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Special Article

The Canadian Cardiovascular Society Heart Failure Companion: Bridging Guidelines to Your Practice

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ABSTRACT

The Canadian Cardiovascular Society Heart Failure (HF) Guidelines Program has generated annual HF updates, including formal recommendations and supporting Practical Tips since 2006. Many clinicians indicate they routinely use the Canadian Cardiovascular Society HF Guidelines in their daily practice. However, many questions surrounding the actual implementation of the Guidelines into their daily prac-

RÉSUMÉ

Le programme des lignes directrices de la Société canadienne de cardiologie en matière d'insuffisance cardiaque (IC) a généré des mises à jour annuelles sur l'IC, y compris des recommandations formelles et des conseils pratiques depuis 2006. De nombreux cliniciens indiquent qu'ils utilisent régulièrement les lignes directrices de la Société canadienne de cardiologie en matière d'IC dans leur pratique

The Canadian Cardiovascular Society (CCS) Heart Failure (HF) Guidelines Program has generated annual HF updates, including formal recommendations and supporting practical tips for the past 9 years.[1-9] Many clinicians indicate they routinely use the CCS HF Guidelines in their daily practice or as a reference for optimal care.[10] Feedback from family physicians, internists, cardiologists, nurses, pharmacists, and others attending Guidelines Workshops held across Canada have indicated that the Guidelines provide great value.[11] They also indicated the need to address issues surrounding

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tice remain. A consensus-based approach was used, including feedback from the Primary and Secondary HF Panels. This companion is intended to answer several key questions brought forth by HF practitioners such as appropriate timelines for initial assessments and subsequent reassessments of patients, the order in which medications should be added, how newer medications should be included in treatment algorithms, and when left ventricular function should be reassessed. A new treatment algorithm for HF with reduced ejection fraction is included. Several other practical issues are addressed such as an approach to management of hyperkalemia/hypokalemia, treatment of gout, when medications can be stopped, and whether a target blood pressure or heart rate is suggested. Finally, elements and teaching of self-care are described. This tool will hopefully function to allow better integration of the HF Guidelines into clinical practice.

quotidienne. Cependant, de nombreuses questions entourant la mise en œuvre effective de ces lignes directrices dans leur pratique quotidienne demeurent. Une approche fondée sur le consensus a été utilisée, y compris les rétroactions des Panels d'IC primaire et secondaire. Ce vade-mecum est destiné à répondre à plusieurs questions clés élaborées par les praticiens spécialistes de l'IC tels que les délais appropriés pour les évaluations initiales des patients et les réévaluations subséquentes, l'ordre dans lequel les médicaments doivent être ajoutés, comment les nouveaux médicaments devraient être inclus dans les algorithmes de traitement, et quand la fonction ventriculaire gauche doit de nouveau être évaluée. Un nouvel algorithme de traitement de l'IC avec une fraction d'éjection réduite est inclus. Plusieurs autres questions pratiques sont abordées telles une approche de gestion de l'hyperkaliémie hypokaliémie, le traitement de la goutte, le moment où les médicaments peuvent être arrêtés, et si une cible de pression artérielle ou d'un rythme cardiaque est suggérée. Enfin, un enseignement et des éléments de l'autosoins sont décrits. Cet outil devrait permettre une meilleure intégration des lignes directrices en matière d'IC dans la pratique clinique.

the implementation of the Guidelines into everyday practice. Efforts are under way to implement Canadian benchmarking of key performance indicators for HF care. Although there is published information regarding hospital discharge medication use in patients admitted with HF, Canadian outpatient data are limited to abstract publications from the Canadian HF Network.[12,13] These data show relatively modest use of evidence-based therapies that increases in the HF clinic setting. Because use of evidence-based therapies for HF is closely related to best outcomes, the current Companion is focused on providing a pathway to achieving optimal treatment.

Who Is This Document Primarily Intended to Reach? What Is the Format?

This document addresses the most commonly asked practical questions that arise from those (in primary and secondary care) who use these HF Guidelines and is written with the main HF care provider in mind. Many of the suggestions and comments made in this article might also be of interest to those who treat a large volume of HF patients or who practice in a HF clinic setting. We have adopted a question and answer approach to the structure of this document and have indicated where published evidence has informed the responses. Otherwise, we have relied on procedures described in large randomized trials, or, where no evidence exists, we have used expert consensus obtained by polling all members of the primary and secondary HF panels and have collated the responses (response rate 29 of 34 [85%]) to the questionnaire.[14] We have also attempted to use graphics, tables, and lists in a user-friendly manner that is accessible via multiple formats so that the busy clinician might conveniently use this tool.

In this report, we provide suggested answers to the following questions:

(1) How soon should I see a newly referred HF patient; how often should my HF patient be seen, and when can a patient be discharged from a HF clinic?
(2) How quickly and in what order should standard HF therapy be titrated for most patients?
(3) When should I measure electrolytes, serum creatinine, and blood urea nitrogen (BUN), and how should I manage abnormal potassium or increasing creatinine levels?
(4) Should I treat my HF patients to a specific heart rate (HR) or blood pressure (BP) and how often should I measure left ventricular (LV) ejection fraction (EF)?
(5) Can I ever stop HF medications?
(6) When should I refer my patient to a heart surgeon?
(7) How should I manage gout in my patient?
(8) In what ways do I care differently for frail older patients with HF?
(9) How do I teach self-care to my patients?

How Soon Should I See a Newly Referred HF Patient?

Table 1 shows situational wait time benchmarks for HF referrals to a specialist.[15] More than 86% of survey respondents agreed that routine referrals should be seen within 4 weeks and 16% suggested this ideally be < 14 days.[14]

How Often Should My HF Patient Be Seen?

There are few published data regarding the optimal frequency of outpatient visits for patients with HF. Most clinical trials that involved stable HF patients scheduled visits every 3-4 months, with the assumption that primary and specialist care was in place. Patients who are not stable or are in the process of medical optimization should be seen more frequently. Table 2 shows the time frames for which > 70% of our respondents believe patients should be seen for HF care (by whomever provides their HF care), based on their risk.[14] Patients often move from one risk group to another after a sentinel event such as an emergency department visit or hospitalization. A suggested pathway for initial and ongoing assessments for patients with HF is shown in Figure 1.

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