A. Friday, R.N., B.S.N.

## Reducing Risk to Young Athletes with CHD

*By Jacqueline Gannuscio, M.S.M., A.R.N.P.*

**A**s a member of the cardiac care team, you may be involved in the care of an athlete with congenital heart disease. You may be the clinician performing an echo on a young athlete with a family history of HCM, or you might be conducting a stress test to clear a young athlete for participation in a competitive sport. You might be counseling a young athlete on ICD implantation because of a family history of prolonged QT syndrome. Are you as fully prepared for these screenings as you could be?

The “36th Bethesda Consensus Conference Report: Eligibility Recommendations for Athletes with Cardiovascular Abnormalities” provides useful guidelines for cardiac care team members involved in this type of screening. These new recommendations, actually an update of recommendations made in 1985 and updated in 1994, aim to reduce



Jackie Gannuscio checks blood pressure of patient athlete.

the risk of sudden cardiac death or disease progression in competitive athletes with cardiac disease.

Understanding the basis of the recommendations alone can help reduce patient risk. Complete knowledge of the document is not

► Gannuscio continued on next page.

## Young Patients, Sports and Parent Issues

*By Nichole Walsh, R.N., B.S.N.*

**M**ost of our pediatric cardiology patients are diagnosed with congenital heart disease early in childhood. As such, by pre-adolescence and adolescence, they have become accustomed to the possibility of athletic limitations. It is never easy, though, to watch their faces when the physician tells them they cannot play a certain sport.



Limitations vary depending on diagnosis. Usually, the heavily restrictive limitations are related to patients with pacemakers and the inability to participate in contact sports and vigorous weight training.

Other mild to moderate limitations include patients with uncorrected defects or those with a severe risk of congestive heart failure. Patients with the severest restrictions are usually not in school due to their health

► Walsh continued on next page.

**Cardiac Care**

June 2005  
Vol. 2, No. 6

Publisher  
Christine W. McEntee  
Chief Executive Officer

Executive Editor  
Sheila Strand

Editor  
Anne Dees

Graphic Designer  
Matthew Duffy

*Cardiac Care* is published monthly by the American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814-1699.

Telephone: (800) 253-4636  
or (301) 897-5400  
Fax: (301) 897-9745  
E-mail: [cardiologyeditor@acc.org](mailto:cardiologyeditor@acc.org)  
Web site: <http://www.acc.org>

To subscribe or report a change of address, call (800) 253-4636, ext. 8603.

All contents © 2005. American College of Cardiology.

Send correspondence and letters to the editor to [cardiologyeditor@acc.org](mailto:cardiologyeditor@acc.org).

**Gannuscio (continued from cover)**

needed, but ability to assess specific patients' situations is.

Why is this topic important? Athletes with cardiac disease are at higher risk for sudden cardiac death than are non-athletes with CV disease. Although the number of competitive athletes who die each year is quite low compared to the number of people who participate, the death of a young, trained, apparently healthy person has enormous impact on the public consciousness and the attitudes of health care providers.

The Conference recommendations are divided into 12 separate task force reports, the first of which deals with preparticipation screening of athletes with cardiac disease. In general, all athletes in competitive sports should be screened for silent cardiac disease that puts them at risk for sudden death. Recommended screening includes taking family and personal histories and conducting a focused cardiac exam that looks for presence of murmurs, stigmata of Marfan's and vascular abnormalities. ECGs and echocardiograms are useful screening tools, but obstacles, such as funding, limit their widespread use.

Sections 2 – 7 provide practical guidelines for determining who needs diagnostic testing, who can or cannot play and who should be disqualified from competitive sports. For example, Section 4 focuses on hypertrophic cardiomyopathy, other cardiomyopathies, mitral valve prolapse, myocarditis and Marfan's Syndrome.

Sections 8 – 12 provide additional information for helping athletes with cardiac disease and includes an excellent review of the Classification of Sports; the use of performance-enhancing supplements; use and availability of automated external defibrillators; the issue of *comotio cordis* and its prevention; and the legal aspects of the document's recommendations.

**Walsh (continued from cover)**

problems, and they are not serious athletes.

Generally, the biggest problems come with a patient's parents, who want to restrict their child's activity levels more than is necessary. We fill out the forms designating unrestricted, restricted, mild, limited or homebound instruction for a patient. Quite often, we find that parents provide additional restrictions to the school's directions.

To counteract this problem, we do a lot of work with school health officials. In this situation, we tell them to follow the forms that they receive directly from and signed by our cardiologists. Our forms have simple, descriptive levels of activity and include lists of various sports with unacceptable sports for an individual patient circled. If there are discrepancies between our form and the parents' directions, the school is asked to call us.

We then devote time to re-educating the parents and the whole family, if need be, as to the child's condition and level of restrictions. Whereas it is understandable why parents are overly cautious, it is important for a child to be able to participate in physical activities and sports to the extent possible with his or her condition.

*Nichole Walsh is a registered nurse for the center for heart, lung and kidney disease inpatient and outpatient services, Children's National Medical Center in Washington, D.C. ■*

How useful are the Conference's recommendations to cardiac care team members? They are useful enough that they could prevent a death. To read the full report, go to <http://www.acc.org/clinical/bethesda/beth36/index.pdf>.

*Gannuscio is clinical director, Heart Failure Service, New England Heart Institute, Manchester, N.H. ■*

## BOOK REVIEW

## Piecing Together the Healthcare Puzzle

By Patricia Lucken, M.S.N., F.N.P.-C.

The underlying keywords of this quick two-hour read are individual responsibility, knowledge and choices. *Piecing Together the Healthcare Puzzle* provides an update of the latest in the health care insurance system. Motivated consumers could potentially save substantial money by gleaning pearls of wisdom offered in this concise, easy-to-digest book. Whether the reader is a seasoned health care worker or a novice consumer, the book includes something of interest for all audiences.

Health promotion resources are included. Valuable tips include suggesting that patients write their medical questions down before they see the doctor and insist that their concerns be addressed.

The authors emphasize that patients should expect two-way provider/consumer communication, and they offer guidance on looking for and finding a compatible provider.

The book includes a nicely done section that explains the various roles of health team members and discusses preparing an



advanced directive. A decision-making chart illustrates medical and treatment options when patients look for second opinions.

One section also explains the various types of health care payer programs with diagrams and tables to compare them.

The authors provide consumers with proactive tools they need to help them piece together their own health care puzzle. They promote patients' making informed personal decisions.

The book is also a useful tool for employees and employers looking for simple, clear explanations about the red tape surrounding health care.

*Lucken is director of Cardiac Care Service Line, St. Mary Medical Center, Victorville, Calif. ■*

*Piecing Together the Healthcare Puzzle.* Authors: Suzanne M. Bethel, R.N., C.C.R.C.; Gina H. Kilgore, R.N.; Emma Wilson Smith, A.R.N.P., C.C.R.N.; Judy A. Spears, R.N. 132 pages, spiral bound. Price: \$10 for one. Discounts for volume purchases. For information, contact Suzanne M. Bethel; phone: (407) 290-3415; e-mail: [suziebethel@earthlink.net](mailto:suziebethel@earthlink.net).

## PAs Look for Professional Growth

Physician Assistants comprise approximately one-third of the Cardiac Care Associate membership category. In a recent e-mail to PA members, we asked them about where they work, what they do and what topics they would like covered in articles or programs. The following is a small portion of the responses we received.

The most interesting work location has to be Gianaclis, Egypt, where Lorick Fox, P.A.-C., works with the U.S. Air Force.

Several members work on heart failure/heart transplant teams; others are involved with lipid clinics and various prevention clinics. One member specializes in exercise

physiology for cardiac rehab; another has focused her research on the CV effects of obstructive sleep apnea.

Developing more expertise in the various imaging modalities is of utmost importance to many respondents who see professional growth possibilities. Several say their practices are expanding into renal, carotid, and vascular intervention and stent placement.

Thanks to all CCAs who have responded to this and other e-mails. Your responses help build *Cardiac Care* and the CCA membership. Please continue to send ideas and feedback to [cardiologyeditor@acc.org](mailto:cardiologyeditor@acc.org) or to [adees@acc.org](mailto:adees@acc.org). ■



See  
**What You  
Missed at  
ACC '05**

✓ View More  
than 1,000  
Sessions

✓ Play Back  
Speakers'  
Slide  
Presentations

✓ FREE to All  
Members and  
Meeting  
Attendees

**www.  
acc05online.  
acc.org**

## Discover Cardiosource



Suzanne Hughes

*By Suzanne Hughes, M.S.N., R.N.*

The recent 36th Bethesda Conference report, *Eligibility Recommendations for Competitive Athletes with Cardiovascular Abnormalities*, raises issues brought to the forefront with the 32nd Bethesda report. The 2001 report, *Care of the Adult with Congenital Heart Disease*, focused on medical advances that have allowed many

patients born with congenital heart disease to live to adulthood. It focused also on the clinical practice and logistical issues related to their ongoing care.

The report pointed to the need for pediatric and adult cardiology communities and CV surgery specialists to collaborate to achieve a high standard of care with this population.

The 32nd Bethesda Conference also called for educating adult congenital heart disease (ACHD) specialists. With the growing number of adults with CHD, all members of the cardiovascular care team need to acquire specialized education and ongoing training to care for these patients and their complex needs.

Most of us work with adults with atherosclerotic cardiovascular disease (CVD). However, we must expect to see an

increasing number of patients in whom acquired CVD may be superimposed on congenital abnormalities.

For them, we need to be prepared for a wide range of issues, ranging from competitive sports to reproduction, employment eligibility and health care insurance.

Cardiosource can help. To access Web-based resources on congenital heart disease, go through the Congenital Heart Disease "Clinical Collections" tab on the Cardiosource home page. To access all the Bethesda Conference reports, click the "Guidelines and Trials" tab, also on the Cardiosource home page.

And don't forget. Starting June 15, a new, revitalized and redesigned Cardiosource will be launched as a free premium benefit for all ACC members.

I encourage new CCA members to familiarize themselves with all that Cardiosource has to offer. Go to [www.cardiosource.com](http://www.cardiosource.com), and on June 15, 2005, log in using your ACC login and your member ID number as a password (member ID number is found on your *JACC* mailing label).

**If you have used Cardiosource in the past and have changed your password, use the password you selected.**

Click yes to accept the user agreement, and begin taking advantage of this member benefit. ■

## To the Cardiac Care Team



Beth A. Friday

I began work as a member of a cardiac care team in 1992 and am fortunate to be in a strong, collaborative, group practice setting. Over the years I have enjoyed respect and strong support from my colleagues there. As a member of the Cardiac Care Team Task Force, I was proud to be a part of the ACC's historic decision to create the

new membership category of Cardiac Care Associate.

Since August 2003, 1,846 nurses, nurse practitioners (NPs) and physician assistants have become Cardiac Care Associate members of the ACC. Through the ACC, CCA members have the opportunity for education and access to programs that meet their professional growth needs.

The October 2003 35th Bethesda Conference, held to address the cardiology workforce crisis, acknowledged the growing need for cardiologists in the next 10 to 15 years. At the same time, it suggested that cardiology training programs had not been growing to meet the increased need.

One of the Conference's solutions was to make better use of cardiac care teams to meet the expanding needs of

delivering care. Cardiologists who work with nurses, NPs or PAs on a cardiac care team can deliver increased levels of care more cost-effectively and also provide wider access to cardiovascular care. They can feel confident that they are taking better care of more patients. Of course, they normally find that having a team means having a better balance of work and home life, too.

We still have work to do to build the membership experience for CCA members. We will continue to develop focused education programs, consider credentialing and discuss issues such as reimbursement topics.

In the future, we hope also to educate the public about the effectiveness of cardiovascular care team models.

All of us have a responsibility to engage our colleagues in building the ACC membership value and to persuade our nonmember colleagues of the value to the cardiac care team when they join the ACC.

I am looking forward to working with you on the growth of the CCA membership and achieving these goals.

Beth A. Friday R.N., B.S.N.  
Cardiology Nurse Specialist  
Marshfield Clinic, Marshfield, Wis.