

2010 CCS National Workshop Initiative

Shaping the Future of Heart Failure Management in Canada

CCS Heart Failure Update 2010

Lake Louise, Alberta
Tuesday, March 23, 2010

4:30 p.m. to 6:00 p.m.
(reception at 4:00)
Chair: Justin A. Ezekowitz, MB



The 2010 CCS National Workshop Initiative, under the auspices of the CCS Heart Failure Guidelines Program, is pleased to present its 5th annual heart failure workshop at ACC Lake Louise and contribute to over 25 years of ACC Lake Louise tradition of providing excellent continuing medical education. This is the first of our eight 2010 case-based and highly interactive workshops which aims at engaging Canadian health care professionals, physicians, trainees, nurses and pharmacists, in the establishment of benchmarks and ongoing improvements of the complex care of your heart failure patients. We will also use this unique opportunity to present you with the newly released 2010 CCS heart failure recommendations.

Your participation and contribution have been and continue to be instrumental to CCS's commitment to establishing, promoting and assessing evidence-based recommendations for the treatment of heart failure in Canada.

Please join us on Tuesday, March 23, 2010 at the annual meeting of ACC Lake Louise.

Agenda

4:00 p.m. – Welcome Reception

5:00 p.m. – Vignette Presentations

4:30 p.m. – Town Hall on Quality Assurance and Disease Management in Heart Failure

5:55 p.m. – Closing Remarks and Evaluations

Town Hall

Heart failure is managed by many different types of clinics ranging from family physicians offices to multidisciplinary heart function clinics.

What is the evidence base for these clinics and what should we expect for 'outcomes'? What are the features that make up a successful HF clinic?

What is the optimal care model and how can this be setup, viable and sustained?

Jonathan Howlett, MD FRCPC

Vignette 1

71 year old Chinese-Canadian male is admitted for treatment of HF. Patient is doing well in hospital and ready for medication additions and up-titration. His vitals are: BP 138/82 mmHg, HR 80 bpm, RR 18. His ejection fraction by echocardiogram is 34% and no major valvular abnormality is seen. His work-up demonstrates a non-ischemic cardiomyopathy. Creatinine is 110 umol/L, potassium 4.0 mmol/L, and other labs are normal.

You are prepared to start an ACE inhibitor. You wonder if you consider his ethnicity in deciding his medications.

Should you change your plans based on ethnicity?

Justin A. Ezekowitz, MBBCh MSc FRCPC

Vignette 2

52 year old Jamaican-Canadian is seen in your outpatient clinic for HF management. She is NYHA III, has a non-ischemic cardiomyopathy and has an ejection fraction of 34%. She is already on an ACE, BB, spironolactone and digoxin and has normal lab values.

What is the next therapy to recommend?

Justin A. Ezekowitz, MBBCh MSc FRCPC

Vignette 3

A 56 year old Eritrean male presents to the ED from the airport after a trip from Ecuador, where he was awaiting immigration status to Canada. He is mildly obese, is on no medications, and has no past medical or surgical history. He now has SOB, orthopnea, and occasional vague CP with exercise. On physical exam: BP 154/90 mmHg, HR 64, RR 22, O₂sat 93%, BMI 29, JVP 6 cm ASA; S1 S2 S3; Crackles to lung bases, no wheeze; no ascites, 1+LEE. ECG has RBBB LAHB. Labs show hemoglobin 135, K 4.3, Na 134, LDL 3.4, BNP 426, troponin negative.

What is the most likely etiology of his heart failure?

Justin A. Ezekowitz, MBBCh MSc FRCPC

Vignette 4

A 32 year old woman is admitted for VT storm and cardiogenic shock. Her symptoms began less than 24h after delivering two healthy babies and after an uneventful 40 weeks pregnancy. Cardiac Echo depicted an LVEF of 10% and a coronary angiogram is normal. Despite intubation, mechanical support, amiodarone and multiple cardioversion she remained in profound shock requiring LVAD implantation; she underwent successful heart transplantation and has been well since.

Is this peripartum cardiomyopathy?

Anique Ducharme MD FRCPC

Vignette 5

A 23 year old lady from the Punjab (India) with no significant past medical history is transferred from an outside hospital for new onset heart failure. Her symptoms have been progressive over the last weeks. She is 16 weeks pregnant, and the mother of a healthy 4 year old girl; her previous pregnancy was uncomplicated but was not closely followed. She remains tachycardic and in low output state despite inotropic support.

What would you do next? Is this peripartum cardiomyopathy?

Anique Ducharme MD FRCPC

Vignette 6

A 32 year old woman is referred for consultation. She suffered from peripartum CMP 3 years ago with cardiogenic shock; transplantation was initially considered but she improved enough to be delisted. She is feeling well and has a very profound desire to have a second child.

What would you tell her? What investigations are required to make a recommendation?

Anique Ducharme MD FRCPC

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