KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Terminale Herzinsuffizienz braucht mindestens zwei Fachleute

Peter Lüdike

ÜBERREGIONALES HFU-ZENTRUM ZERTIFIZIERT
HEART FAILURE UNIT

Essener Fachtag
Mehr Leben im Fokus – Palliativversorgung und Spitzenmedizin
Palliativversorgung für Nicht-Tumorpatienten
28. September 2019
RUHRTURM ESSEN

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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Conflict of Interest - Disclosure

Within the past 12 months, I or my spouse/partner have had a financial interest/arrangement or affiliation with the organization(s) listed below.

Affiliation/Financial Relationship	**Company**
1. Honoraria for lectures	Novartis, Bayer, Alnylam
2. Honoraria for advisory board activities	Novartis, Pfizer
3. Participation in clinical trials	Novartis, Amgen
4. Research funding	Deutsche Forschungsgemeinschaft

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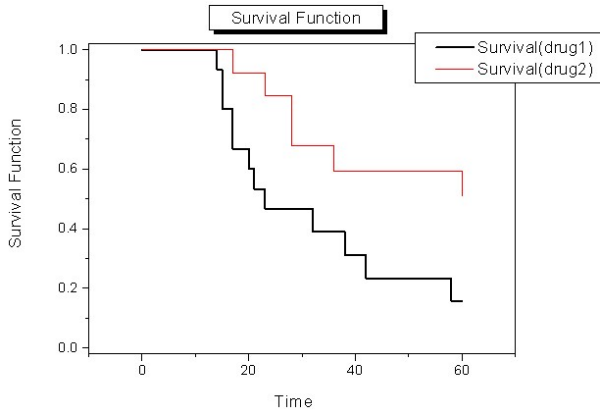
Kardiologie „rettet“ Leben



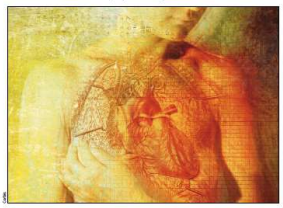
The Art of Medicine

Medical ethics and the art of cardiovascular medicine

Medical ethics has always played a part in cardiovascular medicine, and yet the two disciplines seem to be rather distinct in the general consciousness. Studies have documented that cardiology journals and textbooks contained the fewest references to ethical issues of any medical subspecialty. Perhaps this finding isn't that surprising. The academic disciplines of medical ethics and cardiology are quite different.

Cardiovascular medicine is one of the most well-studied and evidence-based of the subspecialties. Cardiologists are trained to justify clinical recommendations with hard data from randomised controlled trials (RCT). We are accustomed to the iconoclasm of a new study's outcomes shattering the existing therapeutic paradigm. Take β blockers; once contraindicated for patients with heart failure, they now are a mainstay of therapy. Or the fact that a 50% blockage of the left main coronary artery reflexively produced referral for coronary artery bypass grafting in the not so distant past; now, these lesions are stented with regularity. By contrast, bioethics is far less data-driven and, traditionally, focused on the more reflective and philosophical aspects of patients' care. Instead of data, medical ethics looks to established norms and methods of reasoning to guide decisions. The ultimate evidentiary standard is not a large RCT but instead, perhaps, the decisions of a high judicial court or an indication of societal consensus. Critics may quote Leon Kass, the one time head of former President Bush's Commission on Bioethics in the USA: "Though originally intended to improve our deeds, the practice of ethics, if truth be told, has, at best, improved our speech." But medical ethics has had a tremendous impact on medical care. Codes of ethics, ethics committees, Institutional Review Boards, advance directives, informed consent, privacy rules, and disclosure of conflicts of interest have changed the practice of cardiology, along with the rest of medicine. Medical ethics is a dynamic field, but new discoveries every few years don't usually change practice. And good reasoning, like fine wine, may even improve with age. New York appeals court Justice Benjamin Cordozo's 1914 declaration that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" can't be matched in its articulation of the basis for informed consent and advance directives.

Some might point to recent headlines detailing conflicts of interest among cardiovascular researchers, cover-ups of defibrillator failures by device companies, criminal overuse of profitable invasive procedures, and ethnic disparities in the provision of cardiovascular care as further proof of a disconnect between cardiovascular medicine and medical ethics. But medical ethics is about more than combatting bad behaviour. There seems to be increasing recognition that medical ethics has a crucial role in many aspects of modern cardiovascular medicine. Ethical issues were on the agenda of the first European Meeting of Cardiology Practice held earlier this year in Italy. The HEART group of cardiovascular journal editors recently released a joint statement on ethics "to ensure transparency and honesty in the scientific process that promotes ethical conduct in the performance and publication of research". The 1989 and 1997 American College of Cardiology (ACC) Bethesda Conferences were devoted entirely to the application of ethical standards to cardiovascular practice, and the American Heart Association (AHA) joined the ACC in sponsoring a conference on professionalism and ethics in 2004. Why the apparent increased interest in cardiovascular ethics?



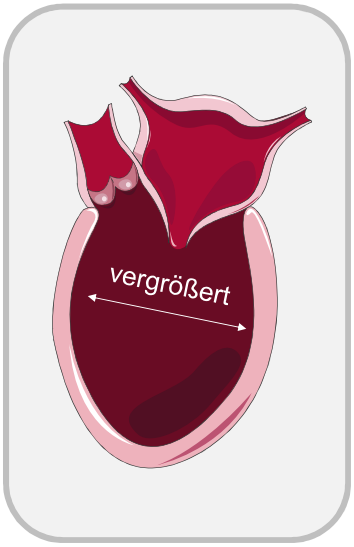
Although the field of medical ethics encompasses a very wide range of perspectives and applications, many involve making a distinction between what "can" be done and what "should" be done, in research and in clinical practice. The technological advances in cardiovascular medicine that have contributed so much to the reduction of cardiac mortality in the past two decades attest to the power of "can". But the practice of modern medicine involves nuances that have taken on greater importance in the face of demographic changes, complexity, and cost. Conflicts between "can" and "should" arise daily, especially in the growing subspecialty of heart failure/heart transplantation. Heart failure is a worldwide epidemic with 22 million cases. In the USA alone, there are 500 000–700 000 new heart failure patients every year. Interestingly, the booming of heart failure can largely be attributed to successful treatment of cardiac disease, at least

Kirkpatrick JN. *Lancet* 2010

- Herzinsuffizienz
- Therapieziele
- Zwei Experten
- Zukunft

KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Systolische Herzinsuffizienz



HFrEF

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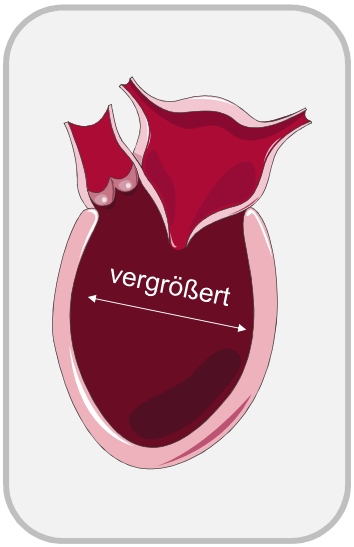
Systolische Herzinsuffizienz



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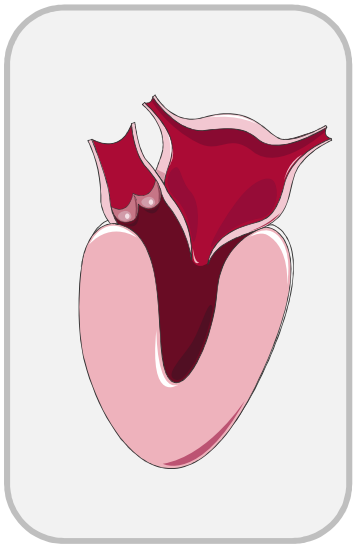
Diastolische Herzinsuffizienz



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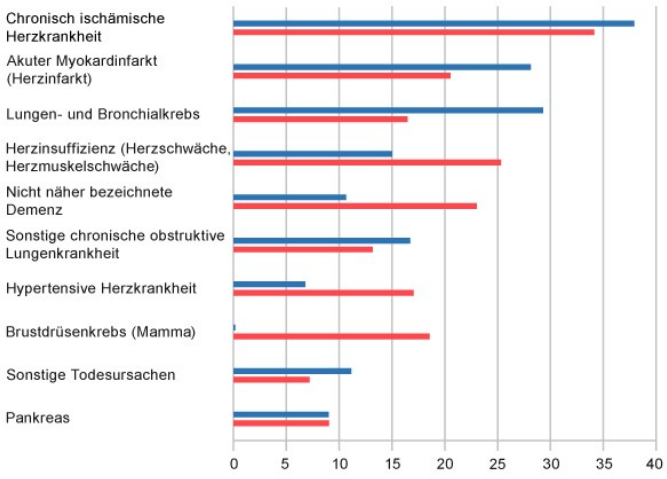
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Todesursachen Deutschland 2016



Statistisches Bundesamt (Destatis), 2019

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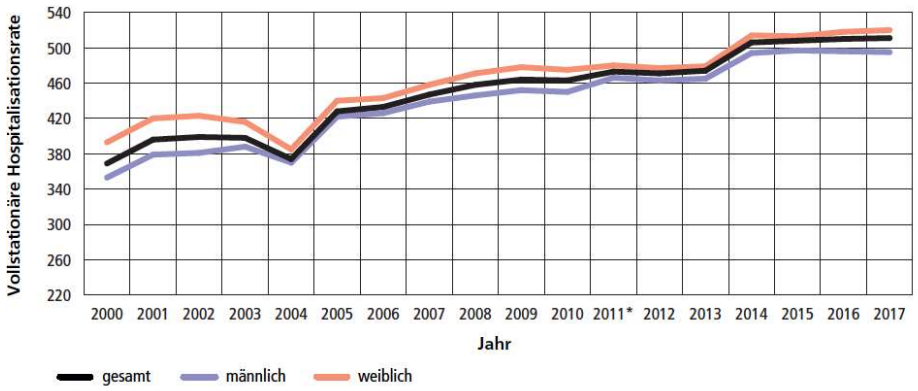
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Herausforderung Herzinsuffizienz

Altersstandardisierte vollstationäre Hospitalisationsrate der Herzinsuffizienz seit 2000



Berechnung auf Grundlage von Daten des Statistischen Bundesamtes
* ab 2011 Bevölkerung auf Grundlage des Zensus 2011

Deutscher Herzbericht 2018 Universitätsmedizin Essen

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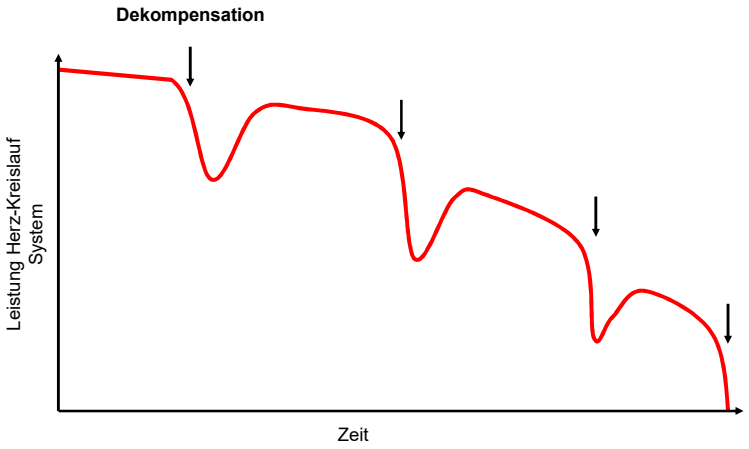
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Verlauf der Herzinsuffizienz
- Wann fängt Palliativmedizin an?-



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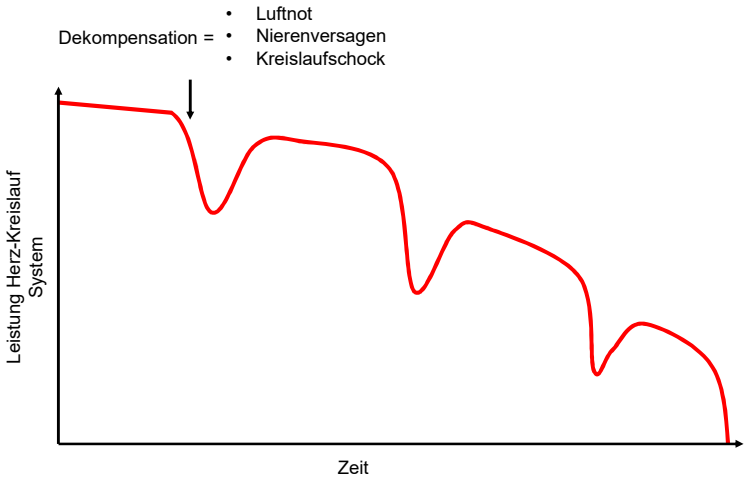
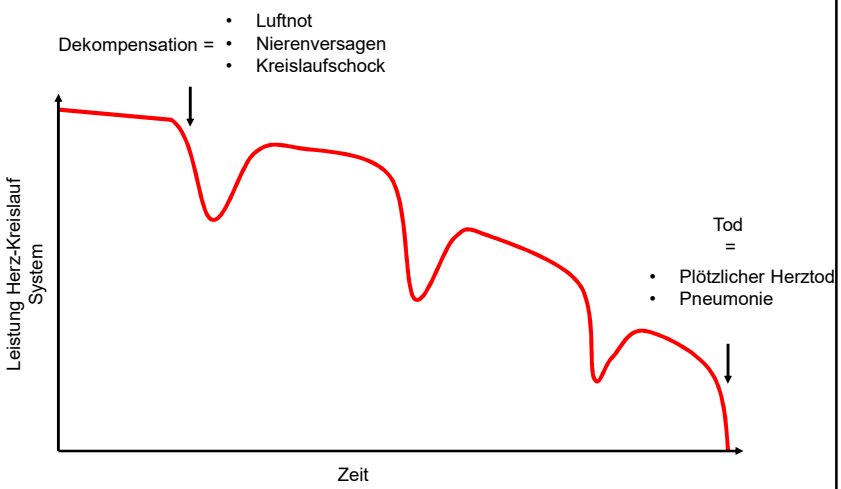


KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM



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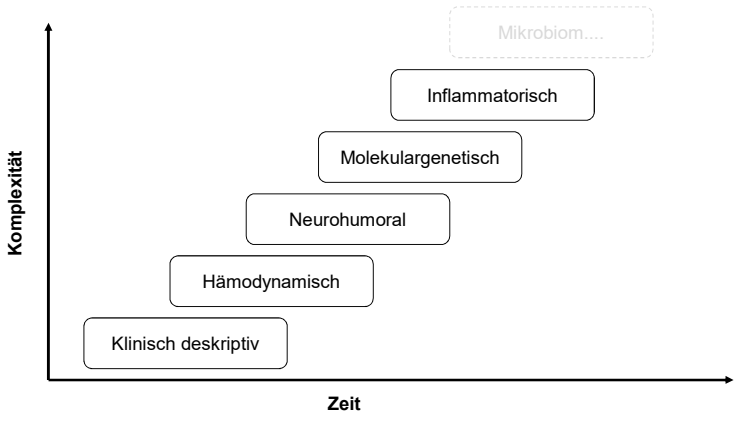
- Herzinsuffizienz
- **Therapieziele**
- Zwei Experten
- Zukunft

KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Verständnis der Herzinsuffizienz



Herzinsuffizienz Therapieprinzip

Medikamentös	Interventionell

KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Herzinsuffizienz Therapieprinzip

Medikamentös	Interventionell

- Diuretikum
- Betablocker
- Aldosteron Antagonist
- „Entresto“ oder ACE-Hemmer
- „SGLT2“.....

Herzinsuffizienz Therapieprinzip

Medikamentös	Interventionell
• Diuretikum • Betablocker • Aldosteron Antagonist • „Entresto“ oder ACE-Hemmer • „SGLT2“.....	• Herzkatheter/Stent • Defibrillator (ICD) • Schrittmacher (CRT) • MitraClip • TAVI • Elektrophysiologische Ablation • Peritonealdialyse • „Kunstherz“ (LVAD) • Herztransplantation (HTX)

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WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Herzinsuffizienz Therapie Nebenwirkungen

Medikamentös
• Diuretikum • Betablocker • Aldosteron Antagonist • „Entresto“ oder ACE-Hemmer • „SGLT2“.....

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Herzinsuffizienz Therapie Nebenwirkungen

Medikamentös

- Diuretikum
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- „Entresto“ oder ACE-Hemmer
- „SGLT2“.....

\+
- Weniger Dyspnoe
- Verbesserung der Lebensqualität
- Verlängerte Überlebenszeit
- Weniger Hospitalisationen

KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

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- Weniger Hospitalisationen

\-
- Schwindel
- Elektrolytstörungen
- Nierenversagen
- Hypotonie
- Abgeschlagenheit

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Herzinsuffizienz Therapie Nebenwirkungen

Interventionell

- Herzkatheter/Stent
- Defibrillator (ICD)
- Schrittmacher (CRT)
- MitraClip
- TAVI
- Elektrophysiologische Ablation
- Peritonealdialyse
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WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

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Herzinsuffizienz Therapie Nebenwirkungen

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- Weniger Dyspnoe
- Verbesserung der Lebensqualität
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- Weniger Hospitalisationen

-

- Tod
- Organversagen
- Schlaganfall
- Sepsis
- .....

Interventionell

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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Interventionelle Kardiologie – DIE Antwort auf alle Fragen?

Schwindel/Stürze → Schrittmacher → Kausale Therapie

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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Interventionelle Kardiologie – DIE Antwort auf alle Fragen?

Schwindel/Stürze → Schrittmacher → Kausale Therapie

Schmerzen/Luftnot → Herzkatheter → Kausale Therapie

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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

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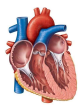

Luftnot/Lebensqualität → Intensivstation, CAPD, CRT, Kunstherz/HTX → Kausale Therapie

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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Interventionelle Kardiologie – DIE Antwort auf alle Fragen?

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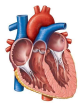

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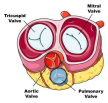

Luftnot/Lebensqualität → TAVI, MitraClip, TrikuspidClip → Kausale Therapie

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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Kausale Therapie ≠ Richtige Therapie

Leidensdruck → Kardiologe → Diagnose

Kardiologe → Therapieoptionen, Risiko / Nutzen

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The Art of Medicine

Medical ethics and the art of cardiovascular medicine

Medical ethics has always played a part in cardiovascular medicine, and yet the two disciplines seem to be rather distinct in the general consciousness. Studies have documented that cardiology journals and textbooks contained the fewest references to ethical issues of any medical subspecialty. Perhaps this finding isn't that surprising. The academic disciplines of medical ethics and cardiology are quite different.

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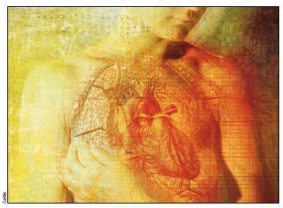

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ESC Pocket Guidelines

Interventionelle Kardiologie – NICHT die Antwort auf alle Fragen?

- Depression
- Dyspepsie
- Obstipation
- Schmerzen
- Gastropathie
- GI Blutungen
- Polypharmazie
- Häusliche Versorgung
- Malignome
- Gicht
- .....etc. !!!

- Herzinsuffizienz
- Therapieziele
- **Zwei Experten**
- Zukunft

KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Terminale Herzinsuffizienz braucht mindestens zwei Fachleute

Leidensdruck → Kardiologe → Behandlungsteam

↓

Diagnose

Universitätsmedizin Essen

Terminale Herzinsuffizienz braucht mindestens zwei Fachleute

Hausarzt/Palliativmediziner

Kardiologie/Herzchirurgie

Palliativteam/Angehörige

Konkrete Probleme bei kardiologischen Erkrankungen am Lebensende

Defi
Schrittmacher

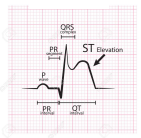
An/Aus?

Konkrete Probleme bei kardiologischen Erkrankungen am Lebensende

Defi Schrittmacher	Kunstherz
	
An/Aus?	An/Aus?

KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Konkrete Probleme bei kardiologischen Erkrankungen am Lebensende

Defi Schrittmacher	Kunstherz	Infarkt
		
An/Aus?	An/Aus?	Coro ja/nein?

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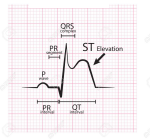
Konkrete Probleme bei kardiologischen Erkrankungen am Lebensende

Defi Schrittmacher	Kunstherz	Infarkt	Lungenödem
			
An/Aus?	An/Aus?	Coro ja/nein?	ITS ja/nein?

Konkrete Probleme bei kardiologischen Erkrankungen am Lebensende
- Polypharmazie –

Table 2. Primary and Secondary Outcomes.*

Outcome	LCZ696 (N = 4187)	Enalapril (N = 4212)	Hazard Ratio or Difference (95% CI)	P Value
Primary composite outcome — no. (%)				
Death from cardiovascular causes or first hospitalization for worsening heart failure	914 (21.8)	1117 (26.5)	0.80 (0.73–0.87)	<0.001
Death from cardiovascular causes	558 (13.3)	693 (16.5)	0.80 (0.71–0.89)	<0.001
First hospitalization for worsening heart failure	537 (12.8)	658 (15.6)	0.79 (0.71–0.89)	<0.001
Secondary outcomes — no. (%)				
Death from any cause	711 (17.0)	835 (19.8)	0.84 (0.76–0.93)	<0.001
Change in KCCQ clinical summary score at 8 mo†	−2.99±0.36	−4.63±0.36	1.64 (0.63–2.65)	0.001
New-onset atrial fibrillation‡	84 (3.1)	83 (3.1)	0.97 (0.72–1.31)	0.83
Decline in renal function§	94 (2.2)	108 (2.6)	0.86 (0.65–1.13)	0.28

McMurray *NEJM* 2015

- Herzinsuffizienz
- Therapieziele
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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Herzinsuffizienz im größten Ballungsraum der Bundesrepublik

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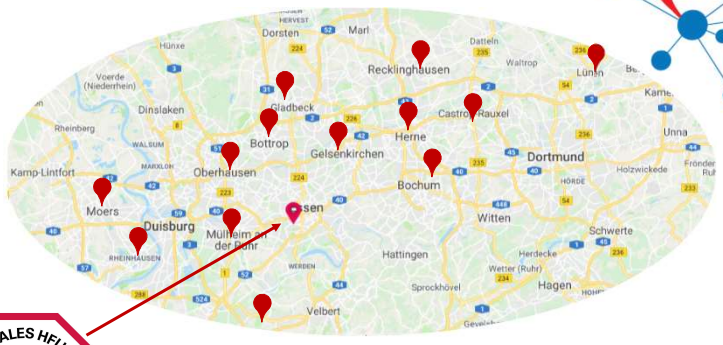
KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Herzinsuffizienz im größten Ballungsraum der Bundesrepublik

RUHR-HF NET



ÜBERREGIONALES HFU-ZENTRUM
HEART FAILURE UNIT
ZERTIFIZIERT

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KLINIK FÜR KARDIOLOGIE UND ANGIOLOGIE
WESTDEUTSCHES HERZ- UND GEFÄßZENTRUM

Kardiologie und Palliativmedizin

RUHR-HF NET

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Aufklärung
+
Interaktion

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Kardiologie und Palliativmedizin

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Einladung

ESSEN HEART FAILURE Symposium

Samstag, 26.10.2019
Deichmann Auditorium
Universitätsklinikum Essen

Eine gemeinsame Veranstaltung der Kliniken des RUHR-HF Netzwerkes mit dem überregionalen Herzinsuffizienz Zentrum Essen

Wissenschaftliche Leitung:
PD Dr. med. P. Lüdike
Univ.-Prof. Dr. med. T. Rassaf

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Vielen Dank für die Aufmerksamkeit

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