



CARDIAC CARE

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

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Behavioral Cardiology: The New Frontier?

In 1959, Friedman and Rosenman suggested a link between “Type A” personality and the predisposition to cardiac disease, stimulating awareness of the link between CV disease and the mind. Yet, few clinical studies have been conducted in the area of behavioral cardiology since then. Significant advances and most clinical research in cardiovascular disease in recent years have focused on the important, although mechanistic, areas of diagnostic and therapeutic options for patients.



Behavioral Cardiology's Place

Behavioral cardiology is truly a subspecialty of cardiology, and it plays an important role in patient treatment. It is a treatment tool that recognizes the mind-body link and focuses on strategies that prevent the development or progression of CV disease.

This specialized field of cardiology differs from preventive cardiology and behavioral

psychology in that it is more comprehensive and broader in its approach. It actually encompasses both disciplines. The approach is so broad that it requires a team with a cardiologist or a nurse practitioner as team leader. The team also includes nurses, dieticians, pharmacists, psychologists and exercise physiologists. ►

Behavioral Cardiology (continued from cover)

Teams Blend Disciplines

Traditional disease management has focused on “improving prescribing practices and reducing the risk of hospitalization, costs, and mortality; successful programs have included patient education, multidisciplinary teams, and specialized follow-up procedures.” (Pickering et al.)

However, most programs have not incorporated behavioral approaches to heart failure although clinical heart failure trials have explored various isolated components including lifestyle modification and depression. Yet, heart failure disease management programs have the potential to blend medical management and behavioral modification.

One Team's Approach

The Heart Failure Disease Management Program at The New England Heart Institute in Manchester, New Hampshire, has integrated traditional disease management and behavioral cardiology. This nurse-practitioner run, physician-directed program has three components:

- guideline-based medical disease management

- lifestyle modification with referral to the CHF Cardiac Rehab Program
- behavioral modification with assessment of depression, stress, anxiety and quality of life.

The team develops a comprehensive approach to psychosocial factors with the patient and family. Prescribed interventions may include pharmacologic or non-pharmacologic treatment of depression, counseling, meditation to modify responses to stress, yoga and TaiChi. When appropriate, spiritual resources have been included, too. Patients are encouraged to explore the full variety of stress reduction techniques.

Anecdotal feedback from participants has been positive. It appears that this broad approach may have contributed to fewer hospital readmissions, too, although no statistical work has been done with that factor.

However, this approach to heart failure management represents a new frontier. It is a frontier that needs to be the focus of clinical trials, which could be directed by nurses and nurse practitioners. ■

* Pickering et al. The Mount Sinai Journal of Medicine. 2003. 70;2:101-12

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Practice Notes and Updates

Working hard to stay up-to-date professionally? Consider adding these two recent articles to your professional library.

- “Neurohumoral Features of Myocardial Stunning due to Sudden Emotional Stress.” Wittstein IS, Thiemann DR, Lima JA, et al. *New England Journal of Medicine* 2005;352:539-548.

The authors set out to determine the clinical, angiographic, and neurohormonal profile of patients presenting with myocardial stunning secondary to severe emotional stress (SES).

They performed coronary angiography and serial echocardiography in 19 patients presenting with severe left ventricular dysfunction precipitated by SES. Their

tests showed that severe emotional stress resulted in reversible left ventricular dysfunction of significant magnitude, which was probably related to exaggerated sympathetic stimulation.

- “Coronary Syndromes Following Aspirin Withdrawal: A Special Risk for Late Stent Thrombosis.” EFerrari, MBenamou, PCerboni, BMarcel. *JACC* 1 February 2005, Volume 45, Issue 3 Pages 456-459

The results support the hypothesis that aspirin withdrawal in coronary patients may represent a real risk for the occurrence of a new coronary event. Many cases involved late uncoated-stent thrombosis.

For more details on both articles, go to Cardiosource at www.acc.org. ■

March 7, 2005 Begins National Patient Safety Awareness Week

The news about NSAIDs and COX-2 inhibitors increasing cardiac events raises issues about the Food and Drug Administration and pharmaceutical manufacturers and their safety mechanisms.

However, safety concerns do not reside with those two groups alone. Patient safety is the responsibility of the health care team members and the patients themselves.

Patient safety week was proposed by the National Patient Safety Foundation, McLean, Va. The Foundation provides many products, some free for health care members to provide to their patients. Two in particular are "Pharmacy Safety — What You Should Expect: a Consumer Fact Sheet" and "What You Can Do to Make Health Care Safer: A Consumer Fact Sheet." The Boxes provides highlights from the fact sheets. For more information, go to www.npsf.org

More from a Member

CCA member Carletta Williams provides her cardiac patients with some additional tips:

- Check your medication information sheets before you eat grapefruit or drink grapefruit juice. Many cardiac medications, including calcium channel blockers and statins, restrict grapefruit juice.
- Keep Nitroglycerin in its original container
- Call 911 if you have chest pain. Do not drive yourself to the hospital.

- Women, know your special symptoms. Women do not experience the "elephant on the chest" type of chest pain.

If you have additional tips that you can provide patients, please send them to cardiologyeditor@acc.org. ■

FOR PATIENTS

What You Can Do to Make Health Care Safer

- Become a more informed health consumer
- Keep track of your medical history
- Work with your doctor and other health care professionals
- Involve a family member or friend in your care
- Follow the treatment plan agreed upon by you and your doctor

Pharmacy Safety — What You Should Expect

- Always double check that you are taking the *right dose* of the *right drug* at the *right time* in the correct way
- Tell your pharmacist about all the drugs you take, including herbal remedies, nutritional supplements and vitamins
- When you pick up your prescriptions, confirm that the drug name and strength are correct
- Confirm the instructions and make sure you understand them
- Learn what your medications look like if you take them over a long period of time
- If the medication is liquid, learn to recognize its smell.

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COMING IN APRIL

What philosophy guides your cardiac care teams? How are you structured?

Send comments to cardiologyeditor@acc.org. Please include editor in subject line.

NHLBI Offers Obesity Education Slides

The National Heart Lung and Blood Institute offers free for public use its Obesity Education Initiative (OEI) Slide Sets. The slides can be downloaded for use in computer slide shows, conventional slide presentations, or for online viewing via the Web site. There are two shows, including:

- Portion Distortion Slide Shows
- Clinical Guidelines: Evaluation and Treatment of Overweight and Obesity in Adults Slide Show

The slides are available at http://hin.nhlbi.nih.gov/oei_ss/menu.htm. ■

Discover Cardiosource



Suzanne Hughes

By Suzanne Hughes

I encourage my fellow Cardiac Care Associate members to explore the expert opinions section of Cardiosource for some new additions, especially relevant to the area of cardiovascular risk reduction.

Among them, an article by Paul Ridker, M.D., F.A.C.C. summarizes new information regarding the role of statin therapy as a strategy to decrease inflammation. Also of relevance is a commentary by Jonathan Abrams, M.D., F.A.C.C. regarding the powerful cardiovascular disease risk conferred by diabetes.

Last, George Bakris, M.D., addresses the issue of gaps in the treatment of hypertension. Each of these features includes an associated PPT file that can be downloaded.

If you want to take an advance look at some ACC '05 Spotlight Sessions, go to www.acc.org, click on Annual Scientific Session and What's New. Check out these topics:

- Kenneth Ellenbogen, M.D., F.A.C.C., EP Spotlight, "Different Phases of Clinical Trials in the Area of Cardiac Resynchronization Therapy"
- William Zoghbi, M.D., F.A.C.C., Echo Spotlight, "Practical Approach to the Quantitation of Mitral Regurgitation: Review of the Guidelines"
- Roberto Lang, M.D., F.A.C.C., Echo Spotlight, "Three-Dimensional Echocardiography"

Then don't miss these and other key presentations on Sunday, March 6 in Orlando, Fla.

And remember to check in with Cardiosource for key information updates. ■

To the Cardiac Care Team



Janet Wyman

Have you ever noticed when you attend a cardiovascular disease program, they always begin with a report of the dismal statistics regarding heart disease? In 2002, the American Heart Association reported 70,100,000 Americans had some form of CV disease. That number alone is numbing. At times

I have thought we were fighting a losing battle.

In Detroit we have a basketball team called the Pistons, maybe you saw them win the Championships last year? In the team interviews after the game, all the players said they couldn't have won without working as a team.

In 2003, the ACC, recognizing that it takes teamwork to effectively challenge CV disease, created the Cardiac Care Associate membership. The basic premise is that when all members on a cardiac care team are knowledgeable and working from the same guidelines and standards, high quality care will be achieved and maintained.

After all, on effective teams every member participates, understands the game plan and supports the efforts of all other team members.

In Michigan we have found developing the Cardiac Care team philosophy to be a rewarding experience. To build the CCA member participation,

we sent letters to practice managers, department heads and colleagues. We made formal presentations to the State chapter council and informal presentations to anyone willing to listen.

On January 27, 2005, Michigan had its inaugural meeting for the Michigan CCA members. Forty attendees listened and enjoyed the presentation by fellow CCA member, Nancy Albert, of the Cleveland Clinic. She spoke about the effectiveness of the team approach in treating people with heart failure. The nurses, PAs, CNSs and NPs who attended enjoyed being together as they shared their common interests in CV disease and health.

Cardiac care teams are powerful tools that can effectively promote cardiovascular health and facilitate management of heart disease. I encourage all ACC members — cardiologists and CCA members — to champion the teams in their institutions or practices. Invite your colleagues or staff to become members of the Cardiac Care Team at ACC.

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