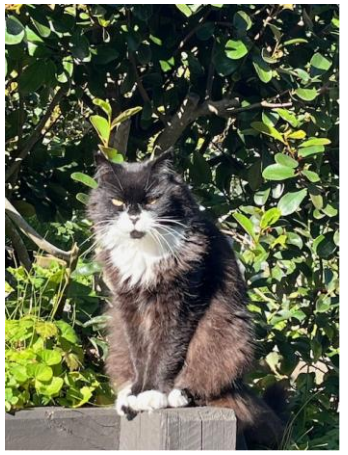


HF management,

including tachycardiomyopathies

Rachel Hall NP

Covering:

- Role of HF Specialist. NP or CNS, coordinator of care
- Selection of Patients
- Optimising medications from day 0
- Clinics
- Incidentals
- Tachycardias
- Discharge

Role of Heart Failure Specialist. NP/CNS

- Optimise medications
- Co-ordinate patient care (ours don’t see Dr while in HF clinic)
- Understanding of when to refer for further procedures, ie Holter monitor, echocardiograms, CRT/ICD, MRI, transplant discussions, Advanced Care Planning.

Selection of Clinic Patients

- Depends on capacity of service, and other roles available within service (we don’t have a rhythm nurse position)
- HFrEF <35% (40%)
- Limited co-morbidities (age, renal function, cognition, mobility)
- Tachycardia myopathies
- Palliative

Setup for success

- Ensure medications are as optimised as possible prior to discharge:
  - House officer and CCU staff education.
- Text patients' day before clinic; asking to bring ‘actual’ medications and HF book (if they have one)
- See within 10/7 of discharge

Clinic day

- ECG, BP, Weight, Assess: JVP, oedema, heart and lung sounds prn.
- Enquire re SOB, exercise, light-headedness, postural hypotension, awareness of tachycardia or arrythmia, cough, fluid intake, sleep position, nocturia.
- Overview meds. Optimise ‘4 Pillars’ soon as able.
  - If vital signs OK, may increase 2 ‘pillars’ in one visit, one current week and one next week.
  - Renal fn 1-2/52 later.
  - Other bloods TFTs, LFTs, Iron Studies, HbA1c, lipids.

Clinic day

- Write plan for increasing diuretic prn in Heart Failure booklet, (separate bottle if meds packed)
- Write plan for increasing exercise
- Letter to GP
- End of letter, I mention things to be discussed the next visit

My heart failure action plan

Heart Foundation™

Good to go

My symptoms

- Weight stable
- No new swelling. Legs and tummy look normal
- Breathing is easy
- Physical activity is normal

Action

- Keep taking heart pills
- Do daily checks
- Stay active
- Eat a healthy, low-salt diet
- See your doctor or nurse regularly

Review this action plan each time you see your heart failure nurse or doctor.

Stay alert

My symptoms

- Target **weight up** 2kg+ in 1-2 days
- Swelling in ankles, legs or tummy
- Hard to breathe when active or at night
- Need to use more pillows at night
- Constant cough or wheeze
- Very tired

Action

If inc in 2 symptoms increase 1/2 Frusemide for 2-3 days

Call my doctor or nurse if symptoms continue

OR

My symptoms

- Target **weight down** 2kg+ in 1-2 days and weight loss ongoing
- Dry mouth/skin
- Dizziness

Action

Call my doctor or nurse

Get help now

My symptoms

- Sudden severe shortness of breath
- Angina not relieved after following angina action plan
- New chest pain, tightness or heaviness

Action

CALL 111 NOW

Useful information

Cardiac nurse/doctor

Name: Rachel Hall

Phone: 0277426351

Name: _____

Phone: _____

My heart pills

_____

_____

_____

_____

_____

My target weight

Kg: _____

Instructions:

Date: 24/5/25

Patient label
NHI

Health New Zealand
Te Whatu Ora

Medication Instructions:

If you feel unwell after starting or changing doses of medications please contact me.

-Increase Spironolactone to whole tablet, 25mg
Blood test 1 week later – E-form at Pathlab
-Next week increase Bisoprolol 2.5 ➡ 5mg daily
-Start daily walking 15min and build
-Fluids 1.5L/24hr. No alcohol!

Rachel Hall Nurse Practitioner
Office phone: 07 557 5265 Mobile: 027 742 6351
Tauranga Hospital Private Bag 12024, Tauranga 3143

Incidentals

- Check for Iron deficiency
  - Ferritin <100 ug/L, or Ferritin 100-300 with TSAT <20%.
- Epworth score – Sleep apnoea referral
- Spirometry, with reversibility
- Mediroll/blister pack
- Uric acid
- Refer to Diabetes nurse
- Diaphragmatic breathing exercises
- Dietician

Next step for general HFrEF patients

- Repeat echo (usually indicated)
- LVEF < 35% and IHD and <70 years – defibrillator discussion
- LVEF <35% and QRS >150ms and NYHA II+ – CRT discussion
  - If NYHA I, put in GP letter, refer for CRT consideration if NYHA II.
  - Less effective if AF, not recommended for RBBB
  - Aim for 98% pacing
- If LVEF > 50% continue meds and discharge
- Refer for Repeat echo for monitoring aorta/valves per guidelines
- Discharge, with letter to Cardiologist.
  - Pt needs to know **meds forever**, and how to **use diuretic** for symptom control, '**remission** not cure'

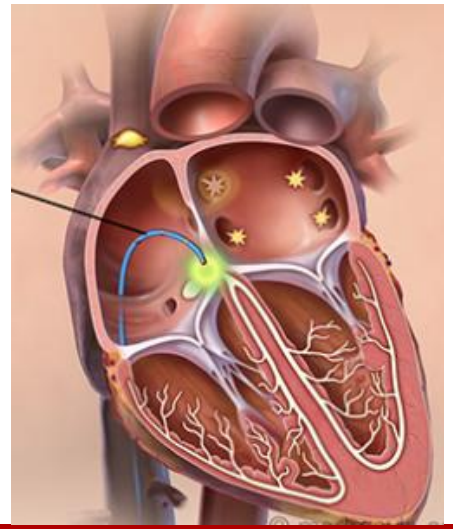
Dealing with tachycardia induced cardiomyopathy
(Growth industry)

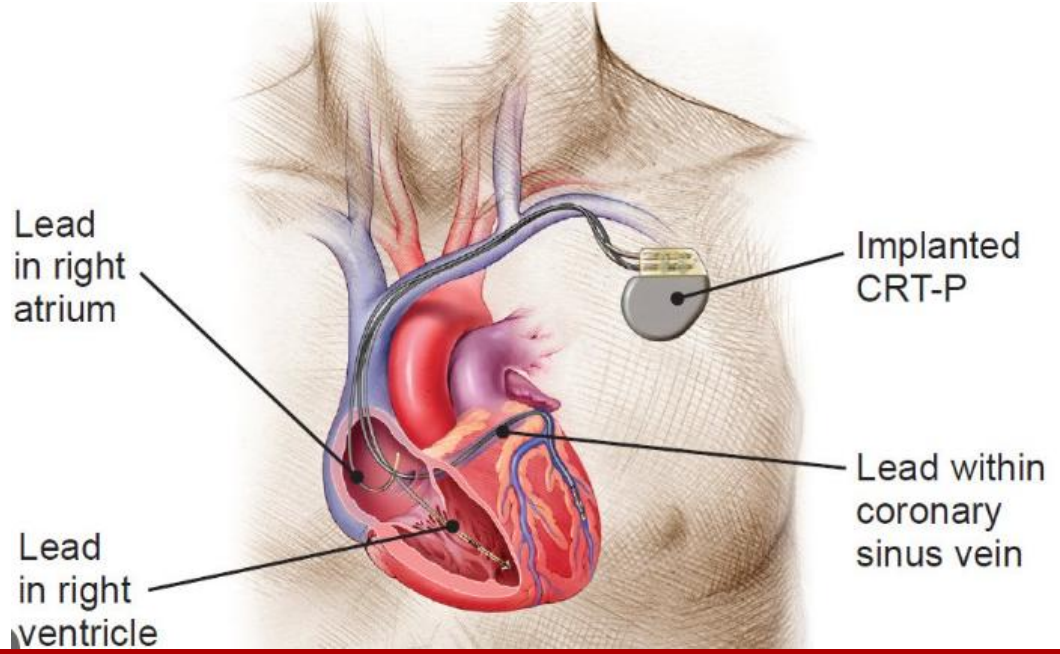
- Development of HF in AF patient causes 2-fold increase in risk of stroke and thromboembolism: Anticoagulation
- Pt education re lifestyle benefit of: reduce excess BMI, regular exercise, no ETOH.
- First response: Up titrate BB –Bisoprolol most cardio selective
  - (Nebivolol more selective, NZ access …)
- Can we achieve sinus rhythm?
- Refer for DCCV,
  - If LA above moderately enlarged and/or large BMI it may be less successful,
  - Worth a try if haven't had DCCV previously / younger
  - Anti-coagulation 1/12 before
  - Can use Amiodarone 1/12 before, or try first DCCV without, monitoring TFTs.
- Re echo once optimal meds 3/12

Dealing with tachycardia induced cardiomyopathy
(Growth industry)

- Ablation in tachycardia induced cardiomyopathy shows prognostic benefit.
  - Consideration of Ablation dependent on pt (risk profile: age, LVEF, BMI, LA size)
  - Atrial Flutter - Ablation recommended
- If LVEF >50%: Stop amiodarone. If under 60 years, consider MRI to check substrate and may use Flecainide. Or stop of BB (2-6/52, after stopping Amiodarone) and replace with Sotalol, ECG 1/52 later (long QT).
- For some pts whom it was thought rhythm control unlikely, after GDMT and echo, heart may have improved to where these can be attempted.
- If LVEF not improved and SR: *means it isn't tachycardia induced*. May stay on Amiodarone longterm with monitoring. Discuss risk/benefit with patient.

- For those with no recovery of LVEF on optimal meds, still symptomatic in AF
  - CRT pace and AV node ablation.
- Digoxin – effect on mortality is neutral in HF, but some feel better.





- Debbie 67 years rapid AF/viral illness, 63kgs.
- Echo 7/6/24: LV mod dilated 5cm. **LVEF 27%.** RV normal size, mod impaired.
- LA severely dilated **56ml/m2**, Mod MR, Mod TR

- Follow up Echo 29/1/25:
- LV normal size, 4.1cm, **LVEF 62%.** RV normal size and function.
- LA normal size **27ml/m2**, trace MR, trace TR.

- LA disease and LA reverse remodeling. European Journal of Heart Failure (2022) **24**, 959–975 doi:10.1002/ejhf.2562
- Prognostic value of reduction in LA size. Shiba M, etal. BMJ Open 2021;11:e044409. doi:10.1136/bmjopen-2020-044409

? 5 pillars of tachycardiomyopathy

Rhythm Control

Beta Blocker

ARNI
ACE/ARB

MRA

SGLT2

The unaddressed essential