ISSUES AND ANSWERS IN CARDIOVASCULAR DISEASE:
Applying the evidence in primary care today
16-17 November 2012, University of Warwick

More than 200 primary care professionals attended the inaugural conference "Issues and answers in cardiovascular disease: Applying the evidence in primary care today" hosted by the Primary Care Cardiovascular Journal (PCCJ) and British Journal of Primary Care Nursing (BJPCN). The meeting was chaired by Professor Mike Kirby, Visiting Professor, Faculty of Health and Human Sciences, University of Hertfordshire, Editor of PCCJ and Jan Procter-King, Editor of BJPCN. Plenary sessions, satellite symposia and workshops addressed the critical issues facing GPs, nurses and other healthcare professionals in the primary care of patients with cardiovascular disease and provided delegates with practical evidence-based guidance. Watch out for more resources including key presentation slides at www.pccj.eu.

"We need to congratulate ourselves for the striking improvements in primary care management of cardiovascular disease (CVD) over the past decade, and grit our teeth for the next decade" said Professor Richard Hobbs, Professor of Primary Care Health Sciences, University of Oxford, in the keynote address.

Professor Hobbs highlighted the recent reductions in vascular risk and dramatic improvements in patient care achieved with improvements in blood pressure, lipid control and smoking reduction. He also singled out the benefit of statins in improving dyslipidaemia. In addition, he praised the National Service Framework (NSF) and Quality and Outcomes Framework (QOF) for significantly accelerating improvements in care. However, despite these impressive developments, there are numerous hurdles to face. The ‘demographic time bomb’ of childhood obesity in the UK is already associated with increasing levels of diabetes. In addition, there are questions over appropriate screening for cardiovascular disease as a significant proportion of the population has unrecognised risk factors. With the current focus on managing high-risk patients, the bulk of disease is hidden in patients with modest risk factors, which suggests major management challenges in the future.

Potential primary care solutions being discussed include major public health initiatives such as the Polypill. At the same time, the growth of home self-monitoring for diabetes and hypertension to increase patient involvement gives the possibility of further cost-saving and efficacy benefits and has resulted in changes to management guidelines. Likewise, practice-based clinics for INR monitoring are performing as well as hospital-based clinics. These and other initiatives are needed to tackle the significant challenges of CVD management in primary care.

"Following the success of this year’s meeting I’m already looking forward to the PCCJ/BJPCN conference next year on 11-12 October. I loved the practical, interactive and friendly approach that allowed us all to ask questions and learn together"
Jan Procter-King

This report provides coverage of the recent PCCJ/BJPCN meeting including a number of symposia sponsored by the pharmaceutical industry. The companies involved were MSD, Takeda, A. Menarini Pharma U.K. S.R.L. Where this report refers to industry-sponsored events, the companies concerned have reviewed the data presented in order to ensure factual accuracy and compliance with industry guidelines. The views expressed in the original presentations and this report are not necessarily the views of the sponsoring companies.
WHAT'S NEW IN MANAGING CVD?

Critically important clinical areas of CVD management in primary care were addressed. Here are the key messages:

**Atrial fibrillation:** Dr Matthew Fay, GPwSI cardiology, Bradford, and National Clinical Lead for AF, encouraged primary care professionals to claim atrial fibrillation (AF) as ‘our disease’, in the same way as hypertension. Primary care has the skills and medications to treat the condition effectively. Recent allocation of QOF points for AF will strengthen their position. He emphasised that aspirin is inappropriate for stroke prevention in AF, and is championing the STOP/START campaign to end the use of aspirin in AF (www.stopstart.org.uk). Using simple measures, such as taking the pulse of older people presenting at the GP surgery, together with comprehensive uptake of the GRASP-AF tool will improve primary care management of AF. Dr Fay also encouraged use of the CHA2DS2-VASc score (not CHADS2) to provide accurate estimates of low-risk patients who should not be treated with anticoagulation.

**Chronic kidney disease:** The need to treat the patient and not just the organ, was highlighted by Dr Kathryn Griffith, GPwSi cardiology, York. She showed the close link between kidneys and heart during her presentation on chronic kidney disease (CKD). Dr Griffith discussed the potential replacement of the MDRD (Modification of Diet in Renal Disease) method of estimating glomerular filtration rate with the CKD-EPI (Epidemiology Collaboration) equation which is under evaluation in the UK. She drew attention to the 2011 NICE Quality Standards on CKD in adults and encouraged focus on Standard 7 that says, “People with CKD who become unwell should have their medication reviewed and volume status assessed”. Dr Griffith reminded delegates to look out for new KDIGO CKD guidelines in 2013.

**Heart failure:** The 2012 ESC guidelines should change our behaviour in managing patients with heart failure (HF), according to Dr Ahmet Fuat, GPwSi cardiology, Darlington. The main changes from the 2008 guidelines include an expanded indication for mineralocorticoid (aldosterone) receptor antagonists (MRA) such as eplerenone. There is a new indication for the sinus node inhibitor ivabradine which should now be considered in patients in sinus rhythm with an ejection fraction ≤35%, a heart rate ≥70 beats per minute and persisting symptoms (NYHA class II–IV) despite treatment with a beta-blocker, ACE inhibitor or angiotensin receptor blocker (ARB) and an MRA (or ARB). The new ESC guidelines also include useful addenda web tables (Appendix E, www.escardio.org) with practical guidelines on use of key drugs used to treat HF.

**Venous thromboembolism:** 2012 NICE (CG 144) guidelines for idopathic venous thromboembolism (VTE) were criticised by Professor David Fitzmaurice, GP and Professor of Primary Care, University of Birmingham, for having an overtly secondary care focus. The new guidelines include recommendations to investigate for cancer with chest X-ray, CT scans and mammograms which may be unreasonable for the majority of patients seen in primary care. Likewise, the recommendation to test for hereditary thrombophilia appears excessive in the primary care setting. Professor Fitzmaurice encouraged primary care to get more involved in the development of appropriate NICE guidelines, rather than specialists setting the agenda. The only currently licensed new oral anticoagulant for treatment and long-term secondary prevention of VTE is rivaroxaban (NICE Technology Appraisal 261) which has proved to be cost-effective and is being increasingly used in this indication. Dabigatran etexilate is expected to be licensed in the near future.

**Diabetic nephropathy:** Dr Mike Kirby, Visiting Professor, Faculty of Health and Human Sciences, University of Hertfordshire, emphasised the role of diabetic nephropathy as a prognostic marker for coronary heart disease. Diabetic nephropathy is the leading cause of chronic renal failure in the industrialised world, with significant long-term morbidity and mortality, and primary care could do much to improve earlier referral of these patients. Professor Kirby recommended a number of actions for effective management of kidney disease in diabetes:

- Blockade the renin-angiotensin system to correct glomerular hypertension, inhibit TGF-β production, improve endothelial function and increase insulin sensitivity.
- Consider ACE inhibitor or ARB as first-line treatment in all patients.
- Maintain strict blood glucose control to prevent development of nephropathy, particularly early in the development of type 2 diabetes.
- Detect diabetes early through screening, and if found, control blood pressure, lipids and glycaemia with all patients on statin therapy, aiming for a target of LDL <2 mmol/L.
- Refer early to tertiary care and avoid nephrotoxic agents (such as NSAIDs),...
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SATELLITE SYMPOSIUM: ‘HAVE I GOT CV NEWS FOR YOU’ HAS A SERIOUS POINT

“Remember that the cost of a disease is in the event and not just the drug” was one of the more challenging statements emerging from a highly amusing tour of current issues in the management of cardiovascular disease (CVD), based on the award-winning panel game and sponsored by MSD.

The chairman Michael Norton, Community Cardiologist, South Tyneside NHS Foundation Trust, put the questions to two highly competitive teams. The “Boys team” comprised Professor Mike Kirby, Visiting Professor, Faculty of Health and Human Sciences, University of Hertfordshire and Editor of PCCJ, and Terry McCormack, GP, Whitby, with the “Girls team” represented by Jan Procter-King, Primary Care Cardiovascular Nurse and Editor of the BJPCN, and Beverley Bostock-Cox, Nurse Practitioner, Coventry.

Amongst all the laughter, a number of important matters were discussed by the panel, with revalidation of doctors and maintenance of good relationships with politicians being early discussion points!

The dramatic impact of cardiovascular drugs going off patent was highlighted by the price of generic atorvastatin falling by 93% during the summer. These changes have resulted in a drop in the NHS drug budget of £40 million per month. However, drugs often comprise a small part of the total disease management costs and the panel urged caution against wholesale switching to cheaper drugs on the basis of cost alone. Many GPs have complained about undue pressures to prescribe cheaper generic alternatives, but switching needs to be managed very carefully, as Professor Kirby said: “It is far more important to get patients to target than to prescribe the cheapest drug.”

Delegates were reminded that not all statins suit all patients, and panel members highlighted the pressure not to prescribe ezetimibe, which has been shown to be effective and get patients to target.

The complexity of dietary advice was highlighted by the ‘odd one out’ round comparing red meat, cheese, peanut butter and fish. Peanut butter was correctly identified by one team for its healthier mono-unsaturated fats in vegetable oil, whereas the others contained less healthy animal fats. Concerns over mercury intake from fish and the difficulty of obtaining the recommended amounts of omega-3 fatty acids from oily fish were also highlighted.

Beverley Bostock-Cox made the important point that good primary care practice is about good relationships. If health professionals are under pressure to prescribe lower-cost drugs, it may come at the ‘cost’ of losing the trust of their patients who are often well-informed about the best drugs to get them to target. It may also negatively affect adherence to therapy.

SATELLITE SYMPOSIUM: ISSUES AND CHALLENGES IN HYPERTENSION – NEW ARB PROVIDES MORE CHOICE

The new angiotensin receptor blocker (ARB) azilsartan medoxomil increases the options available to prescribers as they tackle the challenges in managing hypertension, according to Dr Chris Arden, GPwSI cardiologist, Southampton, during a satellite symposium sponsored by Takeda.

Dr Arden emphasised the scale of the hypertension problem and highlighted the global importance of the triad of hypertension, smoking and dyslipidaemia in CVD. Cardiovascular mortality risk doubles with each 20/10 mmHg blood pressure increment (in people aged 40-70 years starting at 115/75 mmHg) and suboptimal blood pressure remains the most important correctable risk factor for mortality (Lewington S et al. Lancet 2002;60;1903-1913).

He highlighted the importance of self-measurement of blood pressure in assessing response to antihypertensive therapy, improving adherence, and evaluating white coat hypertension. Home and ambulatory blood pressure are more strongly related to target organ damage and have better prognostic accuracy than clinic blood pressure. Despite detection and treatment of hypertension improving in the UK, less than a third of people with hypertension are controlled at blood pressure <140/90 mmHg. Lifestyle modifications, notably weight loss and salt reduction, have an impact on reducing blood pressure, but the growing epidemic of ‘diabesity’ is the worrying shape of things to come unless new management strategies are used.

Next year proposed changes to the QOF could see the existing BP indicator focusing on the percentage of patients with BP ≥150/90 mmHg being replaced with:

- % of patients <80 years with hypertension in whom last recorded BP <140/90 mmHg
- % of patients >80 years with hypertension in whom last recorded BP <150/90 mmHg

This, alongside updates in the 2011 NICE guidelines (CG 127), represents a significant challenge for primary care practice.

ARBs are a popular choice as monotherapy for hypertension, both in terms of efficacy and tolerability. The most recently licensed ARB is azilsartan medoxomil (azilsartan). Azilsartan given once daily has shown superiority to ramipril in achieving blood pressure targets (Böner G et al. J Hypertens 2010;28;2883). In combination with amlodipine, azilsartan has also shown superiority to amlodipine monotherapy in reducing 24-hour systolic blood pressure (Weber MA et al. J Clin Hypertens 2010;12(Suppl 1):A119).

Azilsartan has also shown improvements over other ARBs including valsartan and olmesartan at maximum doses (White WR et al. Hypertension 2011;57;413-420; Sica D et al. J Clin Hypertens 2011;13:467-472; Bakris GL et al. J Clin Hypertens 2011;13:81-88). Dr Arden noted that, in these studies, azilsartan shows good tolerability with a safety profile similar to other ARBs.

Dr Arden concluded that an ARB demonstrating effective and sustained blood pressure reduction and tolerability across different patient populations including general hypertension, those with CV risk, diabetes or renal disease could simplify treatment choice. With the latest NICE hypertension guidelines allowing fine-tuning between drug classes at each step to optimise therapy before moving to the next step, azilsartan may provide a welcome addition to the options available to prescribers.

The prescribing information for azilsartan medoxomil can be found on page 148-149. (AZL121001c, Nov 2012)
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SATELLITE SYMPOSIUM: SHOULD PRIMARY CARE TAKE BACK RESPONSIBILITY FOR ANGINA MANAGEMENT?

It is time to take the bulk of angina management back into primary care, although few patients currently feel confident having their angina managed by GPs, Dr. Terry McCormack, GP Whityb, said. The symposium was sponsored by A. Menarini Pharma U.K. S.R.L.

Dr. McCormack said that, until relatively recently, most stable angina was treated in primary care, with only the young being referred to cardiologists. However, since publication of the NSF for coronary heart disease in 1999 there has been a huge increase in the availability of percutaneous coronary intervention (PCI) which had switched the focus to secondary care.

However, the COURAGE (Clinical Outcomes Utilizing Revascularisation and Aggressive Drug Evaluation) trial suggested that PCI brings little additional improvement to mortality rates over optimal medical therapy in patients with stable coronary artery disease (Boden W et al. NEJM 2007; 356:1-14), and there are strong indications that the tools are available to switch the management of most patients with angina back to primary care.

The case for more primary care treatment is strengthened when healthcare costs of hospital in-patient care of cardiovascular disease are compared. This situation clearly cannot be allowed to continue, and may well change with the development of Clinical Commissioning Groups (CCGs).

The 2011 NICE guideline on stable angina (CG 126) was criticised for being overly complex with a strong secondary care bias. So, Dr. McCormack suggested a simple primary care alternative algorithm beginning with use of nitrates followed by three steps of optimised pharmacological therapy before PCI or CAGB are considered. He also urged GPs to consider psychological aspects such as anxiety in the differential diagnosis of angina rather than simply referring patients to a Rapid Access Chest Pain Clinic in secondary care.

In conclusion, Dr. McCormack encouraged cutting down on unnecessary referrals and developing an improved primary care pathway for angina to shift the present balance back in favour of primary care.

One of the newer drugs used for the treatment of angina is ranolazine. This well-tolerated drug reduces anginal symptoms when used as second-line treatment in combination with beta-blockers or calcium channel antagonists.

It has no negative haemodynamic effects so is well tolerated in patients with low blood pressure, and has some anti-arrhythmic properties. Although caution is required with potential QT prolongation, Dr. McCormack said that in practical day-to-day use this is not a significant issue.

The discussion which followed highlighted the lack of confidence in many GPs in diagnosis and management of angina. Several mentioned the confusing language used in secondary care and NICE guidelines which does little to build confidence, when in fact secondary care could provide much information to train GPs in this area. However, the Canadian Cardiovascular Society (CCS) grading system for angina was highlighted as a useful tool in primary care. A number of speakers suggested that they would be happy to manage angina in primary care, as long as a detailed history had been taken, and there had been a prior evaluation with angiogram or MRI scan in secondary care.

Dr. Clare Hawley, GPwSI cardiology, Bradford, felt that primary care had an important role with patients referred from tertiary care in helping patients deal with underlying psychological issues. Providing patients with detailed information about coronary disease and using cognitive behavioural therapy and motivational interviewing to reduce the fear and sympathetic overdrive reduces symptoms. With additional encouragement to increase exercise and eat healthily, the great majority of patients will require no further interventions for angina.

In conclusion, Dr. McCormack encouraged cutting down on unnecessary referrals and developing an improved primary care pathway for angina to shift the present balance back in favour of primary care.

GRASP-AF POSTER WINS PCCJ/BJPCN BEST PRACTICE AWARD

The winner of this new award, voted for by delegates at the conference, was Ian Robson and team from NHS Improvement (fHeart) and PRIMIS + with their poster titled “How GRASP-AF helped 825 general practices prevent 85 AF-related strokes”. The object of the project was to reduce the number of AF-related strokes using the GRASP-AF free audit tool which stratifies stroke risk for AF patients. The tool is available for use with all GP clinical systems in England. In a subset of 825 practices that downloaded the tool more than once, 2.33% more high-risk patients (CHADS2 score ≥2) were identified who were then managed with a new oral anticoagulant, thus preventing 85 AF-related strokes and resulting in a saving of over £1 million on AF-related stroke care.

More details on GRASP-AF can be found at [www.improvement.nhs.uk/graspat](http://www.improvement.nhs.uk/graspat)

WINNER OF THE MEDTRONIC ECG COMPETITION

All delegates were invited to enter an ECG competition (sponsored by Medtronic) which consisted of correctly identifying eight ECG traces. The winner was Dr. Robert Jennings, Medical Student at St George’s, University of London & Townhill Medical Practice, London.
KEY LEARNING POINTS  Dr Kathryn Griffith, GPwSI cardiology, York

- Smoking cessation at any age is of benefit to patients, but the earlier the better for long-term outcomes. Healthcare professionals should go on a motivational interviewing course to help patients quit smoking and reduce weight.
- Treatment targets in national guidelines have significantly improved care. However, remember that we should treat to beyond QOF as these are audit standards and not targets.
- Self-monitoring works in blood pressure, diabetes and INR control and has resulted in changes to guidelines.
- Atrial fibrillation (AF): Use risk assessment tools to identify patients with a low risk of stroke and then anticoagulate all others. Remember that aspirin has no role to play in treating AF.
- Kidney disease: Always remember to consider the kidneys when treating the heart and blood pressure. Kidney function is optimal between SBP 120-140 mmHg. Avoid NSAIDs. Albuminuria is a target for renoprotective therapy using ACE-Is or ARBs independent of blood pressure management.
- Safety: Treat medication checks seriously, uptitrate drugs and look at interactions.
- Heart failure (HF): Download the 2012 ESC HF guidelines addenda web tables (Appendix E, www.escardio.org) which offer practical guidelines on use of key drugs for treatment of HF.

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