New era in anticoagulation

In November 2011, NICE (National Institute of Health and Clinical Excellence) approved Dabigatran etexilate for use in non valvular AF patients. Dabigatran etexilate is recommended as an option for the prevention of stroke and systemic embolism within its licensed indication, that is, in people with non valvular atrial fibrillation with one or more of the following risk factors:

- Previous stroke, transient ischaemic attack or systemic embolism
- Left ventricular ejection fraction below 40%
- Symptomatic heart failure of New York Heart Association (NYHA) class 2 or above
- Age 75 years or older
- Age 65 years or older with one of the following: diabetes mellitus, coronary artery disease or hypertension.

EXPERT REVIEW: DR MATTHEW FAY

‘For people with Atrial Fibrillation and those who manage their care this is clearly the dawning of a new era where we can move beyond only Warfarin as the only effective intervention for stroke prevention. With the licensing and NICE approval of Dabigatran and the Factor Xa agents to follow there is now an array of alternatives with advantages beyond the reduction in monitoring. However with potentially over a million people in the UK with Atrial Fibrillation and approximately 75% meeting the criteria to be considered from Stroke Prevention intervention (one of the factors listed above) we will have to be mindful of the cost to maximise our coverage of this prevention agenda.

Clearly there are people for who these new agents are the only option; those with allergy or intolerance of Warfarin, those where Warfarin cannot be adequately controlled due to genetic make-up or co-prescription of other necessary medication and those where the bleeding risk on Warfarin could be consider unacceptable compared to the new alternatives.

However with the size of the population to be treated, consideration must still be given to the cheaper and effective alternative. This responsibility to be conscious of the restrictive budget of NHS can not only fall to the newly appointed guardians of NHS spend in Clinical Commissioning Groups (CCG), but also to the teams based in the secondary and tertiary care centres. The responsibility falls further in to the wider health care community to include those of the profession who can lead public opinion with a voice in the media and the editors of the health pages of our print media and the health programs on the TV.

With effective alternatives to Warfarin we should now endeavour as a health community to ensure a wider uptake of anticoagulation in the AF population. The current levels of 50% of those in need not receiving anticoagulants shows marked room for improvement, but this cannot be with uncontrolled spend but with a mixed economy of Warfarin, Xa inhibitors and of course Dabigatran.’

Has UK health policy disproportionately promoted the care of plumbing problems over electrical heart faults, despite both being equally deadly?

Arrhythmia Alliance is planning a significant research project to answer this question, and to investigate how its implications might be addressed. Whatever the answer, greater insight is urgently required into why UK arrhythmia patients are currently so poorly-served. The provision of arrhythmia care in the UK is also wildly uneven leaving patients at the mercy of their postcode instead of in the hands of an equitable and efficient cardiac care service.

Specifically, implantable devices that offer pacing, defibrillation and resynchronisation are among the most effective technologies to correct arrhythmias. Many of these devices not only represent excellent value, they are simple to implant and are easy to manage. In most cases they are without side effects, require no daily administration, little monitoring and yet they deliver therapy 24/365 regardless of patient interest, attention, motivation, lifestyle or age.

In many cases, an implanted device is the only life-saving or life-enhancing option available for a patient. For these reasons, they have become standard treatment for a range of arrhythmic conditions.

National and regional inequity

As the excellent device audit report (www.devicesurvey.com) demonstrates every year, access to these treatments in the UK is not determined by clinical need, cost nor by physician preference. In the UK, the biggest single factor that determines whether or not you’ll gain access to a life-saving heart rhythm treatment is your postcode.

If you don’t live in the right area of Britain your chances of benefiting from the most appropriate device treatment might be lower than for citizens of Greece, the Czech Republic or Spain. In fact, of the 17 European countries for which there are available data, only Ireland and Norway have lower pacemaker implant rates than the UK. We are not even meeting our own standards. In the UK we fall short of every one of the professionally-agreed minimum expected implant rates.

Yet it is when we examine differences across the UK that the real horror emerges. Every single one of the Cardiac and Stroke regions in England and Wales is under-treating arrhythmias with pacemakers. On average, we miss the minimum target by 23%. In the worst performing regions, this minimum target is missed by a massive 46%.

Our current half-hearted approach

Heart disease is frequently cited at the biggest killer in the UK. This is true. While true, nearly half of these deaths result from arrhythmias. In the UK 100,000 people die each year from SCA and yet 80% could be saved if diagnosed and treated with life-saving devices.

Yet it is the plumbing that has received the lion’s share of the clinical attention, and which also receives nearly all the focus of government policy. Despite a brief resurgence of DoH interest following the campaign for arrhythmias to feature in the NSF for cardiology, it now appears to be on the decline.

It is vital that this trend is reversed, and that the reasons for it are uncovered. It is also vital that we don’t just report that scale of the problem with metronomic regularity but that we explore all the possible reasons behind the UK-aversion to providing effective and equitable care for arrhythmia patients. Without knowledge of the reasons, we will forever remain incapable of implementing change. For these reasons, the Arrhythmia Alliance is embarking upon a major research project into the policy and practice of implanting cardiac devices across the UK, and across Europe. Our goal is to identify good practice, and to highlight and eliminate the reasons it is not more widely replicated. We look forward to keeping you posted on our progress.

www.devicesurvey.com
Take part in
Heart Rhythm Week
21st – 27th May 2012

Order your awareness pack and receive free new educational tools to help you raise awareness of heart rhythm disorders and encourage patients to seek further advice for their symptoms.

For more information and to order your awareness pack please contact caroline@heartrhythmcharity.org.uk

The Unify Quadra CRT-D and Quartet LV Lead feature first-to-market quadripolar pacing technology in a downsized device. Uniquely designed with 4 electrodes on the LV lead, this innovative CRT system enables LV pacing at the preferred site without compromising lead stability for better management of heart failure patients.

Find clinical resources and access downloadable education materials at SJMquadripolar.com

Products registered are CE marked. May not be available for sale in the U.S. Brief Summary: Prior to using these devices, please review the Instructions for Use for a complete listing of indications, contraindications, warnings, precautions, potential adverse events and directions for use. Devices depicted may not be available in all countries. Check with your St. Jude Medical representative for product availability in your country. Unless otherwise noted, ™ indicates that the name is a trademark of, or licensed to, St. Jude Medical or one of its subsidiaries. ST. JUDE MEDICAL, the nine-squares symbol and MORE CONTROL. LESS RISK. are trademarks and service marks of St. Jude Medical, Inc. and its related companies. ©2011 St. Jude Medical, Inc. All Rights Reserved.
Jayne Mudd: Outstanding Medical Contribution to Cardiac Rhythm Management Services

Describe your role – what is a typical day like for you?
My role as a nurse consultant in cardiac rhythm management (CRM) can vary from day to day. The role itself is split into components that include clinical practice, education, service development and research. My clinical commitments include providing nurse services for patients with or suspected of experiencing arrhythmia and for those experiencing transient loss of consciousness. I am based within the cardiology department at James Cook University Hospital, Middlesbrough and work as part of the cardiac rhythm management team. I routinely work within clinics which include new patient, review and preadmission as well as outreach arrhythmia clinics in the community and transient loss of consciousness clinics. As a team we provide a comprehensive service for our patients which also includes a patient helpline manned by the nursing team.

Your award reflects the outstanding contribution you have made to arrhythmia services, is there a particular initiative that you are most proud of?
I take pride in all aspects of my work but the initiatives that I have been most proud to be involved in have been the development of our outreach arrhythmia clinics which resulted in improved access to specialist services for patients within their own locality and the more recent development of the transient loss of consciousness (TLOC)service. This is a multi-disciplinary / multi-specialty service with cardiology and neurology teams working together to provide prompt access to assessment, diagnosis and treatment for this patient group. The service has been running for 11 months and has proven to be very successful to date.

If there was a Quality Standard for arrhythmia management, what key things do you think all arrhythmia patients should be entitled to receive? Prompt assessment and triage, access to ECG monitoring and other pertinent diagnostic tests, access to an arrhythmia specialist, access to an arrhythmia helpline which offers support and advice, access to appropriate treatments.

Jean Maloney: Allied Professional Award for Outstanding Contribution to Arrhythmia Management

Describe your role – what is a typical day like for you?
My priority at the Northern General Hospital is to ensure that all of our inpatients who have heart rhythm investigations and procedures receive adequate education and support throughout their hospital stay. If required, this will continue after discharge until such a time that the patient feels they no longer need help or information.

A typical day would first involve me checking messages left overnight and then heading out on to the wards to
see the first list patients about to undergo pacemaker or defibrillator implants. From here, I visit four cardiology wards to see any overnight admissions and all new referrals who the nurses may be concerned about. At lunchtime, I meet with the consultants to discuss any concerns I have and the afternoon is either spent in clinic doing CBT, counselling or assessing suitability for heart devices.

What aspects of your work do you find the most rewarding?
I love my job and am incredibly lucky to have the ability to interact comfortably with most people. However, one aspect of my job which really does spur me on is telling our heart failure patients that they have been accepted onto our four week waiting list for a cardiac resynchronisation device. Not that long ago, medication was all we could offer to some patients with the prospect of nothing else if this failed, however, we now can go one step further by implanting a ‘special’ pacemaker or defibrillator which can help improve quality of life.

You attended HRC 2011, what were the highlights for you?
Attending HRC is a fantastic opportunity for me and one that I would never have done as a ward sister. Whilst I enjoy the variability in themes at HRC, my biggest highlight is the networking opportunity it provides. Being allowed to share my experience and knowledge whilst gaining from other often more experienced nurses is invaluable. I have made some good friends and useful contacts through HRC and am still very humbled at being asked to speak at patients’ day.

Team of the Year
Dorset Cardiac & Stroke Network: Stroke Prevention and Public Awareness Subgroup and the Arrhythmia Subgroup

Tell us what inspired you to make the ‘Know Your Pulse’ film
We made the Know Your Pulse film as a result of the emphasis we have placed on raising awareness of stroke and risk factors within our Network. This was discussed with our Cardiac and Stroke Network subgroups (which include patients and carers) and there was widespread support for the development of the video (we actually made two – one to highlight the signs and symptoms of TIA and the Know Your Pulse campaign). We feel that people should be able to take responsibility for their own health and the video campaign allows people to learn how to take their own pulse and check for abnormalities.

What advice would you give to other teams to achieve such excellent practice in this field?
Collaborate. We had such a fantastic team of people working across primary care, secondary care, social care and voluntary organisations. They brought their own ideas to the table and made sure that the video was promoted widely.

How has the film been used locally?
We have shown the video in a number of forums including: 90% of GP surgeries on The Life Channel (a health education channel) and our local ‘Fifty Plus forums’ (16 across the county). We are currently looking at how we can get the video played in local cinemas, libraries and leisure centres. We participate in local Know Your Pulse events and can use the video as an adjunct to this. The video is also available for local hospitals to use in their waiting rooms.

Full interview with our Award Winners

Find out more about the Know Your Pulse campaign
www.knowyourpulse.org
2011 Summary

Arrhythmia Alliance and HRUK hosted the sixth annual Heart Rhythm Congress from October 2nd - 5th 2011. HRC remains the largest and fastest growing cardiology meeting in the UK welcoming over 3000 delegates.

HRC 2011 provided a first class educational opportunity to members of the medical, allied professional and industry communities offering a wide range of symposia, debates, patient group discussions, and was well supported by exhibitors with the largest exhibition to date.

International medical experts presented to packed out rooms during notable sessions including ‘Innovative Therapies to Advance Patient Care’ chaired by and featuring a presentation from Dr Paolo Della Bella of the Institute of Cardiology, Milan and the STARS Syncope session including Beverly Karabin Associate Professor at the University of Toledo, Ohio USA.

The hottest topic of the congress proved to be ‘Devices in Inherited Cardiac Conditions’ thanks to excellent presentations on Hypertrophic Cardiomyopathy by Dr. Perry Elliott, ARVC by Dr Pier Lambiase, Long QT Syndrome by Dr Elijah Behr and Brugada Syndrome presented by Dr Derek Connelly. Look out for these topics in the Regional Cardiac Update Courses in 2012. Here’s what the delegates had to say about this session:

“The devices in inherited cardiac conditions session was excellent with clear review of evidence and sensible recommendations. Well done to all four speakers”.

“Devices in inherited conditions was excellent - could have been longer”.

“Devices in inherited cardiac conditions was very informative and a good presentation on this difficult subject”

To register an interest in attending HRC 2012 please send an email to melanie@heartrhythmcharity.org.uk and you will be informed when registration opens.
To register an interest in attending your local Cardiac Update Course in 2012 please send an email to melanie@heartrhythmcharity.org.uk and you will be sent course details and registration forms when available.

**2010/11 Summary**

Arrhythmia Alliance travelled across the UK hosting sixteen Cardiac Update Courses during 2010 and 2011 reaching over 800 medical and allied professionals. 2010 marked the first year that the courses offered CPD Points and were certified by the Royal College of Physicians.

We have been delighted to feature expert faculty from various fields of Cardiology including Professor John Camm in London and Dr Mark Anderson and Dr Peter O’Callaghan in Carmarthen, Wales. Oxford’s course received excellent feedback with Dr Tim Betts chairing the day and our first visit to Newcastle proved a huge success thanks to the faculty including Dr Janet McComb, Dr Andreas Wolff and syncope expert Dr Steve Parry.

Course topics followed the theme of Stroke Prevention in AF and Syncope Guidelines and covered key issues including Care Pathways in AF Management, Drugs versus Devices, Emerging Oral Anticoagulants, Ablation Techniques, The Role of the Arrhythmia Nurse and The Identification of Cardiac Syncope.

**Areas we have been asked to develop:**

The role of the ambulance service in delivering care and referral of cardiac patients

Syncope management for GPs

Update on drugs with feedback from prescribers on benefits and side effects

How drugs are comparing in practice to the trial data

Geriatrician’s view on the pros and cons of anticoagulation and new drugs in the elderly

**Delegate Feedback**

**General Comments:**

“The course was excellent, could not really be improved upon!”

“More audience participation, perhaps audience to bring cases for discussion.”

“The day was extremely informative, relaxed and relevant.”

“Similar topics with an update on new drugs for next year will be great!”

**Our Aims for 2012 Cardiac Update Courses**

Through sixteen Cardiac Update Courses across the UK we aim to continue our efforts from 2010/11 to increase awareness of arrhythmias, including Atrial Fibrillation and Syncope, and their effects to Primary, Secondary and Tertiary Care across the UK.

**Locations**

You will find Arrhythmia Alliance, AFA and STARS in the following towns and cities in 2012:

- Belfast
- Birmingham
- Bristol
- Cambridge
- Edinburgh/Glasgow
- Exeter/Plymouth
- Hull
- Leeds
- Liverpool
- London
- Manchester
- Newcastle
- Nottingham
- Southampton
- Swansea
- Wrexham

Consultant: 23.2%
Nurse: 22.8%
Physiologist: 19.4%
Industry: 11.0%
Physiotherapist: 8.8%
Cardiac Network: 5.9%
Trainee: 3.4%
Pharmacist: 2.1%
Other: 2.1%
Paramedic: 1.5%

Cardiac Update Courses 2010/11
Which Centralized ECG Solution Would You Choose?

Cardiac Safety Yesterday

Cardiac Safety Today

Scan Me!

Better Science, Lower Cost, Most Convenience

Step into the future of cardiac safety analysis at www.ert.com/ecg

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