‘Personalized care’: attitude and implantable cardioverter-defibrillator (ICD) therapy in Denmark

Johann Christoph Geller*

Arrhythmia Section, Division of Cardiology, Zentralklinik Bad Berka, Robert Koch Allee 9, 99437 Bad Berka, Germany

Received 10 November 2010; accepted after revision 19 November 2010; online publish-ahead-of-print 7 January 2011

This editorial refers to ‘Attitudes towards implantable cardioverter-defibrillator therapy: a national survey in Danish health-care professionals’ by J.B. Johansen et al., on page 663.

Implantable cardioverter-defibrillator (ICD) therapy for primary prevention is a class I indication in high-risk patients with both ischaemic and non-ischaemic heart disease, supported by evidence from several randomized trials. However, despite the overall positive results of the studies and the recommendation in the guidelines, only a fraction of patients with an indication for ICD therapy will actually receive a device, and there are also substantial differences in implant rates across the European countries. The likely reasons for this discrepancy include: (i) reimbursement issues, (ii) personal attitude of implanting and particularly, referring physicians, (iii) patient preference, (iv) medical traditions in some countries, and (v) other practical limitations of device availability.

In addition, difficulties with ICD therapy remain [e.g. multiple shocks, inappropriate therapy, device infections, lead malfunction, quality-of-life (QoL) issues, etc.], and there is more compelling evidence of the benefit of ICD therapy in patients with ischaemic heart disease than in non-ischaemic cardiomyopathy. Finally, patients often develop anxiety and depression as a consequence of underlying disease and heart failure as well as device discharges. This has a significant effect on QoL after implantation and may also be related to the occurrence of the arrhythmia. How much the prevention is a class I indication in high-risk patients with both ischaemic and non-ischaemic heart disease, supported by evidence from several randomized trials. However, despite the overall positive results of the studies and the recommendation in the guidelines, only a fraction of patients with an indication for ICD therapy will actually receive a device, and there are also substantial differences in implant rates across the European countries. The likely reasons for this discrepancy include: (i) reimbursement issues, (ii) personal attitude of implanting and particularly, referring physicians, (iii) patient preference, (iv) medical traditions in some countries, and (v) other practical limitations of device availability.

First, physicians spent less time talking to patients and were more likely to talk about clinical issues and less likely to discuss psycho-social matters with patients. However, one important aspect of this observation is that there was no way of differentiating whether this was true for both primary and secondary prevention implantation. In patients who survived an episode of sudden cardiac death, the preoperative discussion would appropriately focus on medical issues, whereas in primary prevention, a more extensive discussion of all matters related to prophylactic ICD therapy is usually warranted. In particular, discussion of the possibility of inappropriate therapy and other ICD-related problems should play a bigger role in the discussion with the patient.

Secondly, although all healthcare professionals were positive towards primary prevention ICD implantation in ischaemic heart disease, there was more doubt with respect to primary prevention in non-ischaemic heart disease. However, physicians believed more strongly in primary and secondary ICD prevention in non-ischaemic cardiomyopathy compared with non-physicians.

The role of the attitude of personnel not directly involved in the ICD care is not answered by this study. This is likely to determine in most instances whether a patient is referred for ICD implantation in the first place. Many referring physicians may not be aware of the international guidelines, and the shared decision-making involving the referring physician and the patient is not common. Differences in the preferences of referring physicians may explain, in part, a significant variability in the delivery of care to patients at risk for sudden cardiac death across Europe.

The complementary role of implanting physicians and other staff members (ideally also including a psychologist) in discussions with workers. The questionnaire was mailed to implanting and referring cardiologists, nurses, and technicians assisting during implant, working on the ward or in outpatient clinics. Despite the inherent limitations associated with data generated from surveys and enrolling only professionals involved with ICD therapy, several interesting aspects were observed in this study.

The study by Johansen et al.1 evaluated the influence of the ‘personal’ attitude of healthcare providers towards ICD therapy on how this therapy is delivered. Using a questionnaire that was mailed to healthcare professionals working in one of the five centres performing ICD implantation in Denmark, differences in attitudes and issues discussed with patients prior to implantation of the device were analysed for different groups of healthcare workers. The questionnaire was mailed to implanting and referring cardiologists, nurses, and technicians assisting during implant, working on the ward or in outpatient clinics. Despite the inherent limitations associated with data generated from surveys and enrolling only professionals involved with ICD therapy, several interesting aspects were observed in this study.
patients prior to implantation is probably one of the major points of this study. Currently, there is little or no training for physicians in how to address difficult issues with patients. The ability to counsel patients on therapy and the alternatives should receive more emphasis. Because patients may have significant functional impairment, co-morbidities, and a high rate of depression, the care of these patients may require an integrated approach. Potentially, the outcome of ICD therapy could be improved by better selecting patients prone to have QoL-related problems and anxiety after implant and by counselling early in the treatment (i.e. before shocks occur or before patients show symptoms of anxiety and/or depression). This may help decrease symptoms, improve satisfaction, and increase the overall success of ICD therapy.

Johansen et al are to be congratulated for analysing some of the factors involved in ICD therapy in ‘real life’, even if several questions remain unanswered.

Conflict of interest: none declared.

References

Circumferential isolation of a common ostium of the left and right inferior pulmonary veins

Alonso Pedrote*, Eduardo Arana-Rueda, and Manuel Frutos-López

Virgen del Rocío University Hospital, Sevilla, Spain

* Corresponding author. Tel: +34 955012336, Email: pedroteal@hotmail.com

Midline common ostium (CO) of the left and right inferior pulmonary veins (PV) is an unusual anomaly, with a close proximity to the oesophagus. A 44-year-old man with paroxysmal atrial fibrillation was referred for PV isolation. In a cardiac computed tomography, a CO of the inferior PV was evident. A three-dimensional mapping of the left atrium, the PV, and the oesophagus was carried out with the CARTO® 3 System (Biosense Webster) (Panel A: superior view, Panel B: right lateral view). Each superior PV was isolated with a single circumferential ablation line to include the carina region. Afterwards, complete isolation of the inferior veins was achieved by a ‘box’ shape ablation line far away from the CO and the oesophagus (Panel C: posterior view).

Conflict of interest: none declared.