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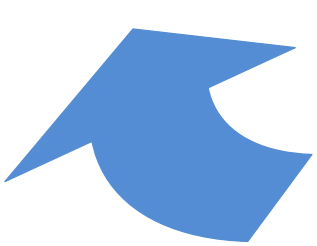
CORONARY CARE UPDATE 8: Winter 2019



Electronic resources and healthcare databases: Contact us for training

Welcome to the latest copy of this Update. The aims of this publication are:

- To bring together a range of recently-published research reports, articles and electronic resources to help all staff keep up-to-date with research and practice.
- To remind readers of the services available from the Library and Knowledge Service – we can supply you with 1:1 or small group training in evidence searching skills; obtain full-text articles for you; or provide you with an evidence search service to help you with your evidence based practice, patient care, decision making and research.
- To respond to your information needs – if you have any suggestions on the type of information sources you would find helpful in future editions of the Update, then please let us know.

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Accessing Articles

The following abstracts are taken from a selection of recently published articles.
If the article is available electronically, this is noted in the Abstract. [Press CTRL-click to open the link. You will need to be registered for OpenAthens (see above) to be able to access the full text.]
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Feedback

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Please send your feedback or suggestions for the update to holly.cook3@nhs.net

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18. The management of childhood cancer survivors at risk for stroke: A Delphi survey of regional experts

19. Aspirin use and cardiovascular outcome in patients with type 2 diabetes mellitus and heart failure: A population-based cohort study

20. Projecting incidence of post-stroke cognitive impairment and dementia in the Irish population aged 40-89 years in 2015 to 2025

21. "Heart disease never entered my head": Women's understanding of coronary heart disease risk factors

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NICE Resources – Updates and New Products.

1. Potential use of PCSK9 inhibitors as a secondary preventative measure for cardiovascular disease following acute coronary syndrome: A UK real-world study

Author(s): Elamin A.F.M.; Obafemi T.; Katira R.; Grafton-Clarke C.; Wen Chen K.; Luvai A.; Davis G.

Source: Postgraduate Medical Journal; 2019

Publication Date: 2019

Publication Type(s): Article

Available at Postgraduate Medical Journal - from BMJ Journals

Abstract: Background: Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors are a major development in the prevention of cardiovascular disease (CVD) and is one of the most significant discoveries since the development of statin therapy. Administration of two human monoclonal antibodies to PCSK9 (alirocumab and evolocumab) can significantly reduce low-density lipoprotein cholesterol (LDL-c) concentrations, thus improving lipid management. Accordingly, guidelines on the specific indications for alirocumab and evolocumab usage have been released. This multicentre study aimed to estimate the proportion of patients treated for an acute myocardial infarction (MI) who could be considered for PCSK9 inhibitors under the current National Institute for Health and Care Excellence (NICE) lipid targets criteria. Method(s): The records of 596 patients in two large hospitals in Liverpool, UK were analysed. Information was collected on lipid profiles during and after admission, lipid-lowering therapy and previous CVD. Result(s): At least 2.2% of patients were eligible for PCSK9 inhibitors post-MI under the current NICE guidance. Additionally, 29% of patients failed to achieve LDL-c concentrations <2.0 mmol/L despite maximum statin therapy and failed to meet eligibility for PCSK9 inhibitors as per the NICE criteria. This cohort represents a group of patients in limbo', in which statin therapy alone is not sufficient to reduce LDL-c. Conclusion(s): PCSK9 inhibitors are expensive and so their use must be highly selective. At present, in a real-world setting with ezetimibe underprescribing, ~2% of patients are eligible and a further 30% are deprived of benefit and improved outcomes by lack of optimisation and/or potential use of PCSK9 inhibitors.

Database: EMBASE

2. Corrigendum to: UK Stroke Forum Abstracts 2018 (International Journal of Stroke, (2018), 13, 3_suppl, (10-65), 10.1177/1747493018801108)

Author(s): anonymous

Source: International Journal of Stroke; 2019

Publication Date: 2019

Publication Type(s): Article In Press

Abstract: The UK Stroke Forum organisers wish to highlight the following corrections: 001 Screening for atrial fibrillation in primary care by pulse check at the time of influenza vaccination Lund J, Saunders K, Edwards D, Mant J Department of Public Health and Primary Care, University of Cambridge, Cambridge, UK 009 A 'traffic light' system of TIA clinic referral stratification Dearnley N, Mahbubur C, Siu J, Patel R, Sengupta N, Williams P, Siddegowda S Department of Stroke Medicine, Worthing Hospital, Western Sussex Hospitals NHS Foundation Trust, West Sussex, UK 121 Subclavian steal syndrome - a diagnostic challenge Macdonald FE, Pearce O, Thavanesan K, Dharmasiri M Department of Stroke Medicine, Royal Bournemouth and Christchurch NHS Foundation Trust, Bournemouth, UK 134 Improving stroke care across the stroke pathway Bhalla S Barking, Havering

and Redbridge University Hospitals NHS Trust, London, UK 136 Effects on service delivery by vertically aligning the stroke therapy services from in-patient through to community in Bolton Crozier S, Crofts K Royal Bolton Hospital Foundation Trust, Bolton, UK 147 A tool to aid shared decision-making on treatments after severe stroke Visvanathan A1, Dennis MS1, Whiteley WN1, Mead GE1, Doubal F1, Lawton J2 1Centre for Clinical Brain Sciences, University of Edinburgh, Edinburgh, UK 2Usher Institute of Population Health Sciences and Informatics, University of Edinburgh, Edinburgh, UK 149 Experiences and acceptability of diagnostic ultrasound-guided shoulder rehabilitation programme for people with stroke: physiotherapists' and patients' perspectives Kumar P, Murphy Z, Dean M, Rondel S, Burn J, Naylor Z, Montgomery O, Pearson J University of West of England, Bristol, UK Lancashire Stroke Hydration Project (LancSHoP) - developing research capacity in stroke nursing via collaborative working Gibson JME1, Timoroksa AM2, Romagnoli E3, Howard J3, Maley A3, Jeffs C3, Miller C1, Jones SP1 1University of Central Lancashire, Preston, UK 2Lancashire Teaching Hospitals NHS Foundation Trust, Lancashire, UK 3Blackpool Teaching Hospitals NHS Foundation Trust, Blackpool, UK 224 The Acute Bundle of Care for IntraCerebral Haemorrhage (ABC-ICH) project: evaluation of a regional quality improvement project to improve outcomes after acute intracerebral haemorrhage Parry-Jones A1, Brunton L1, Birleson E2, Sammut-Powell C1, Paroutoglou K2, Suman A3, Kawafi K4, McQuaker C3, Greaves N4, Cross S3, Alzouabi O4, Patel H2, Boaden R1, Peek N1 1University of Manchester, Manchester, UK 2Salford Royal NHS Foundation Trust, Salford, UK 3Stockport NHS Foundation Trust, Manchester, UK 4Pennine Acute Hospitals NHS Trust, Manchester, UK 238 Improving the effectiveness of patient information transfer between the inpatient and community stroke teams within the Greater Manchester Stroke Operational Delivery network Azam L1, Anderson J2 1Salford NHS Foundation Trust, Salford, UK 2King's College London, London, UK.

Database: EMBASE

3. Nurses' attitudes, beliefs and practices on sexuality for cardiovascular care: A cross-sectional study

Author(s): Wang, Panpan; Ai, Jiansai; Davidson, Patricia M; Slater, Tammy; Du, Ruofei; Chen, Changying

Source: Journal of Clinical Nursing; Mar 2019; vol. 28 (no. 5-6); p. 980

Publication Date: Mar 2019

Publication Type(s): Journal Article

Available at Journal of Clinical Nursing - from Wiley

Abstract: Aims and objectivesTo describe nurses' attitudes, beliefs, and practices regarding sexuality care for patients with cardiovascular disease.BackgroundLimited sexual activity is common among patients with cardiovascular disease, yet assessment of sexuality and counselling is frequently not undertaken by nurses.DesignCross-sectional study.MethodsThis study recruited 268 cardiac nurses from seven tertiary hospitals in five cities of Henan province. The Sexual Attitudes and Beliefs Survey, along with investigator-developed questions regarding practices and perceived barriers, was administered to the nurses. The STROBE checklist was used to ensure quality reporting during this observational study (see Supporting Information Data S1).ResultsThe average age of nurses who participated was 31.81 years (SD = 7.41). The average score of Sexual Attitudes and Beliefs Survey was 47.72 (SD = 7.40), indicating moderate attitudinal barriers for nurses to discuss sexual activities with patients. Most nurses (91%) perceived that sexuality was too private to discuss with patients. Only 20% of nurses expressed that they would provide time to discuss sexual concerns with patients.

Eighty per cent of nurses revealed that they felt uncomfortable discussing sexuality; moreover, they believed that hospitalised patients were too sick to be engaged in these types of conversations. Additionally, almost 85% of nurses conveyed that they have never conducted discussions regarding sexuality care in patients with cardiovascular disease. The most frequently reported perceived barriers preventing nurses from discussing sexual concerns included fear of offending patients (77.2%), uncertainty of how to communicate with patients (69.4%), feelings of embarrassment (67.5%), lack of safe and private environments (61.9%) and lack of knowledge (54.9%).ConclusionNurses in this cross-sectional sample rarely discussed sexual concerns with their patients. There were several key barriers identified by nurses regarding providing sexuality care, including personal attitudes and beliefs, limited skills and knowledge, culture and organizational-related barriers.Relevance to clinical practiceTargeted training for nurses and creating a culturally safe environment is recommended to improve management of sexuality in patients with CVD.

Database: BNI

4. Interventions to promote patient utilisation of cardiac rehabilitation

Author(s): Santiago de Araujo Pio C.; Grace S.L.; Chaves G.S.S.; Davies P.; Taylor R.S.

Source: Cochrane Database of Systematic Reviews; Feb 2019; vol. 2019 (no. 2)

Publication Date: Feb 2019

Publication Type(s): Review

Available at Cochrane Database of Systematic Reviews - from Cochrane Collaboration (Wiley)

Abstract: Background: International clinical practice guidelines routinely recommend that cardiac patients participate in rehabilitation programmes for comprehensive secondary prevention. However, data show that only a small proportion of these patients utilise rehabilitation. Objective(s): First, to assess interventions provided to increase patient enrolment in, adherence to, and completion of cardiac rehabilitation. Second, to assess intervention costs and associated harms, as well as interventions intended to promote equitable CR utilisation in vulnerable patient subpopulations. Search Method(s): Review authors performed a search on 10 July 2018, to identify studies published since publication of the previous systematic review. We searched the Cochrane Central Register of Controlled Trials (CENTRAL); the National Health Service (NHS) Centre for Reviews and Dissemination (CRD) databases (Health Technology Assessment (HTA) and Database of Abstracts of Reviews of Effects (DARE)), in the Cochrane Library (Wiley); MEDLINE (Ovid); Embase (Elsevier); the Cumulative Index to Nursing and Allied Health Literature (CINAHL) (EBSCOhost); and Conference Proceedings Citation Index - Science (CPCI-S) on Web of Science (Clarivate Analytics). We checked the reference lists of relevant systematic reviews for additional studies and also searched two clinical trial registers. We applied no language restrictions. Selection Criteria: We included randomised controlled trials (RCTs) in adults with myocardial infarction, with angina, undergoing coronary artery bypass graft surgery or percutaneous coronary intervention, or with heart failure who were eligible for cardiac rehabilitation. Interventions had to aim to increase utilisation of comprehensive phase II cardiac rehabilitation. We included only studies that measured one or more of our primary outcomes. Secondary outcomes were harms and costs, and we focused on equity. Data Collection and Analysis: Two review authors independently screened the titles and abstracts of all identified references for eligibility, and we obtained full papers of potentially relevant trials. Two review authors independently considered these trials for inclusion, assessed included studies for risk of bias, and extracted trial data independently. We resolved disagreements through consultation with a third review author. We performed random-effects meta-regression for each outcome and

explored prespecified study characteristics. Main Result(s): Overall, we included 26 studies with 5299 participants (29 comparisons). Participants were primarily male (64.2%). Ten (38.5%) studies included patients with heart failure. We assessed most studies as having low or unclear risk of bias. Sixteen studies (3164 participants) reported interventions to improve enrolment in cardiac rehabilitation, 11 studies (2319 participants) reported interventions to improve adherence to cardiac rehabilitation, and seven studies (1567 participants) reported interventions to increase programme completion. Researchers tested a variety of interventions to increase utilisation of cardiac rehabilitation. In many studies, this consisted of contacts made by a healthcare provider during or shortly after an acute care hospitalisation. Low-quality evidence shows an effect of interventions on increasing programme enrolment (19 comparisons; risk ratio (RR) 1.27, 95% confidence interval (CI) 1.13 to 1.42). Meta-regression revealed that the intervention deliverer (nurse or allied healthcare provider; P = 0.02) and the delivery format (face-to-face; P = 0.01) were influential in increasing enrolment. Low-quality evidence shows interventions to increase adherence were effective (nine comparisons; standardised mean difference (SMD) 0.38, 95% CI 0.20 to 0.55), particularly when they were delivered remotely, such as in home-based programs (SMD 0.56, 95% CI 0.37 to 0.76). Moderate-quality evidence shows interventions to increase programme completion were also effective (eight comparisons; RR 1.13, 95% CI 1.02 to 1.25), but those applied in multi-centre studies were less effective than those given in single-centre studies, leading to questions regarding generalisability. A moderate level of statistical heterogeneity across intervention studies reflects heterogeneity in intervention approaches. There was no evidence of small-study bias for enrolment (insufficient studies to test for this in the other outcomes). With regard to secondary outcomes, no studies reported on harms associated with the interventions. Only two studies reported costs. In terms of equity, trialists tested interventions designed to improve utilisation among women and older patients. Evidence is insufficient for quantitative assessment of whether women-tailored programmes were associated with increased utilisation, and studies that assess motivating women are needed. For older participants, again while quantitative assessment could not be undertaken, peer navigation may improve enrolment. Authors' conclusions: Interventions may increase cardiac rehabilitation enrolment, adherence and completion; however the quality of evidence was low to moderate due to heterogeneity of the interventions used, among other factors. Effects on enrolment were larger in studies targeting healthcare providers, training nurses, or allied healthcare providers to intervene face-to-face; effects on adherence were larger in studies that tested remote interventions. More research is needed, particularly to discover the best ways to increase programme completion.

Database: EMBASE

5. The International comparison of Systems of care and patient outcomes In minor Stroke and Tia (InSIST) study: A community-based cohort study

Author(s): Levi C.R.; Spratt N.; Lasserson D.; Quain D.; Zareie H.; Garcia Esperon C.; Valderas J.; Dewey H.M.; Alan Barber P.; Cadilhac D.A.; Feigin V.; Davey A.; Najib N.; Magin P.

Source: International Journal of Stroke; Feb 2019; vol. 14 (no. 2); p. 186-190

Publication Date: Feb 2019

Publication Type(s): Article

Abstract: Rationale: Rapid response by health-care systems for transient ischemic attack and minor stroke (TIA/mS) is recommended to maximize the impact of secondary prevention strategies. The applicability of this evidence to Australian non-hospital-based TIA/mS management is uncertain. Aim(s): Within an Australian community setting we seek to document processes of care, establish

determinants of access to care, establish attack rates and determinants of recurrent vascular events and other clinical outcomes, establish the performance of ABC2-risk stratification, and compare the processes of care and outcomes to those in the UK and New Zealand for TIA/mS. Sample size estimates: Recruiting practices containing approximately 51 full-time-equivalent general practitioners to recruit 100 TIA/mS per year over a four-year study period will provide sufficient power for each of our outcomes. Methods and design: An inception cohort study of patients with possible TIA/mS recruited from 16 general practices in the Newcastle-Hunter Valley-Manning Valley region of Australia. Potential TIA/mS will be ascertained by multiple overlapping methods at general practices, after-hours collaborative, and hospital in-patient and outpatient services. Participants' index and subsequent clinical events will be adjudicated as TIA/mS or mimics by an expert panel. Study outcomes: Process outcomes-whether the patient was referred for secondary care; time from event to first patient presentation to a health professional; time from event to specialist acute-access clinic appointment; time from event to brain and vascular imaging and relevant prescriptions. Clinical outcomes-recurrent stroke and major vascular events; and health-related quality of life. Discussion(s): Community management of TIA/mS will be informed by this study.

Database: EMBASE

6. A closer look at stroke services in Scotland and the challenges facing community rehabilitation

Author(s): Conroy S.

Source: Physiotherapy (United Kingdom); Jan 2019; vol. 105

Publication Date: Jan 2019

Publication Type(s): Conference Abstract

Abstract: Purpose: The survey was intended to give a snap shot of what was happening in stroke services across Scotland to help inform the 'Rehab Matters' campaign. Method(s): A simple questionnaire was circulated through Scottish Board members to their staff working in stroke services and via a few stroke physiotherapist known to the CSP. Result(s):* Responses were received from each of the 14 Boards although there was considerable variation in the numbers from each. * Considerable variation was seen in the distribution of specialist as compared to generalist physiotherapy staff. Specialists were almost exclusively found in the acute setting. * Huge discrepancies were also found between waiting times in acute as compared to community services. Waiting times increased progressively as patients moved along the stroke pathway. 35% of patients had to wait for more than 4 weeks for rehabilitation on leaving hospital and there was a wait of over 6 weeks for specialist community physiotherapy where this service existed. * While in hospital patients well over 60% of patients receive daily therapy with the remaining percentage getting therapy 2-3 times per week. The vast majority of community patients, 93%, received physiotherapy once a week or less. * A huge number of outcome measures (54) were listed as being used frequently. Conclusion(s): Overall, the findings suggest that when a patient is acutely unwell in hospital with the main focus being on stabilising their medical condition/saving their life, physiotherapy from a specialist physiotherapist is offered daily in the majority of cases. Yet, on discharge from hospital when medically stable and arguably more able to participate with rehabilitation, patients can largely expect weekly physiotherapy delivered by a 'generalist.' Implications: This survey findings have been a very useful means of improving our advocacy and influencing ability around the rehabilitation agenda. However, the survey is not without its limitations and perhaps raises more questions than it actually answers. Perhaps most importantly it raises many questions of our profession;* How can acute and community services better work

together to provide seamless quality patient care? * Is it right that the majority of our specialist stroke physiotherapists work within acute services or do we need a fluid movement of staff in order to meet patient needs? * Should community teams be condition specific or should we be moving towards more 'specialist generalist' roles? * What should the profession be doing in order to demonstrate impact and compare service models in terms of cost and outcomes for the patient? Funding acknowledgements: N/A.Copyright © 2018

Database: EMBASE

7. Is practising standing-up and moving between sitting and standing early after a severe stroke feasible? A feasibility randomised controlled trial

Author(s): Logan A.; Freeman J.; Kent B.; Marsden J.; Pooler J.; Barton A.; Vickery J.; Creanor S.; Enki D.

Source: Physiotherapy (United Kingdom); Jan 2019; vol. 105

Publication Date: Jan 2019

Publication Type(s): Conference Abstract

Abstract: Purpose: The most common physical deficit caused by stroke is muscle weakness which limits a person's mobility (e.g. out of bed activities, sitting, standing and walking). Moving between sitting and standing is an essential pre-requisite to walking, and one of the most frequently performed functional tasks of daily living. These activities are of paramount importance to people who have had a stroke. There is a critical window of opportunity following stroke, when performing functional tasks, such as standing and sit-to-stand, enhances recovery. However, moving between sitting and standing is significantly affected in people with severe stroke who require physical assistance and/or equipment to move, therefore, opportunities to routinely practise these tasks are often lacking during hospital-based rehabilitation. Primary aim: determine whether a randomised controlled trial (RCT) of a functional standing frame programme (standing and repeated sit-to-stand) during inpatient sub-acute stroke rehabilitation setting is feasible for people with severe stroke. Secondary aim: explore experiences of the functional standing frame programme and trial processes, from the perspective of the person with stroke and their relative; explore physiotherapists' experiences delivering the intervention and trial processes. Method(s): Assessor blinded RCT. Participants aged >=18 years with new/recurrent severe stroke (Modified Rankin Scale 4 or 5) from four Stroke Rehabilitation Units across Cornwall and Devon were randomly allocated into one of two groups:1. Functional standing frame programme (30 minutes) plus 15 minutes of usual physiotherapy (minimum 5x week for 3 weeks) to assess and/or progress transfers or undertake activities identified by participant/physiotherapist (intervention) 2. Usual physiotherapy (45 minutes; minimum 5x week for 3 weeks) (control) Primary outcome measures: Barthel Index and Edmans Activity of Daily Living Index Twenty semi-structured interviews (participants, relatives, physiotherapists) and one focus group (physiotherapists) were undertaken and data is currently being analysed using thematic analysis utilising a framework approach. Process evaluation using Medical Research Council framework will enable conclusions to be made about the strengths and weaknesses of the trial to facilitate decision-making for the anticipated main trial. Result(s): Forty-five adults (51-96 years; 42% male, 58% female) with severe or very severe stroke (modified Rankin Scale 4 = 87% 5 = 22%) were recruited. Fifty-one percent had partial artery circulation stroke; 27% total anterior circulation stroke, 7% posterior circulation stroke and 15% lacunar stroke, 82% suffered fatigue and 53% were aphasic. Data collection ends 21/10/2018 when the last participant has completed their 12-month follow-up. A CONSORT flow diagram will display progress of all participants through the trial. Qualitative data will be presented. Twenty individual interviews (n = 6

control group; n = 4 intervention group; n = 4 relatives; n = 6 physiotherapists) and one focus group (n = 5 physiotherapists). Conclusion(s): The functional standing frame programme combines two existing evidence-based interventions not tested previously in people with sub-acute severe stroke. Initial findings suggest this novel combination is acceptable to, and feasible for people with severe stroke, during their hospital-based rehabilitation early after stroke. Implications: Initial findings suggest a definitive RCT of a functional standing frame programme is feasible for people with severe stroke. A future trail will investigate the effectiveness and cost effectiveness. Funding acknowledgements: This abstract presents independent research funded by the National Institute for Health Research (NIHR). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

Database: EMBASE

8. Impact of early intervention and rehabilitation on functional decline in patients hospitalised for acute heart failure

Author(s): Eriksen S.

Source: Physiotherapy (United Kingdom); Jan 2019; vol. 105

Publication Date: Jan 2019

Publication Type(s): Conference Abstract

Abstract: Purpose: Acute heart failure (AHF) is the most common cause of admissions for patients aged 65 and over in the UK. The occurrence of functional decline in elderly adults with hospitalisation for acute illness is well established with decline occurring as early as day 2 of admission. With an average length of stay of 18.7 days, patient age of 71.4 years, and 77.1% of patients having at least one other chronic disease, the patients admitted to the Heart Failure Unit at St George's Hospital are high risk for functional decline throughout their stay. Traditionally these patients would not be seen by a physiotherapist until after their intravenous diuretic treatment was completed. The aim was to assess the impact of early and specialist physiotherapy assessment and intervention on functional decline during hospitalisation of patients with AHF. Method(s): The Elderly Mobility Scale (EMS) was used to assess mobility on both admission and discharge from the heart failure unit. Patients were provided with individualised physiotherapy intervention whilst an inpatient aimed at preventing functional decline, planning for discharge, and promoting rehabilitation and self-management. Admission and discharge EMS scores for patients admitted between March 2016 and October 2017 were compared. Patients who passed away, transferred for onward medical care, or who were at the ceiling of the EMS on both admission and discharge were excluded. 153 sets of data were compared in total Details on admission date to first assessment by physiotherapy were collected. Result(s): The median EMS score was 14.00 (IQR = 11.00-18.00) on admission and 16.00 (IQR = 13.00-18.00) on discharge. From admission to discharge the number of patients scoring less than 10, indicating they would need a high level of help with mobility and ADLs, decreased from 30 to 9. The number of patients scoring 10-13, indicating borderline in terms of safe mobility and independence, decreased from 42 to 36. The number of patients scoring 14 to 20, indicating independence with mobility and ADLs, increased from 81 to 108. Seven patients (5%) had a decrease, seventy-four patients (48%) showed no change and seventy-two patients (47%) had an increase in their EMS score on discharge compared with admission. Patients waited for physiotherapy an average of 0.98 days. Conclusion(s): Early physiotherapy intervention for patients hospitalised with acute heart failure appears to maintain or improve their function from admission to discharge. Only a small percentage of patients scored lower on discharge than admission and the dependence level of the patients decreased during their stay. Physiotherapy intervention appears

beneficial to increase mobility and decrease dependence of a predominantly elderly population with multiple comorbidities. Further statistical analysis of the data to prove any significance in difference in admission to discharge scores would be beneficial along with a sample population of patients admitted with AHF to other wards as a comparison. Implications: The expected benefits of early physiotherapy intervention include reduced reliance on care and improved quality of life in the community on discharge. This information would be useful for new or evolving heart failure services to ensure appropriate therapeutic representation. Funding acknowledgements: This work was unfunded.Copyright © 2018

Database: EMBASE

9. Does service timing matter for psychological outcomes in cardiac rehabilitation? Insights from the national audit of cardiac rehabilitation

Author(s): Sumner J.; Bohnke J.R.; Doherty P.

Source: European Journal of Preventive Cardiology; 2018; vol. 25 (no. 1); p. 19-28

Publication Date: 2018

Publication Type(s): Article

PubMedID: 29120237

Available at European Journal of Preventive Cardiology - from Unpaywall

Abstract: Background: The presence of mental health conditions in cardiac rehabilitation (CR) patients such as anxiety and depression can lead to reduced programme adherence, increased mortality and increased re-occurrence of cardiovascular events undermining the aims and benefit of CR. Earlier research has identified a relationship between delayed commencement of CR and poorer physical activity outcomes. This study wished to explore whether a similar relationship between CR wait time and mental health outcomes can be found and to what degree participation in CR varies by mental health status. Methods: Data from the UK National Audit of Cardiac Rehabilitation, a dataset that captures information on routine CR practice and patient outcomes, was extracted between 2012 and 2016. Logistic and multinomial regression models were used to explore the relationship between timing of CR and mental health outcomes measured on the hospital anxiety and depression scale. Results: The results of this study showed participation in CR varied by mental health status, particularly in relation to completion of CR, with a higher proportion of non-completers with symptoms of anxiety (5% higher) and symptoms of depression (8% higher). Regression analyses also revealed that delays to CR commencement significantly impact mental health outcomes post-CR. Conclusion: In these analyses CR wait time has been shown to predict the outcome of anxiety and depression status to the extent that delays in starting CR are detrimental. Programmes falling outside the 4-week window for commencement of CR following referral must strive to reduce wait times to avoid negative impacts to patient outcome.Copyright © The European Society of Cardiology 2017.

Database: EMBASE

10. Participants' Experiences of a Sexual Counseling Intervention During Cardiac Rehabilitation: A Nested Qualitative Study Within the CHARMS Pilot Randomized Controlled Trial

Author(s): D'Eath, Maureen, MSc; Byrne, Molly, PhD; Murph, Patrick, PhD; Jaarsma, Tiny, PhD; McSharry, Jenny, PhD; Murphy MD, Andrew W; Doherty, Sally, PhD; Noone, Chris, PhD; Casey, Dympna, PhD

Source: The Journal of Cardiovascular Nursing; 2018; vol. 33 (no. 5); p. E35

Publication Date: 2018

Publication Type(s): Journal Article

Available at The Journal of Cardiovascular Nursing - from lww.com

Abstract: Background: International guidelines recommend sexual assessment and counseling be offered to all patients with cardiovascular disease during cardiac rehabilitation. However, sexual problems are infrequently addressed. The Cardiac Health and Relationship Management and Sexuality (CHARMS) intervention is a complex, multilevel intervention designed to increase the provision of sexual counseling in cardiac rehabilitation. It was piloted in 2 cardiac rehabilitation centers to assess the acceptability and feasibility of the intervention and to inform and refine a definitive cluster randomized controlled trial protocol. Objectives: The aim of this study was to explore the experiences, perceptions, and opinions of patients, partners, and cardiac rehabilitation staff who participated in the CHARMS staff-led patient education class. Methods: A qualitative, descriptive study using semistructured interviews to collect the data. Cardiac rehabilitation staff (n = 8) were interviewed when the intervention commenced in their center and 3 months later (n = 6). Patients (n = 19) and partners (n = 2) were interviewed after delivery of the class; 7 were interviewed again 3 months postintervention to explore temporal changes in opinions. Results: Most cardiac rehabilitation staff were comfortable delivering the CHARMS intervention but would prefer a less structured format. Some staff perceived discomfort among patients. Few patients reported discomfort. Most patients and partners considered that the intervention was a welcome and acceptable part of a cardiac rehabilitation program. Conclusion: Incorporating sexual counseling into cardiac rehabilitation programs is feasible. Although the views of the patients and staff diverged on a number of issues including the perceived comfort of patients, its inclusion was welcomed by patients and was acceptable overall to both staff and patients.

Database: BNI

11. Cardioprotective whole-diet advice in cardiac rehabilitation

Author(s): Parker, Tracy; Taylor, Victoria

Source: British Journal of Cardiac Nursing; 2018; vol. 13 (no. 9); p. 428

Publication Date: 2018

Publication Type(s): Journal Article

Abstract: Seven out of ten people are surviving a heart attack. Good quality cardiac rehabilitation with dietary advice as a core component is a vital part of the management of these patients. In the past, cardiac rehabilitation advice focused on single risk factors and nutrients, such as fats and lipid modification. However, as knowledge about nutrition and cardiovascular disease (CVD) has grown, it has become clear that there is a much broader role for dietary change; advice must focus on the diet as a whole and the balance of food within it, to reduce CVD risk. Despite this, much of the debate around nutrition and the cardiac patient continues to focus on individual foods or risk factors. This can detract from the advice given to patients in national guidelines on a whole-diet approach. The traditional Mediterranean diet is recommended consistently across national guidelines and is one of the most well-researched dietary patterns. This approach has been associated with a lower risk of

CVD; however, other models, including the 'dietary approaches to stop hypertension' (DASH) diet, have also been found to be successful.

Database: BNI

12. Cardiovascular Disease in Korean Americans: A Systematic Review

Author(s): Shin, Cha-Nam, PhD, RN; Keller, Colleen, PhD, RN, FAHA, FAAN; An, Kyungeh, PhD, RN; Sim, Jeongha, PhD, RN

Source: The Journal of Cardiovascular Nursing; 2018; vol. 33 (no. 1); p. 82

Publication Date: 2018

Publication Type(s): Journal Article

Abstract: Background: Despite Korean Americans being one of the fastest growing immigrant groups in the United States, little is known about their cardiovascular health or cardiovascular disease risk factors. Purpose: The purpose of this report is to describe the prevalence of cardiovascular disease risks and their contributing factors in Korean Americans and recommend future directions for the development of cardiovascular disease prevention or management research to meet the unique needs of this ethnic group. Methods: We conducted a systematic review using databases of PubMed, CINAHL, PsycINFO, Web of Science, and the Cochrane Database of Systematic Reviews and identified 27 studies that reported the prevalence of cardiovascular disease or its risk factors in Korean Americans, published in English between 2000 and 2016. Results: We found high rates of unhealthy behaviors (eg, consumption of a high-sodium diet, physical inactivity, smoking) and risk factors (eg, hypertension, diabetes) for cardiovascular disease. Moreover, they were less likely to receive counseling about their diseases from healthcare providers and modify their lifestyle (eg, reduce their diet sodium intake, control their weight) to manage their diseases than were other ethnic populations. Individual-, interpersonal-, community-, and societal-level influences contributed to the high prevalence of cardiovascular risk factors. Conclusions: Data on subgroups of Asian Americans indicate that Korean Americans have significant lifestyle-related cardiovascular disease risks, which could be a critical agenda for researchers and clinicians to better understand cardiovascular health disparities in the United States.

Database: BNI

13. A Randomized Clinical Trial of the Effect of an Angina Self-Management Intervention on Health Outcomes of Patients With Coronary Heart Disease

Author(s): Kimble, Laura P, PhD

Source: Rehabilitation Nursing; 2018; vol. 43 (no. 5); p. 275

Publication Date: 2018

Publication Type(s): Evidence Based Healthcare Journal Article

Abstract: Purpose The aim of this study was to test the effect of a psychoeducational intervention to enhance angina pectoris (AP) symptom self-management. Design A two-group, single-blind, randomized controlled trial. Methods Following institutional review board approval, a convenience sample of cardiac inpatients was recruited. Within 2 weeks following discharge, the Angina Self-Management (ASM) intervention group (n = 39) received a nurse-delivered, telephone intervention focused on AP symptom monitoring and management. The control group (n = 41) received an attention-control telephone call. Physical function, anxiety, and angina frequency were assessed

between 3 and 6 months postintervention. Findings Men in the ASM group (n = 24) reported better physical function and lower anxiety than men in the control group (n = 26). Women in the ASM group (n = 15) reported worse physical function and higher anxiety than women (n = 15) in the control group. Conclusions Angina symptom monitoring may be more difficult for women. Rehabilitation nurses should be proactive in addressing issues associated with women's AP symptom management.

Database: BNI

14. Implantable cardiac defibrillators for people with non-ischaemic cardiomyopathy

Author(s): El Moheb M.; Nicolas J.; Iskandarani G.; Khamis A.M.; Akl E.A.; Refaat M.

Source: Cochrane Database of Systematic Reviews; Dec 2018; vol. 2018 (no. 12)

Publication Date: Dec 2018

Publication Type(s): Review

PubMedID: 30537022

Available at Cochrane Database of Systematic Reviews - from Cochrane Collaboration (Wiley)

Abstract: Background: There is evidence that implantable cardioverter-defibrillator (ICD) for primary prevention in people with an ischaemic cardiomyopathy improves survival rate. The evidence supporting this intervention in people with non-ischaemic cardiomyopathy is not as definitive, with the recently published DANISH trial finding no improvement in survival rate. A systematic review of all eligible studies was needed to evaluate the benefits and harms of using ICDs for primary prevention in people with non-ischaemic cardiomyopathy. Objective(s): To evaluate the benefits and harms of using compared to not using ICD for primary prevention in people with non-ischaemic cardiomyopathy receiving optimal medical therapy. Search Method(s): We searched CENTRAL, MEDLINE, Embase, and the Web of Science Core Collection on 10 October 2018. For ongoing or unpublished clinical trials, we searched the US National Institutes of Health Ongoing Trials Register ClinicalTrials.gov, the World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP), and the ISRCTN registry. To identify economic evaluation studies, we conducted a separate search to 31 March 2015 of the NHS Economic Evaluation Database, and from March 2015 to October 2018 on MEDLINE and Embase. Selection Criteria: We included randomised controlled trials involving adults with chronic non-ischaemic cardiomyopathy due to a left ventricular systolic dysfunction with an ejection fraction of 35% or less (New York Heart Association (NYHA) type I-IV). Participants in the intervention arm should have received ICD in addition to optimal medical therapy, while those in the control arm received optimal medical therapy alone. We included studies with cardiac resynchronisation therapy when it was appropriately balanced in the experimental and control groups. Data Collection and Analysis: The primary outcomes were all-cause mortality, cardiovascular mortality, sudden cardiac death, and adverse events associated with the intervention. The secondary outcomes were non-cardiovascular death, health-related quality of life, hospitalisation for heart failure, first ICD-related hospitalisation, and cost. We abstracted the log (hazard ratio) and its variance from trial reports for time-to-event survival data. We extracted the raw data necessary to calculate the risk ratio. We summarised data on quality of life and cost-effectiveness narratively. We assessed the certainty of evidence for all outcomes using GRADE. Main Result(s): We identified six eligible randomised trials with a total of 3128 participants. The use of ICD plus optimal medical therapy versus optimal medical therapy alone decreases the risk of all-cause mortality (hazard ratio (HR) 0.78, 95% confidence interval (CI) 0.66 to 0.92; participants = 3128; studies = 6; high-certainty evidence). An average of 24 patients need to be treated with ICD to

prevent one additional death from any cause (number needed to treat for an additional beneficial outcome (NNTB) = 24). Individuals younger than 65 derive more benefit than individuals older than 65 (HR 0.51, 95% CI 0.29 to 0.91; participants = 348; studies = 1) (NNTB = 10). When added to medical therapy, ICDs probably decrease cardiovascular mortality compared to not adding them (risk ratio (RR) 0.75, 95% CI 0.46 to 1.21; participants = 1781; studies = 4; moderate-certainty evidence) (possibility of both plausible benefit and no effect). Implantable cardioverter-defibrillator was also found to decrease sudden cardiac deaths (HR 0.45, 95% CI 0.29 to 0.70; participants = 1677; studies = 3; high-certainty evidence). An average of 25 patients need to be treated with an ICD to prevent one additional sudden cardiac death (NNTB = 25). We found that ICDs probably increase adverse events (possibility of both plausible harm and benefit), but likely have little or no effect on non-cardiovascular mortality (RR 1.17, 95% CI 0.81 to 1.68; participants = 1781; studies = 4; moderate-certainty evidence) (possibility of both plausible benefit and no effect). Finally, using ICD therapy probably has little or no effect on quality of life, however shocks from the device cause a deterioration in quality of life. No study reported the outcome of first ICD-related hospitalisations. Authors' conclusions: The use of ICD in addition to medical therapy in people with non-ischaemic cardiomyopathy decreases all-cause mortality and sudden cardiac deaths and probably decreases mortality from cardiovascular causes compared to medical therapy alone. Their use probably increases the risk for adverse events. However, these devices come at a high cost, and shocks from ICDs cause a deterioration in quality of life.

Database: EMBASE

15. UK Stroke Forum 2018

Author(s): anonymous

Source: International Journal of Stroke; Dec 2018; vol. 13 (no. 3)

Publication Date: Dec 2018

Publication Type(s): Conference Review

Abstract: The proceedings contain 305 papers. The topics discussed include: glyceryl trinitrate for pre-hospital ultra-acute stroke: main results from the rapid intervention with glyceryl trinitrate in hypertensive stroke trial-2 (RIGHT-2); the FOCUS (fluoxetine or control under supervision) trial results: effects of a 6 month course of fluoxetine on the primary outcome, the modified rankin scale, in patients with stroke; time varying cerebral autoregulation in response to gradual transition in head positioning - experiences in acute ischaemic stroke and healthy controls; platelet receptor glycoprotein VI-dimer is overexpressed in ischaemic but not hemorrhagic stroke: a promising future anti-thrombotic target?; the association of imaging markers of small vessel disease and "brain frailty" with clinical outcome following acute stroke; do people with pre-existing cognitive impairments receive less stroke rehabilitation?; timing of vision screening and assessment in an acute population; how do stroke survivors with communication difficulties manage life after stroke in the first year? a qualitative study; and risk of recurrent intracerebral haemorrhage and ischaemic stroke after intracerebral hemorrhage: a multicentre prospective cohort study.

Database: EMBASE

16. The model of impact on the length of stay and bed days at NHS Trust on mechanical thrombectomy eligible patients

Author(s): Sinha D.; Norris I.; Derekshani S.

Source: International Journal of Stroke; Dec 2018; vol. 13 (no. 3); p. 19

Publication Date: Dec 2018

Publication Type(s): Conference Abstract

Abstract: Introduction: Acute ischaemic stroke (AIS) is the main type of stroke and 1 of the leading causes of inpatient stays in the UK. This project aims to determine the potential reduction of the current hospital length of stay arisen from the AIS treatment by implementing the mechanical thrombectomy (MT) at a tertiary hospital. Method(s): 136 patients potentially eligible for a mechanical thrombectomy with the inclusion and exclusion criteria's were used. In this study, the main clinical variables considered to calculate were the (modified Rankin Scale (mRS)) score and length of stay (LOS). To model the expected treatment outcomes per intervention, patient's distribution by mRS score was extracted from the meta-analysis in the context of the SEER Collaboration which is pooled patient data from RCT (SWIFTPRIME, ESCAPE, EXTEND-IA, REVASCAT). The distribution of mRS scores and shift on mRS populated in the study group to observe the expected length of stay on basis of scenario analysis and time horizon basis. Result(s): Out of all MT eligible patients group, the patient group with NIHSS>10 (n=61) the respective length of stay of HASU, ASU and total were 5.84, 15.16 and 21.01 days. The distribution of patients of MTeligible patients group were mRS=0 were 0%, mRS=1 were 7.61%, mRS=2 were 11.96%, mRS=3 were 27.17%, mRS=4 were 34.78%, mRS=5 were 10.87% and mRS=6 were 7.61%. The patients with mRS 4 were largest in distribution (n=26) but patients in mRS 5 group had longest length of stay in HASU, ASU and total respectively 5.36, 30.55 and 35.92 days. Expanding the MT treatment access to a total of 200 patients with SEER modelling in over the period could lead to a total of 1,795 days saved at the hospital. Most of the days of inpatient care reductions are concentrated in the mRS 4 and 5 and in the Stroke Unit (51%) and the Rehabilitation (41.3%). On average, that means about 8.9 days saved per MT patient. Conclusion(s): The impact model estimates potential bed days saving to stroke services. Most of the days of inpatient care reductions are concentrated in the mRS 4 and 5. The model estimates about 8.9 days bed days saving in stroke services. In future, an analysis of the direct cost involved in the defined patient pathway will be carried out with a further follow-up mRS score and a cost analysis of the potential reduction in long-term health care and social care costs for the whole health economy.

Database: EMBASE

17. Factors Influencing Patients' Self-reported Lifestyle Changes and Medication Adherence Following an Acute Cardiac Event In 12 Countries: A Specialist Study Within the Euroaspire V (EAV) Survey

Author(s): Jennings C.S.; De Bacquer D.; Prescott E.; Hansen T.; Gale C.; Astin F.

Source: Global Heart; Dec 2018; vol. 13 (no. 4); p. 377

Publication Date: Dec 2018

Publication Type(s): Conference Abstract

Abstract: Introduction: Lifestyle changes and drug adherence may not be sustained in coronary patients (CP) after an acute event. Patients' perspectives are under-investigated. Objectives: To assess in CP illness perceptions, health literacy, socio-demographics and health related quality of life (HRQoL) as factors that may be related to perceived barriers to behavioural change and medication adherence. Methods: Patients from Egypt, Ireland, Kazakhstan, Lithuania, Netherlands, Poland, Portugal, Russian Federation, Sweden, Turkey, Ukraine and UK completed the brief illness perception questionnaire (B-IPQ), a Health Literacy Questionnaire (HLQ SCALE 9), the Hospital

Anxiety and Depression Scale (HADS), the HeartQol, the EQ-5D and interview administered questions on barriers to achieving lifestyle changes and medication adherence. Retrospectively identified patients between 6 months and 2 years post acute cardiac event were invited to an examination and interview with a study nurse. Results: 3408 patients (75.6% male, mean age 63.9) completed at least one of the questionnaires. Table 1 shows B-IPQ, HLQ-9 mean scores and % of non-adherence. Women (p<0.0001), lower income groups (p<0.0001), patients with lower educational levels (p=0.02), obese patients (p<0.0001), inactive (p<0.0001) and those with diabetes (p<0.0001) had higher B-IPQ scores. HLQ-9 scores were lower in obese patients (p=0.02) and in those who were inactive (p=0.0001). The most commonly reported barrier to achieving smoking cessation (54%); dietary (45%) and physical activity (51%) change was a lack of confidence. 84% reported not smoking; 66% reported eating healthily and 51% being active. Non-adherence with cardio-protective drugs was associated with lower income (p=0.007) and not attending cardiac rehabilitation (12.5% compared to 4.6%). [Figure presented] [Figure presented] Conclusion: Many patients believe they have healthy lifestyles. A lack of confidence is given as the principal reason for not adhering to behavioural changes. Patients with more threatening illness perceptions are more likely to be female, have lower education and income, be obese, inactive and have diabetes. Lower health literacy is associated with inactivity and obesity. Increased anxiety and depression and lower ratings of HRQoL are associated with more threatening perceptions of illness, lower health literacy and higher non-adherence. Disclosure of Interest: None declaredCopyright © 2018

Database: EMBASE

18. The management of childhood cancer survivors at risk for stroke: A Delphi survey of regional experts

Author(s): Kenney L.B.; Manley P.E.; Ames B.; Michaud A.L.; Williams D.N.; Ullrich N.J.

Source: Pediatric Blood and Cancer; Dec 2018; vol. 65 (no. 12)

Publication Date: Dec 2018

Publication Type(s): Article

PubMedID: 30094926

Available at Pediatric Blood and Cancer - from Wiley

Abstract: Background: Evidence is not available to guide management of childhood cancer survivors (CCS) at risk for radiation-associated cerebral vascular disease (CVD) and stroke. We propose to use a consensus-based methodology to describe the collective opinion of regional experts for the care of these patients and identify areas of controversy. Procedure: Thirty physicians from the New England region who care for CCS participated in a Delphi panel querying their management approach (imaging, laboratory tests, medications, counseling, referrals) to a CCS treated with cranial radiation formatted as five clinical scenarios (asymptomatic, small- and large-vessel CVD, transient ischemia, stroke) in three rounds of anonymous questionnaires. Consensus defined as >=90% agreement. Results: Response rate was 100% for all three rounds. Panelists reached consensus on laboratory tests to assess stroke risk factors, stroke risk and prevention counseling, brain imaging to monitor survivors with known CVD, and acute care for stroke symptoms. Only 67% panelists agreed with MRI screening asymptomatic survivors with no history of CVD, 87% endorsed aspirin as stroke prevention for large-vessel CVD and 57% for small-vessel CVD. There was no consensus on specialty referrals. Overall, panelists practicing at large institutions and neurology subspecialists were more likely to advocate for screening, interventions, and referrals. Conclusions: Despite lack of evidence to guide stroke prevention in CCS treated with cranial radiation, a panel of regional physicians reached

consensus on managing most clinical scenarios. Controversial areas requiring further study are surveillance imaging for asymptomatic survivors, aspirin for stroke prevention, and indications for specialty referral.

Database: EMBASE

19. Aspirin use and cardiovascular outcome in patients with type 2 diabetes mellitus and heart failure: A population-based cohort study

Author(s): Abi Khalil C.; Al Suwaidi J.; Taheri S.; Omar O.M.

Source: Journal of the American Heart Association; Nov 2018; vol. 7 (no. 21)

Publication Date: Nov 2018

Publication Type(s): Article

PubMedID: 30608202

Available at Journal of the American Heart Association - from Europe PubMed Central - Open Access

Available at Journal of the American Heart Association - from HighWire - Free Full Text

Available at Journal of the American Heart Association - from Wiley Online Library Free Content - NHS

Abstract: Background-Aspirin is of uncertain benefit for primary prevention in patients with type 2 diabetes mellitus (T2D). We assessed whether primary prevention with aspirin is beneficial in patients with T2D and heart failure (HF). Methods and Results-Data from The Health Improvement Network, a UK multicenter prospective primary care database, were analyzed. Those with T2D and HF, age >=55 years, and no previous history of myocardial infarction and/or coronary artery disease, stroke, peripheral artery disease, or atrial fibrillation were included. We compared outcomes for those on aspirin to no aspirin after diagnosis of HF and T2D and assessed the role of a >75-mg dose. The primary outcome was a composite of all-cause mortality and hospitalization for HF; secondary outcomes were nonfatal stroke, nonfatal myocardial infarction, or major bleeding. There were 5967 participants on aspirin and 6567 not on aspirin. The mean age (SD) was 75.3 (9.6) years, 53.9% were men, and the mean follow-up (SD) was for 5 (4.2) years. After propensity-score matching and further multivariable adjustment, aspirin was significantly associated with a decrease in the primary outcome and all-cause mortality (hazard ratio=0.88, 95% confidence interval 0.82-0.93; 0.88, 0.83-0.94], respectively); and an increased risk of nonfatal myocardial infarction (hazard ratio=1.66; 95% confidence interval 1.49-1.85) and nonfatal stroke (hazard ratio=1.23, 1.01-1.50). Major bleedings and hospitalization for HF were not significantly higher with aspirin (hazard ratio=0.68, 0.45-1.03; 0.87, 0.66-1.15, respectively). There was no additional benefit for a dose >75 mg. Conclusions-Primary prevention with aspirin in patients with T2D and HF is associated with lower all-cause mortality.

Database: EMBASE

20. Projecting incidence of post-stroke cognitive impairment and dementia in the Irish population aged 40-89 years in 2015 to 2025

Author(s): Sexton E.; Merriman N.; Hickey A.; Bennett K.; Donnelly N.; Wren M.-A.; O'Flaherty M.; Guzman-Castillo M.

Source: The Lancet; Nov 2018; vol. 392

Publication Date: Nov 2018

Publication Type(s): Conference Abstract

Abstract: Background: Post-stroke cognitive impairment (PSCI) is a common consequence of stroke, leading to reduced quality of life and increased care needs. However, cognitive impairment receives less attention in stroke rehabilitation relative to physical disability. We aimed to apply estimates of PSCI incidence to the Irish population and project the number of patients who could potentially benefit from cognitive rehabilitation. Method(s): We developed the StrokeCog deterministic model to estimate incidence of PSCI in the population aged 40-89 years living in Ireland in 2015, and project cumulative incidence in this cohort over 10 years. Population data, estimates, and projections to 2025 were obtained from the Central Statistics Office. Age-specific and sex-specific stroke incidence was estimated with 2015 stroke hospital discharge data (n=6155). Transition probabilities across five health states defined by cognitive impairment, physical disability, and dementia were estimated with data from participants reporting stroke in the English Longitudinal Study on Ageing (n=523). An annual stroke recurrence risk of 5% was assumed. Finding(s): Projections show that the Irish population aged 40-89 years in 2015 (2.05 million) will have a cumulative incidence of stroke of 3.7% by 2025 (74 948), of whom 19 082 (25.5%) will die from stroke and 20 580 (27.5%) from another cause. Of 35 287 survivors, 17 614 (49%) are predicted to have cognitive impairment without dementia, and 8677 (24.6%) to have dementia. Interpretation(s): In 2025, three quarters of Irish people who have survived a stroke in the preceding 10 years will have cognitive impairment and could potentially have benefited from cognitive rehabilitation. The model will be developed further to project yearly incidence and prevalence of PSCI in the Irish population to 2046, and to include a probabilistic sensitivity analysis to allow for uncertainty in any estimates; it will also be used to evaluate cost-effectiveness of cognitive rehabilitation. The model could also be adapted for use with UK populations. Funding(s): Health Research Board in Ireland (grant number ICE-2015-1048 and award RL-15-1579).

Database: EMBASE

21. "Heart disease never entered my head": Women's understanding of coronary heart disease risk factors

Author(s): Smith, Rita; Frazer, Kate; Hyde, Abbey; O'Connor, Laserina; Davidson, Patricia

Source: Journal of Clinical Nursing; Nov 2018; vol. 27 (no. 21-22); p. 3953

Publication Date: Nov 2018

Publication Type(s): Journal Article

Abstract: Aims and ObjectivesThis study investigated experiences of women with a primary diagnosis of ACS (NSTEMI & Unstable Angina). The study explored how women interpreted their risk for coronary heart disease (CHD) and how this influenced their treatment-seeking decisions.BackgroundEfforts to reduce the incidence of cardiovascular disease, the number one killer of women, require aggressive risk factor modification, risk assessment and evidence-based treatments. CHD is largely preventable; however, despite the availability of evidence on prevention and risk factor reduction, it appears that misunderstandings persist.DesignA naturalistic case study design guided this study.MethodsThirty women participated (n = 30); a within-case analysis was followed by a cross-case analysis. Data collection included participant diaries and face-to-face

interviews. Data were analysed using modified analytic induction which allowed the emergence of theoretical insights.ResultsThis article provides insight into women's perception of risk for CHD, particularly in relation to smoking. The findings provide a platform for a wider discourse on women's interpretation of their risk for CHD and their treatment-seeking decisions. The data reflect the ongoing misunderstanding that CHD affects men more than women.ConclusionsMore focus is needed on risk factor management and CHD symptom presentation in women. An emphasis on the chronic disease aspect of CHD may promote a timely focus on secondary prevention and the follow-up needed through patient education and empowerment.Relevance to Clinical PracticeThis study demonstrates that primary and secondary prevention education initiatives are needed for CHD risk factor management and symptom interpretation. The implications of smoking on cardiovascular health need further dissemination. Efforts to support smoking cessation need to be strengthened and widely accessible. Primary care can have a key role to play in managing CHD risk and supporting women with positive risk factors.

Database: BNI

22. Physical Activity after Cardiac EventS (PACES) - A group education programme with subsequent text-message support designed to increase physical activity in individuals with diagnosed coronary heart disease: Study protocol for a randomised controlled trial

Author(s): Herring L.Y.; Dallosso H.; Schreder S.; Chatterjee S.; Bodicoat D.; Khunti K.; Yates T.; Seidu S.; Davies M.J.; Hudson I.

Source: Trials; Oct 2018; vol. 19 (no. 1)

Publication Date: Oct 2018

Publication Type(s): Article

PubMedID: 30286797

Available at Trials - from BioMed Central

Available at Trials - from Europe PubMed Central - Open Access

Available at Trials - from EBSCO (MEDLINE Complete)

Abstract: Background: Coronary heart disease (CHD) represents approximately 13% of deaths worldwide and is the leading cause of death in the UK with considerable associated health care costs. After a CHD event, timely cardiac rehabilitation optimises patient outcomes. However, a high percentage of these services do not meet necessary performance indicators such as course length and follow-up attendance. Uptake of such services is only 50% in UK patients and support provided 12 months after an event is often limited. To delay and prevent further CHD events leading to hospitalisation, supplementary self-management strategies such as group education, are necessary. Method(s): This is a single-centre, randomised controlled trial (RCT) recruiting participants (n = 290) aged >=18 years who are 12 to 48 months post diagnosis of a CHD-related cardiac event (myocardial infarction, angina and any other acute coronary syndrome). The study aims to implement a structured education programme, with text-message support over 12 months, and identify whether delivery of the programme, to individuals who have a history of a cardiac event, would be an effective and cost-effective strategy for increasing walking. The primary outcome, objectively measured average daily physical activity, specifically step count through walking activity, is assessed using the wrist-worn GENEActiv accelerometer at baseline, 6 and 12 months. Secondary outcomes at 12 months include cardiovascular risk factors such as smoking status, blood pressure, lipid profile, glycated haemoglobin (HbA1c), obesity, self-efficacy, quality of life, physical activity and physical

function. Participants are randomised to either the control group receiving standard care and a physical activity information leaflet, or the intervention group whose partcipants receive the leaflet and are invited to attend two group-based structured education sessions. These encourage participants to adopt and maintain healthy behaviours and self-manage their lifestyle. They are delivered approximately 2 weeks apart by trained facilitators and reinforced via subsequent text-message support. Discussion(s): To our knowledge, this is the first trial designed to assess the effectiveness of a group education programme 12 to 48 months after a CHD event diagnosis. If successful, the PACES programme could be translated into effective post-operative cardiac care and complement the current post-operative services available. Trial registration: ISRCTN, ID: ISRCTN91163727. The trial was registered on 27 February 2017.

Database: EMBASE

23. POTENTIAL REDUCTION IN MORTALITY AND HOSPITALISATIONS WITH OPTIMAL USAGE OF SACUBITRIL/VALSARTAN THERAPY FOR THE TREATMENT OF HEART FAILURE WITH REDUCED EJECTION FRACTION IN IRELAND

Author(s): O'Brien S.; Carney P.; Sweeney C.

Source: Value in Health; Oct 2018; vol. 21

Publication Date: Oct 2018

Publication Type(s): Conference Abstract

Abstract: Objectives: PARADIGM-HF, a phase III trial conducted in Heart Failure (HF) patients with reduced ejection fraction (HFrEF), showed that sacubitril/valsartan, a first-in-class angiotensin receptor neprilysin inhibitor for treatment of HFrEF, provided incremental cardiovascular and overall survival benefit compared with enalapril. This analysis aims to quantify the number of all-cause deaths and acute HF hospitalisations that could be avoided with optimal usage of sacubitril/valsartan in the treatment of HFrEF in Ireland. Method(s): Epidemiology data from the UK Clinical Practice Research Datalink was extrapolated to the Irish population by age and sex to estimate the national HF population. The target HF population, was then estimated based on a literature review of HFrEF and NYHA II-IV prevalence in Ireland. The number needed to treat (NNT) to avoid one death and one hospitalisation standardized to 12 months, was derived from the PARADIGM-HF trial. The potential number of deaths prevented or postponed and HF hospitalisations avoided with optimal sacubitril/valsartan treatment was estimated along with multi-way sensitivity analysis. The savings in acute hospital bed-days per annum were calculated based on the cost and Length of Stay (LoS) for HF patients. Result(s): An estimated 92,000 people have HF in Ireland (1.9/100). Of those, approximately 50% are considered clinically diagnosed with NYHA class II -IV HF. Of these, 40.7% have HFrEF. Further adjustment for HFrEF <=35% and contraindications (8.6%) yielded a target population of 14,985 patients. Based on a NNT of 80.3 (for both deaths and HF hospitalisations), optimal usage of sacubitril/valsartan was estimated to prevent 187 deaths and (187 x 11.44 LoS) acute hospital bed-days per annum. The cost savings from HF hospitalisations avoided is estimated at 1.22m. Conclusion(s): The findings from this analysis showed the cost savings, all-cause deaths and hospitalisations that could be prevented with optimal implementation of sacubitril/valsartan therapy for patients suitable for treatment.

Database: EMBASE

24. HOSPITAL ADMISSIONS FOR HEART FAILURE IN ENGLAND; AN INCREASING BURDEN ON NHS RESOURCES AND THE FOCUS OF EFFECTIVE COST CONTAINMENT

Author(s): Hickey D.A.; Beecroft S.

Source: Value in Health; Oct 2018; vol. 21

Publication Date: Oct 2018

Publication Type(s): Conference Abstract

Abstract: Objectives: Cardiovascular disease is a major target for the NHS in terms of prevention, improved outcomes and cost containment. The number of people in the UK with heart failure is growing by 10,000 per year and the condition costs the NHS more than 2 billion per year, with 60-70% related to the costs of hospitalisation. The objective of this study was to assess current trends in secondary care resource utilisation by patients with heart failure in the NHS in England between 2013 and 2016. Method(s): A study based on secondary use of record-level data obtained from the Hospital Episode Statistics (HES) database in England. Patients who had an initial ICD-10 diagnosis code for heart failure, congestive heart failure, left ventricular failure and heart failure unspecified were included in the analysis. Admissions for cardiology (320) to all secondary care providers were selected for the period January 2013 to December 2016. Result(s): Total annual cardiology admissions for patients diagnosed with heart failure increased between 2013 and 2016 from 8,727 to 14,106; a 62% increase. The total cost of spells in the same period increased from 5.1m to 5.8m; a 13% increase. Average length of stay (LOS) for this patient cohort has declined in 55% of hospitals between 2013 and 2016. Conclusion(s): The rapidly rising trend in hospital visits for people with heart failure is caused by our ageing population and improved heart attack survival rates. This results in an increasing number of people living with the debilitating impact of heart failure. As cardiology admissions for patients diagnosed with heart failure are increasing, one of the ways in which the NHS is managing this increase would appear to be by reducing length of hospital stay. This may have been achieved by the introduction of Best Practice Tariffs and Heart Failure Nurses.Copyright © 2018

Database: EMBASE

25. The value of a nurse led helpline in preventing hospital attendance following ablation for atrial fibrillation

Author(s): Champney F.; Julia-Calvo J.; Patel M.; Silberbauer J.; O'Nunain S.; McCready J.

Source: Europace; Oct 2018; vol. 20

Publication Date: Oct 2018

Publication Type(s): Conference Abstract

Abstract: Introduction: Reducing hospital readmission rates has been identified both as a national and international priority, with some healthcare funding arrangements reducing or denying payments for patients who re-admit as an emergency. Strategies to reduce hospital attendance vary between centers and there is a lack of evidence regarding their efficacy. Objective(s): In 2015, a Nurse-Led helpline for patients following AF ablation was introduced at the Royal Sussex County Hospital, Brighton (UK) to reduce patients presenting to acute services post procedure. This study evaluates the impact of this intervention. Methodology: All patients being discharged following an AF ablation were given the contact details of the Cardiac Care Unit and advised they could call 24/7 with any clinical concerns. Consecutive phone calls from January 2015 to June 2017 were included in this single centre, retrospective, non-randomised study. All calls received more than 30 days post

procedure were excluded. No patients or calls were excluded based on either the procedure type or the result of the ablation. Where a patient made more than one call, the most severe complaint or outcome was recorded. Result(s): During the study period, 593 patients underwent an AF ablation procedure. Among them, 63 (10.6%) patients used the Nurse-Led helpline following their AF ablation. The mean time to the first call was 4.9661.4 days. The breakdown of query type is shown in table 1. In total, 24 (38.1%) of calls had an outcome of telephone advice only, with a further 14 (22.2%) being advised to contact other community or outpatient services. None of these patients were readmitted or presented to hospital within the first 30 days following the procedure. Only 16 (25.4%) of patients following telephone triage were asked to attend the Cardiac Centre that day for clinical review. Among them, 4 (25%) were discharged after being seen by a nurse only, while 12 patients (75%) required medical review. Eight (50%) of the latter were discharged and 4 (25%) required admission. Finally, 14.3% (n=9) of patients were advised to seek help either by ambulance or by presenting to the Emergency Department (ED). Overall, 32 out of 593 patients (5.4%) were readmitted within the first 30 days post procedure. Among them, 7 (22.0%) had contacted the helpline. Conclusion(s): The Nurse-Led helpline offered 60% of the patients who used it clinical advice, enabling them to self-manage their recovery from AF ablation which may have prevented these patients unnecessarily presenting to acute services. This service was introduced without any increase in staffing which further suggests potential cost-savings to the health economy whilst simultaneously improving patient experience.

Database: EMBASE

26. The positive impact that a nurse led vascular access team can have on central line-associated complications

Author(s): Baker H.; Shawyer V.; Coutice C.; Nixon J.; Hill S.; Bellamy S.

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Publication Type(s): Conference Abstract

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Abstract:INTRODUCTION. Peripherally inserted central venous catheters have become an increasingly common method of venous access in the ICU patient (Wilson et al, 2012). The development of a nurse lead Vascular Access Team (VAT) within an acute care hospital has reduced catheter related blood stream infections (CRBSI) and minimalized the incidence of venous thromboembolism (VTE). The VAT placed peripherally inserted central catheters (PICCS) as an alternative to short term central venous catheters, which have a low incidence of CLABSI. An initial rise in CLABSI correlated with the increase in number of patients requiring parental nutrition. Consequently an education programme was implemented trust wide to reduce the CLABSI. OBJECTIVES. Review 10 years of nurse led PICC line placement in relation to ICU patients to establish safety and efficacy of PICC in this population. METHODS. A retrospective single centre study in general ICU in the UK. We included patients aged between 18 and 99 years, requiring a PICC during a period between January 2008 and January 2018. Our primary endpoints were CRBSI up to 30 days after catheter placement, UEVTE or misplacement. We defined CLABSI based on the Centre for Disease Control and Prevention's National Healthcare Safety Networks (NHSN) 2015 surveillance definitions. Secondary endpoints were numbers of line related days, indications for placement,

number of attempts. All PICCS were inserted by the VAT at the patient's bedside, using ultrasound and full sterile precautions in adherence to EPIC 2 guidelines. Infection rates were calculated per 1000 line days, from the introduction of the Vascular access service 8 months prior to the implementation of the educational programme and then for 12 months after. The educational programme involved Ward based teaching Junior Doctors training Monthly central line workshops Patient education RESULTS. There were no insertion related bacteraemia during the surveillance period. The increase in line infections correlated with the increase in patients prescribed PN. There were 3 VTE in 2015 this correlated in greater surveillance. Through the surveillance of all the lines inserted by the VAT the specific educational needs of the staff and patients were identified and targeted. CONCLUSION. A structured educational programme that includes doctors, nurses and patients has a direct impact on the reduction of central line associated bloodstream infections and VTE. This positive impact can be sustained through ongoing education and surveillance of line infections and VTE.

Database: EMBASE

27. Implementing multiple health behaviour change interventions for cardiovascular risk reduction in primary care: a qualitative study

Author(s): Alageel S.; Gulliford M.C.; McDermott L.; Wright A.J.

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Publication Type(s): Article

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Available at BMC family practice - from EBSCO (MEDLINE Complete)

Abstract:CONCLUSIONS: Advancing the prevention agenda will require strategies to support the delivery of behaviour change interventions in primary care. Greater emphasis needs to be given to promoting behaviour change through supportive environmental context. Further research is needed to evaluate current external lifestyle services to improve the intervention outcomes.RESULTS: Thirty participants were recruited including ten general practitioners, ten practice nurses, seven healthcare assistants and three practice managers from 23 practices. Qualitative analysis identified three main themes: healthcare professionals' conceptualising health behaviour change; delivering multiple health behaviour change interventions in primary care; and delivering the health check programme. Healthcare professionals generally recognised the importance of health behaviour change for CVD risk reduction but were more sceptical about the potential for successful intervention through primary care. Participants identified the difficulty of sustained behaviour change for patients, the lack of evidence for effective interventions and limited access to appropriate resources in primary care as barriers. Discussing changing multiple health behaviours was perceived to be overwhelming for patients and difficult to implement for healthcare professionals with current primary care resources. The health check programme consists of several components that are difficult to fully complete in limited time.BACKGROUND: The implementation of multiple health behaviour change interventions for cardiovascular risk reduction in primary care is suboptimal. This study aimed to identify barriers and facilitators to implementing multiple health behaviour change interventions for

cardiovascular disease (CVD) risk reduction in primary care.METHODS: Qualitative study using semi-structured interviews informed by the Theoretical Domains Framework. Interviews were conducted with a purposive sample of healthcare professionals working in the implementation of the NHS Health Check programme in London. Data were analysed using the Framework method.

Database: EMBASE

28. The effect of a self-help psychoeducation programme for people with coronary heart disease: A randomized controlled trial

Author(s): Wang, Wenru; Jian Yang Lim; Lopez, Violeta; Vivien Xi Wu; Chi-Hang Lee; Hong-Gu He; Jiang, Ying

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Publication Date: Oct 2018

Publication Type(s): Journal Article

Available at Journal of Advanced Nursing - from Wiley

Abstract: AimTo examine the effect of a self-help psychoeducation program for people with coronary heart disease in Singapore.BackgroundCardiac rehabilitation has shown benefits for mitigating many cardiac risk factors and can lead to improvement in health-related quality of life and psychological well-being in people with heart disease. However, traditional hospital-based cardiac rehabilitation faces substantial challenges. A self-management cardiac rehabilitation program offers an avenue to increase uptake and empowers patients to manage their condition at home.DesignA two-arm, randomized controlled trial.MethodsA total of 129 patients with coronary heart disease were recruited from an outpatient clinic in a public hospital in Singapore from April 2015–January 2016. They were randomly assigned to the intervention group or the control group. Participants in the intervention group received the 4-week home-based self-help psychoeducation program. Outcomes were measured at baseline and at 4 weeks and 16 weeks from the baseline.ResultsThere were no significant differences in health-related quality of life, psychological status (i.e., perceived stress level, anxiety, and depression levels), or cardiac physiological risk parameters between the intervention and the control groups immediately after the program or at different time points. There was also no significant difference in unplanned health service use at the 16 week posttest point between the two groups.ConclusionsThis study did not find any significant effect of our program on outpatients with coronary heart disease. Nonetheless, findings on participant characteristics may offer healthcare professionals valuable insights to help facilitate future development of an effective cardiac rehabilitation program catered to outpatients with coronary heart disease.Trial registrationThe study has been registered with ISRCTN registry. The trial registration number is ISRCTN15839687. 目的研究新加坡自助心理教育计划对冠心病患者的影响。背景心脏康复结果不但已经显示出了减轻许多心脏危险因素带来的益处,还可以改善心脏病患者与健康相关的生活质量和心理健康。然而,传统的立足于医院的心脏康复工作面临着巨大的挑战。针对自我管理的心脏康复计划为患者提供了一种改善吸收的途径并使患者能够在家里管控自己的病情。设计双臂随机对照试验。方法2015年4月至2016年1月,从新加坡一家公立医院门诊部招募了共129名冠心病患者。将他们随机分配到干预组或对照组。对分配到干预组的参与者实施了为期4周的家庭自助心理教育计划。将患者刚开始的结果定为基线水平,在开始时、开始后第4周及第16周分别测量患者的结果。结果在实施该计划后或任何不同的时间点,干预组和对照组之间的与健康相关的生活质量、心理状态(即感受到的压力水平、焦虑和抑郁水平)或心脏生理风险参数没有显著差异。在对两组提供计划外的健康服务

后的第16周,两组之间依然没有显著差异。结论本研究发现我们的计划对冠心病门诊患者无任何显著影响。尽管如此,关于参与者特征的研究结果可能为医疗保健专业人员提供有价值的见解,以帮助促进有效的心脏康复计划在未来的发展,以满足冠心病门诊患者的需求。试验注册该研究已在国际标准随机对照临床试验编号注册处注册。试验注册号为ISRCTN15839687。

Database: BNI

29. Albiglutide and cardiovascular outcomes in patients with type 2 diabetes and cardiovascular disease (Harmony Outcomes): a double-blind, randomised placebo-controlled trial

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Publication Date: Oct 2018

Publication Type(s): Evidence Based Healthcare Journal Article

Available at The Lancet - from ProQuest (Hospital Premium Collection) - NHS Version

Abstract: Summary Background Glucagon-like peptide 1 receptor agonists differ in chemical structure, duration of action, and in their effects on clinical outcomes. The cardiovascular effects of once-weekly albiglutide in type 2 diabetes are unknown. We aimed to determine the safety and efficacy of albiglutide in preventing cardiovascular death, myocardial infarction, or stroke. Methods We did a double-blind, randomised, placebo-controlled trial in 610 sites across 28 countries. We randomly assigned patients aged 40 years and older with type 2 diabetes and cardiovascular disease (at a 1:1 ratio) to groups that either received a subcutaneous injection of albiglutide (30–50 mg, based on glycaemic response and tolerability) or of a matched volume of placebo once a week, in addition to their standard care. Investigators used an interactive voice or web response system to obtain treatment assignment, and patients and all study investigators were masked to their treatment allocation. We hypothesised that albiglutide would be non-inferior to placebo for the primary outcome of the first occurrence of cardiovascular death, myocardial infarction, or stroke, which was assessed in the intention-to-treat population. If non-inferiority was confirmed by an upper limit of the 95% CI for a hazard ratio of less than 1·30, closed testing for superiority was prespecified. This study is registered with ClinicalTrials.gov, number NCT02465515. Findings Patients were screened between July 1, 2015, and Nov 24, 2016. 10 793 patients were screened and 9463 participants were enrolled and randomly assigned to groups: 4731 patients were assigned to receive albiglutide and 4732 patients to receive placebo. On Nov 8, 2017, it was determined that 611 primary endpoints and a median follow-up of at least 1·5 years had accrued, and participants returned for a final visit and discontinuation from study treatment; the last patient visit was on March 12, 2018. These 9463 patients, the intention-to-treat population, were evaluated for a median duration of 1·6 years and were assessed for the primary outcome. The primary composite outcome occurred in 338 (7%) of 4731 patients at an incidence rate of 4·6 events per 100 person-years in the albiglutide group and in 428 (9%) of 4732 patients at an incidence rate of 5·9 events per 100 person-years in the placebo group (hazard ratio 0·78, 95% CI 0·68–0·90), which indicated that albiglutide was superior to placebo (p<0·0001 for non-inferiority; p=0·0006 for superiority). The incidence of acute pancreatitis (ten patients in the albiglutide group and seven patients in the placebo group), pancreatic cancer (six patients in the albiglutide group and five patients in the

placebo group), medullary thyroid carcinoma (zero patients in both groups), and other serious adverse events did not differ between the two groups. There were three (<1%) deaths in the placebo group that were assessed by investigators, who were masked to study drug assignment, to be treatment-related and two (<1%) deaths in the albiglutide group. Interpretation In patients with type 2 diabetes and cardiovascular disease, albiglutide was superior to placebo with respect to major adverse cardiovascular events. Evidence-based glucagon-like peptide 1 receptor agonists should therefore be considered as part of a comprehensive strategy to reduce the risk of cardiovascular events in patients with type 2 diabetes. Funding GlaxoSmithKline.

Database: BNI

30. Canadian Cardiovascular Harmonized National Guidelines Endeavour (C-CHANGE) guideline for the prevention and management of cardiovascular disease in primary care: 2018 update

Author(s): Tobe, Sheldon W, MD MScCH; Stone, James A, MD PhD; Anderson, Todd, MD; Bacon, Simon, PhD; Cheng, Alice Y Y, MD; Daskalopoulou, Stella S, MD PhD; Ezekowitz, Justin A, MBBCh MSc; Grégoire, Jean C, MD; Gubitz, Gord, MD; Jain, Rahul, MD MScCH; Keshavjee, Karim, MSc MD; Lindsay, Patty, RN PhD; L'Abbé, Mary, PhD; Lau, David CW, MD PhD; Leiter, Lawrence A, MD; O'Meara, Eileen, MD; Pearson, Glen J, PharmD; Rabi, Doreen M, MD MSc; Sherifali, Diana, RN, PhD; Selby, Peter, MBBS, MHSc; Tu, Jack V, MD PhD; Wharton, Sean, MD PharmD; Walker, Kimberly M, MPH; Hua-Stewart, Diane, MPH; Liu, Peter P, MD

Source: Canadian Medical Association. Journal; Oct 2018; vol. 190 (no. 40); p. E1192

Publication Date: Oct 2018

Publication Type(s): Journal Article

Available at Canadian Medical Association. Journal - from Europe PubMed Central - Open Access

Available at Canadian Medical Association. Journal - from EBSCO (MEDLINE Complete)

Abstract: Tobe et al cite that the Canadian Cardiovascular Harmonized National Guideline Endeavor (C-CHANGE) is a nationally endorsed guideline process, targeting primary care health care practitioners. C-CHANGE promotes patient care by bringing nine guideline groups together, to provide a composite set of recommendations to help clinicians formulate a comprehensive treatment plan directed toward patient priorities. The 2018 update to the C-CHANGE guideline includes a total of 77 recommendations and 52 recommendations that are newly added or updated. A new category for hypertension for high-risk individuals has been developed with a new lower threshold for treatment (130 mm Hg systolic) and target blood pressure (< 120 mm Hg systolic). Multifaceted care for patients with cardiovascular risks includes the cornerstones of health behavior change, such as healthy eating and regular physical activity.

Database: BNI

31. Effectiveness of primary healthcare educational interventions undertaken by nurses to improve chronic disease management in patients with diabetes mellitus, hypertension and hypercholesterolemia: A systematic review

Author(s): Gorina, Marta; Limonero, Joaquín T.; Álvarez, María

Source: International Journal of Nursing Studies; Oct 2018; vol. 86 ; p. 139

Publication Date: Oct 2018

Publication Type(s): Evidence Based Healthcare Journal Article Literature Review

Abstract: Background: Diabetes, hypertension and hypercholesterolemia are important chronic health problems that are becoming increasingly frequent worldwide. Educational interventions are a challenge for health teams. Nurses play a major role in overall health by providing educational interventions to help improve self-management outcomes. Objectives: To evaluate the effectiveness of primary health care educational interventions undertaken by nurses to improve metabolic control and/or chronic disease management in individuals with Type 2 diabetes mellitus, hypertension, and hypercholesterolemia. Methods: The methodology drew on systematic review without meta-analyses, methods developed by the Cochrane Collaboration. Elements related to content were chosen following the PRISMA statement. The databases of Pubmed, Web of Science, CINAHL, PsycInfo, Cuiden, Enfispo, and the Cochrane Library were consulted. Reference lists from relevant articles were also examined for additional references. Three authors independently assessed eligibility of studies for inclusion. A review of randomised controlled trials published between 2000 and 2015 was undertaken. Furthermore, an analysis of selected studies was carried out, in which nurses actively participated in the implementation of educational interventions in primary health care centres in order to improve control and chronic disease management in Type 2 diabetes mellitus, hypertension and hypercholesterolemia. Results: Out of the 20 studies included in the systematic review, one had a low risk of bias, 14 an uncertain risk of bias, and five a high risk of bias. Although several studies showed significant changes in the measured variables, few significant differences were maintained over time, observed only in metabolic indicators and clinical variables more than in lifestyle behaviour. In addition, although most of the studies dealt with issues related to lifestyle behaviours such as nutrition, physical activity, and tobacco and alcohol use, few measured changes after the intervention. Finally, the difficulty in comparing the studies included in the review laid in the heterogeneity in educational strategies, the evaluation methods used, and the disparity of assessment tools, which made it difficult to establish the characteristics of the most effective interventions during the time of treatment for diabetes, hypertension, and hypercholesterolemia. Conclusions: Although there are numerous interventions that aim to control diabetes, hypertension, and hypercholesterolemia, the observation was that the results obtained are difficult to maintain over time. Therefore, it is necessary to continue to create high-quality interventions, with a low risk of bias and based on solid theoretical frameworks, not only to treat current symptoms of the disease but also to help prevent cardiovascular disease.

Database: BNI

32. Variation in the incidence and timing of diagnosis of hospital-associated venous thromboembolism using linked administrative data

Author(s): Stubbs J.M.; Assareh H.; Achat H.M.; Curnow J.; Hitos K.

Source: Internal Medicine Journal; Sep 2018; vol. 48 (no. 9); p. 1137-1141

Publication Date: Sep 2018

Publication Type(s): Article

PubMedID: 30182393

Available at Internal Medicine Journal - from Wiley

Abstract: Venous thromboembolism (VTE) is a potentially preventable adverse effect of hospitalisation. Inter-hospital variation in the incidence of hospital-associated VTE (HA-VTE) and timing of diagnosis (in-hospital or post-discharge) in New South Wales public hospitals were examined. Large variations in incidence (22% risk difference) and post-discharge diagnosis (115%

odds difference) were evident after adjustment for case mix, which only explained 59% and 32% of inter-hospital variation respectively. The need for improved compliance with best practice guidelines is reinforced.

Database: EMBASE

33. US Preventive Services Task Force recommendation statement regarding screening for peripheral artery disease with the ankle-brachial index: déjà vu all over again

Author(s): Olin, Jeffrey W; Halperin, Jonathan L

Source: The Lancet; Sep 2018; vol. 392 (no. 10153); p. 1160

Publication Date: Sep 2018

Publication Type(s): Commentary

Abstract: Furthermore, evidence supporting targeted screening appears in the evidence report by Guirguis-Blake and coworkers.6 The 2016 AHA/American College of Cardiology guidelines on the management of patients with lower extremity peripheral artery disease recommends targeted screening by measuring the ABI in asymptomatic individuals meeting the following criteria (the 2017 European Society of Cardiology peripheral artery disease guidelines are similar):2,3 individuals older than 65 years; those aged 50–64 years with risk factors for atherosclerosis (eg, diabetes, prior smoking, hyperlipidaemia, hypertension) or family history of peripheral artery disease; those younger than 50 years with diabetes and at least one additional risk factor for atherosclerosis; and those with known atherosclerosis involving another vascular bed (eg, coronary, carotid, subclavian, renal, or mesenteric artery stenosis, or abdominal aortic aneurysm). Both the American and European peripheral artery disease guidelines recommend statin and antiplatelet therapy for patients with peripheral artery disease regardless of symptom status.2,3 Second, the USPSTF found "inadequate evidence to assess whether screening for and treatment of PAD in asymptomatic patients leads to clinically important benefits in either preventing the progression of PAD or preventing cardiovascular disease events".1 We disagree, because guideline-directed therapy in asymptomatic individuals with peripheral artery disease (subclinical atherosclerosis) reduces all-cause and cardiovascular mortality.10,11 The USPSTF report acknowledges the National Health and Nutrition Examination Study (1999–2004) estimate that 5·9% of the US population that is older than 40 years has an ABI of 0·9 or less, indicating peripheral artery disease.10 What is not mentioned is that administration of more than two preventive therapies to individuals who have peripheral artery disease without other identified cardiovascular disease was associated with a 65% reduction in all-cause mortality compared with no treatment (HR 0·35, 95% CI 0·2–0·86, p<0·02) after multivariable adjustment. In this case, concern about cascaded procedures should be balanced against the much greater risk of leaving peripheral artery disease undetected in individuals at high risk of disease. Because peripheral artery disease is a public health issue that is often under-recognised by patients, providers, and insurance companies, not performing this simple, inexpensive, and readily available diagnostic test is potentially harmful in people at high risk for peripheral artery disease.14 In conclusion, it is clear from the data available that although individuals at low risk would gain little benefit, those at high risk should be screened for peripheral artery disease by measuring the ABI, and when subclinical atherosclerosis is detected, appropriate lifestyle modification (smoking cessation and regular exercise) and medications (including statins, antiplatelets, and angiotensin-converting-enzyme inhibitor agents) should be prescribed to reduce the risk of myocardial infarction, stroke, and cardiovascular death.

Database: BNI

34. Nurses' barriers to the use of cardiovascular guidelines in practice

Author(s): McKee G.; Hayes M.; Caples N.; Cronin E.; Lowry A.; Shine M.; Hannon B.; Lodge E.; Teehan S.; Hill L.; Tuohy M.; Gillen N.

Source: European Journal of Cardiovascular Nursing; Aug 2018; vol. 17 (no. 1); p. 100-101

Publication Date: Aug 2018

Publication Type(s): Conference Abstract

Abstract: Background: Guidelines are updated on a regular basis based on updates in empirical evidence. Previous research has indicated that there are major barriers to implementation, however, little research has been conducted with staff nurses and practice nurses. Aim: The aim of this study was to ascertain nurses use and knowledge of guidelines and the factors that influenced these. Methods: A cross-sectional prospective survey design recruited qualified nurses working with patients with cardiovascular disease (CVD) from across Ireland in 2017-18. A previously validated anonymous questionnaire was given to the participants via a gatekeeper and returned by post. Analysis used SPSS V 22, descriptive statistics and logistic regression. Results: The profile of the 445 respondents was: 7% male, 58% were staff nurses, 45% had a postgraduate diploma or higher, 44% rated their knowledge of European Society of Cardiology (ESC) guidelines as poor/average and 51% had consulted ESC guidelines in the last year. Barriers to use of guidelines included time (66%), resources (66%) and workload (57%). A high proportion of participants perceived that they were not in a position to challenge others (59%), needed further education (76%), no leadership (64%), not in a position to influence practice (49%), with regard to guidelines and their implementation. Logistic regression analyses examining 9 factors and leadership and workload were significant ($p<0.001$). Those who agreed leadership was a barrier were more likely not to have read ESC prevention guidelines recently and cited that they had poor knowledge of guidelines. Those who cited workload as a barrier to implementation were more likely to be younger, not have a degree, and not be a member of the national cardiac nursing association. Conclusions: In this cohort of nurses, from all levels, knowledge and use of guidelines was poor. In addition, the common barriers cited in the literature to the use and implementation of guidelines were further supported. Initiatives on a large scale such as Be Guideline Smart from CCNAP have started to work on these barriers. Now is the time to also start influencing change at a local level. Developing local practice changes, having more guideline updates at national conferences, using national nursing websites and communications such as twitter to start the conversation about guideline implementation. Initiatives are needed to increase knowledge and empowerment to ensure the optimal use of guidelines in assisting to achieve patient outcome goals.

Database: EMBASE

35. Effectiveness of nurse-led patient-centered care behavioral risk modification on secondary prevention of coronary heart disease: A systematic review

Author(s): Chiang, Chung-Yan; Choi, Kai-Chow; Ho, Ka-Ming; Yu, Sau-Fung

Source: International Journal of Nursing Studies; Aug 2018; vol. 84 ; p. 28

Publication Date: Aug 2018

Publication Type(s): Journal Article

Abstract: Background Despite establishment of advocacies centered on using patient-centered care to improve disease-related behavioral changes and health outcomes, studies have seldom discussed incorporation of patient-centered care concept in the design of secondary cardiac prevention. Objectives This review aimed to identify, appraise, and examine existing evidence on the effectiveness of nurse-led patient-centered care for secondary cardiac prevention in patients with coronary heart disease. Design A systematic review of randomized controlled trials focusing on nurse-led patient-centered care for secondary cardiac prevention was conducted. Primary outcomes were behavioral risks (e.g. smoking, physical activity), secondary outcomes were clinically relevant physiological parameters (e.g. body weight, blood pressure, blood glucose, blood lipoproteins), health-related quality of life, mortality, and self efficacy. Data sources Twenty-three English and seven Chinese electronic databases were searched to identify the trials. Review methods The studies' eligibility and methodological quality were assessed by two reviewers independently according to the Joanna Briggs Institute guidelines. Statistical heterogeneities of the included studies were assessed by Higgins I2 and quantitative pooling was performed when studies showed sufficient comparability. Results 15 articles on 12 randomized controlled trials were included in this review. Methodological quality of the included studies was fair. Based on the Joanna Briggs Institute critical appraisal tool for experimental studies, the included studies had met a mean of six criteria out the ten in this appraisal tool. The meta-analyses of the included studies revealed that nurse-led patient-centered care had significantly improved patients' smoking habits, adherence toward physical activity advices, and total cholesterol level with medical regime optimization, in short- to medium-term. The intervention was also favorable in improving the patients' health-related quality of life in several domains of SF-36. Furthermore, from single-study results, the intervention was favorable in improving the patients' weight management and alcohol consumption. However, it did not show significant effects on improving the patient's dietary habits, certain cardiac physiological parameters, mortality and self-efficacy. Currently, no addition long-term benefit of the intervention on secondary cardiac prevention was identified. Conclusion This review has systematically analyzed the effects of nurse-led patient-centered care on patients' behavioral risks, cardiac physiological parameters, mortality, health-related quality of life and self-efficacy. Given limited quantity of existing evidence regarding certain outcomes and long-term follow-up period; cross-trial heterogeneity of the interventions, measurement methods and statistical results; high or unclear risk of bias in some quality dimensions, the effectiveness of the intervention on secondary cardiac prevention remains inconclusive and subject to additional trials and evidences.

Database: BNI

36. Urinary sodium excretion, blood pressure, cardiovascular disease, and mortality: a community-level prospective epidemiological cohort study

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Publication Type(s): Journal Article

Available at Lancet (London, England) - from ProQuest (Hospital Premium Collection) - NHS Version

Abstract: Summary Background WHO recommends that populations consume less than 2 g/day sodium as a preventive measure against cardiovascular disease, but this target has not been achieved in any country. This recommendation is primarily based on individual-level data from short-term trials of blood pressure (BP) without data relating low sodium intake to reduced cardiovascular events from randomised trials or observational studies. We investigated the associations between community-level mean sodium and potassium intake, cardiovascular disease, and mortality. Methods The Prospective Urban Rural Epidemiology study is ongoing in 21 countries. Here we report an analysis done in 18 countries with data on clinical outcomes. Eligible participants were adults aged 35–70 years without cardiovascular disease, sampled from the general population. We used morning fasting urine to estimate 24 h sodium and potassium excretion as a surrogate for intake. We assessed community-level associations between sodium and potassium intake and BP in 369 communities (all >50 participants) and cardiovascular disease and mortality in 255 communities (all >100 participants), and used individual-level data to adjust for known confounders. Findings 95 767 participants in 369 communities were assessed for BP and 82 544 in 255 communities for cardiovascular outcomes with follow-up for a median of 8·1 years. 82 (80%) of 103 communities in China had a mean sodium intake greater than 5 g/day, whereas in other countries 224 (84%) of 266 communities had a mean intake of 3–5 g/day. Overall, mean systolic BP increased by 2·86 mm Hg per 1 g increase in mean sodium intake, but positive associations were only seen among the communities in the highest tertile of sodium intake (p<0·0001 for heterogeneity). The association between mean sodium intake and major cardiovascular events showed significant deviations from linearity (p=0·043) due to a significant inverse association in the lowest tertile of sodium intake (lowest tertile 5·08 g/day, mean intake 5·75 g/day, >5·08–7·49; change 0·37 events per 1000 years, –0·03 to 0·78, p=0·0712). A strong association was seen with stroke in China (mean sodium intake 5·58 g/day, 0·42 events per 1000 years, 95% CI 0·16 to 0·67, p=0·0020) compared with in other countries (4·49 g/day, –0·26 events, –0·46 to –0·06, p=0·0124; p<0·0001 for heterogeneity). All major cardiovascular outcomes decreased with increasing potassium intake in all countries. Interpretation Sodium intake was associated with cardiovascular disease and strokes only in communities where mean intake was greater than 5 g/day. A strategy of sodium reduction in these communities and countries but not in others might be appropriate. Funding Population Health Research Institute, Canadian Institutes of Health Research, Canadian Institutes of Health Canada Strategy for Patient-Oriented Research, Ontario Ministry of Health and Long-Term Care, Heart and Stroke Foundation of Ontario, and European Research Council.

Database: BNI

37. American Association of Clinical Endocrinologists/American College of Endocrinology Management of Dyslipidemia and Prevention of Cardiovascular Disease Clinical Practice Guidelines

Author(s): Jellinger, Paul S

Source: Diabetes Spectrum; Aug 2018; vol. 31 (no. 3); p. 234

Publication Date: Aug 2018

Publication Type(s): Journal Article

Available at Diabetes Spectrum - from HighWire - Free Full Text

Abstract: In Brief In February 2017, the American Association of Clinical Endocrin-ologists and the American College of Endocrinology published updated "Guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease." The update encompassed recent important clinical trial

outcomes and additional research related to the treatment of dyslipidemia. This article summarizes key recommendations from this important guideline.

Database: BNI

38. Practice patterns and outcomes after stroke across countries at different economic levels (INTERSTROKE): an international observational study

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Kitoleeko S.; Yusufali A.M.; Zuberi B.J.; Mirza H.Z.; Saleh A.A.; BinAdi J.M.; Hussain F.; Muir K.; Walters M.; McAlpine C.; Ghosh S.; Doney A.; Johnston S.; Mudd P.; Black T.; Murphy P.; Jenkinson D.; Kelly D.; Whiting R.; Dutta D.; Shaw L.; Mcfarlane C.; Ronald E.; McBurnie K.

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Abstract: Background: Stroke disproportionately affects people in low-income and middle-income countries. Although improvements in stroke care and outcomes have been reported in high-income countries, little is known about practice and outcomes in low and middle-income countries. We aimed to compare patterns of care available and their association with patient outcomes across countries at different economic levels. Method(s): We studied the patterns and effect of practice variations (ie, treatments used and access to services) among participants in the INTERSTROKE study, an international observational study that enrolled 13 447 stroke patients from 142 clinical sites in 32 countries between Jan 11, 2007, and Aug 8, 2015. We supplemented patient data with a questionnaire about health-care and stroke service facilities at all participating hospitals. Using univariate and multivariate regression analyses to account for patient casemix and service clustering, we estimated the association between services available, treatments given, and patient outcomes (death or dependency) at 1 month. Finding(s): We obtained full information for 12 342 (92%) of 13 447 INTERSTROKE patients, from 108 hospitals in 28 countries; 2576 from 38 hospitals in ten high-income countries and 9766 from 70 hospitals in 18 low and middle-income countries. Patients in low-income and middle-income countries more often had severe strokes, intracerebral haemorrhage, poorer access to services, and used fewer investigations and treatments ($p<0.0001$) than those in high-income countries, although only differences in patient characteristics explained the poorer clinical outcomes in low and middle-income countries. However across all countries, irrespective of economic level, access to a stroke unit was associated with improved use of investigations and treatments, access to other rehabilitation services, and improved survival without severe dependency (odds ratio [OR] 1.29; 95% CI 1.14-1.44; all $p<0.0001$), which was independent of patient casemix characteristics and other measures of care. Use of acute antiplatelet treatment was associated with improved survival (1.39; 1.12-1.72) irrespective of other patient and service characteristics. Interpretation(s): Evidence-based treatments, diagnostics, and stroke units were less commonly available or used in low and middle-income countries. Access to stroke units and appropriate use of antiplatelet treatment were associated with improved recovery. Improved care and facilities in low-income and middle-income countries are essential to improve outcomes. Funding(s): Chest, Heart and Stroke Scotland.

Database: EMBASE

NICE Resources

Round up of Guidance and advice.

For the full range of Guidance please see https://www.nice.org.uk/guidance/conditions-and-diseases/cardiovascular-conditions

Percutaneous insertion of a temporary heart pump for left ventricular haemodynamic support in high-risk percutaneous coronary interventions
Interventional procedures guidance [IPG633]
Published date: November 2018
https://www.nice.org.uk/guidance/ipg633

Pipeline Flex embolization device with Shield Technology for the treatment of complex intracranial aneurysms (MTG10)
Medical technologies guidance
Last updated: 9th January 2019
https://www.nice.org.uk/guidance/conditions-and-diseases/cardiovascular-conditions/cranial-aneurysms/products?ProductType=Guidance&Recent=UpdatedInLast6Months

Chronic heart failure in adults: diagnosis and management (NG106)
NICE guideline
Published date: 12th September 2018
https://www.nice.org.uk/guidance/ng106

Chronic heart failure in adults (QS9)
Quality standard
Last updated: 12th September 2018
https://www.nice.org.uk/guidance/qs9

Leadless cardiac pacemaker implantation for bradyarrhythmias (IPG626)
Interventional procedures guidance
Published date: 29th August 2018
https://www.nice.org.uk/guidance/ipg626

Cerebrotech Visor for detecting stroke (MIB165)
Medtech innovation briefing
Published: 12 December 2018
https://www.nice.org.uk/guidance/conditions-and-diseases/cardiovascular-conditions/stroke-and-transient-ischaemic-attack/products?ProductType=Advice&Recent=NewInLast6Months

Sutureless aortic valve replacement for aortic stenosis
Interventional procedures guidance [IPG624]
Published date: August 2018
https://www.nice.org.uk/guidance/ipg624

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