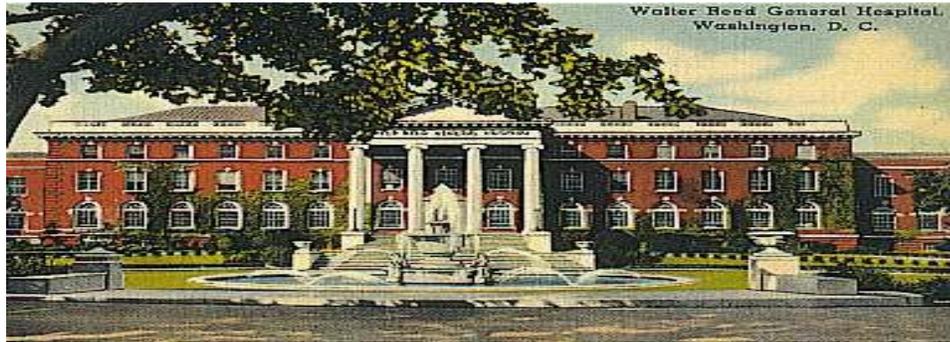


Walter Reed Cardiovascular Center



A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

Commentary

Daniel E. Simpson, MD FACC

Unfortunately, we have had to stop our Outreach Clinics at Ft. Meade, Fairfax and Woodbridge. All patients requiring Cardiology services will be accommodated here. With the institution of the “CONSULT” menu on CHCS, we will be able to screen referrals to ensure the patient receives the appropriate appointment (Cardiologist, stress test, Holter, ECHO, pacemaker).

We remain available for e-mail, phone or page consultations for all of our providers throughout the NCA/NARMC. Many consult questions can be answered via this method, which eliminates any inconvenience the patient may experience coming to DC. Utilize the provided contact information for patient diagnostic or treatment questions. Or call 202-782-3832/3833 and ask to speak with the “E-DOC” or page 202-356-1111 x107-3311.

Walter Reed Cardiology is directly handling all inpatient transfers from outside facilities. **Page 202-356-1111 x107-3384 to speak with the Cardiology Fellow on call -24/7.** Feedback indicates that this is improving responsiveness, efficiency and access for all of our beneficiaries and referring providers.

Our website is available at www.wramc.amedd.army.mil
Go to Clinical Departments → Medicine → Cardiology.

Cardiovascular Update

Daniel E. Simpson, MD FACC

*Rates of Hyperkalemia after Publication of the Randomized Aldactone Evaluation Study**

Background: The Randomized Aldactone Evaluation Study (RALES) demonstrated an improvement in morbidity and mortality with the use of spironolactone in patients with severe heart failure (most taking ACE inhibitor at baseline but minority on a b-blocker). Patients were monitored closely for hyperkalemia and many were excluded from trial based on advanced renal disease or mild hyperkalemia.

Methods: Population-based time series analysis of patients > 65 in Ontario to examine the trends in spironolactone prescriptions,

and the rate of hospitalization for hyperkalemia before and after the publication of RALES (1999).

Results: The spironolactone-prescription rate in patients treated with an ACE inhibitor after hospitalization for CHF increased from 34/1000 patients in 1994 to 149/1000 by 2001 ($P < 0.001$). Hyperkalemia hospitalization increased from 2.4/1000 in 1994 to 11.0/1000 in 2001 (< 0.001). The associated mortality went from 0.3/1000 to 2.0/1000 ($P < 0.001$).

Conclusion: Following the publication of the RALES trial, the prescription rate of spironolactone went up as did the rate of hyperkalemia and hyperkalemia-associated mortality.

Comments: The application of this inexpensive therapy to a broad, non-clinical trial population requires careful pre-RX assessment of hyperkalemia risk and close clinical & laboratory follow-up. We recommend referral to our Congestive Heart Failure Clinic for evaluation and treatment (call or e-mail Cathy Franklin or Stacy Walsh).

*N Engl J Med 2004;351:543-51.

www.nejm.org

Guideline Review

J. Edwin Atwood, MD FACC

*Recommendations for Treatment of Symptomatic Left Ventricular Systolic Dysfunction (Stage C)**

Class I

- Diuretics in pts who have evidence of fluid retention
- ACE inhibition in all, unless contraindicated
- B-blockers in all stable pts, unless contraindicated
- Digitalis for treatment of symptoms, unless contraindicated
- Withdrawal of drugs known to adversely affect the clinical status (NSAIDs, most anti-arrhythmics, and most Ca⁺⁺ blockers)
- Class I measures for pts in Stage A and B

Class IIa

- **Spironolactone in patients with recent or current class IV symptoms, preserved renal function and normal K⁺ level**
- Exercise training

- Angiotensin receptor blockade (ARB) in pts on digitalis, diuretic, and b-blocker and who cannot receive an ACE inhibitor due to cough or angioedema
- Combination of hydralazine and a nitrate in patients on digitalis, diuretic, and b-blocker and who cannot receive an ACE due to hypotension or renal insufficiency

Class IIb

- Addition of an ARB to an ACE inhibitor
- Addition of a nitrate (alone or with hydralazine) to an ACE inhibitor in patients who are on digitalis, diuretic and b-blocker

Class III

- Long-term infusion of a positive inotropic drug
- Use of an ARB instead of an ACE inhibitor in patients who have not received or who can tolerate an ACE inhibitor
- Use of ARB prior to b-blocker in pts on an ACE inhibitor
- Use of a Ca⁺⁺ blocker as a treatment for HF
- Routine use of nutritional supplements or hormonal therapies for the treatment of HF

Class I – General agreement that procedure/treatment is useful & effective

Class II – Conflicting evidence and/or divergence of opinion

Class III – Not useful/effective and in some cases may be harmful

*ACC/AHA Guidelines for the Evaluation and Management of

Chronic Heart Failure in the Adult (2001)

www.acc.org/clinical/statements.htm

Cardiovascular Trials at WRAMC

CARDIASTAR

PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology

Questions/Referrals: Please contact Daniel Simpson

OPTIMIZE-HF

Assessment of inpatients with CHF and/or LV dysfunction to determine if guideline treatment is appropriately implemented

Questions/Referrals: Please contact Stephen Welka

WARCEF

Randomized, double-blind comparison of coumadin versus aspirin for the reduction of death and stroke in heart failure patients (EF < 30% and in sinus rhythm)

Questions/Referrals: Please contact Stephen Welka