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Advocating for Continuity of Cardiac Care during Pandemics

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Introduction

- Today, it is clear that **THE WORLD** was not prepared to cope with the unexpected occurrence of pandemics
- In the beginning, we were limited to communicate with each other to **try to understand** what was going on and **invent ideas** to manage a tsunami that was devastating the health care system around the globe
- In less than a year, we learnt a new way of living in our societies, how to re-organise our health care system, and we created efficient vaccines
- We finally managed the emergency, but:

  1 - the price paid due to inexperience is very high, and...

  2 - ... it is not said that this situation - or any other similar - will not happen again

Therefore...

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Introduction

- As HCPs dedicated to the cardiovascular care, **we CANNOT remain passive** in front of the inadequacy of political and organisational systems that, staring at the tree, lose the vision of the woods
- In the past year, we assisted everywhere to the **interruption of essential cardiovascular care** in a desperate attempt to cope with the COVID emergency. Similarly, patients **stopped seeking help** because of the fear of contracting the infection in hospitals
- Conversely, care for other medical specialties – i.e. oncology - was not halted and patients, although fragile and at risk, continued to go to hospitals. This behaviour put in clear evidence the **ignorance of both medical systems and patients** about the inherent risk of cardiovascular diseases
- As a result, **cardiovascular mortality increased** over 40% compared to previous years

WE ARE COMMITTED TO CHANGE THIS UNACCEPTABLE SITUATION THROUGH A WIDE SPECTRUM OF COORDINATED ACTIONS.

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Strategic Recommendations

- **Participate** in fair mass media information related to the availability/safety of CV care in each area with continuous update
- **Proactive** role regarding hospital organisation for the management of COVID and non-COVID patients avoiding patient allocation for speciality
- **Apply**, in local practice, guidelines from National Societies of Cardiology regulating indications for management of urgent and elective cases, cardiologic consultations, and cases in waiting list that cannot be delayed
- **Prioritise** a list of life-saving interventions that cannot be delayed
- **Shift** some conventional surgical indications to endovascular options
- **Limit** “routine” outpatient clinic controls but prioritising first consultations for suspected CV symptoms
- **Organise** remote consultations for GP referring patients with suspected cardiovascular symptoms
- **Set-up** medical teams with young doctors and nurses from different specialities, available to support COVID areas for general clinical care during peaks of the hospital admissions
- **Protect** sanitary personal at risk (older, chronic or auto-immune diseases), excluded from COVID areas

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Prepare for the Management of COVID

- Given the nature of the cardiologic patients, the cardiology division should be kept as a **«COVID-free» destination**

- Patients needing primary PCI or PPM implantation should be warranted treatment in a **clean cathlab environment**

- After treatment, suspected patients remain isolated in pre-specified monitored areas of the ward until COVID diagnosis exclusion. If COVID positive, the patient is transfered to a COVID-intensive area.

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How to Deal with the Disease in the ER

Divide the ER in two sections:

1. One isolated part dedicated to **respiratory and infective syndromes**

2. One part dedicated to **non-suspected patients**

Even after this first triage, patients undergoing emergency CV procedures should be treated as COVID until ruled-out

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How to Deal with the Disease in the Cathlab

- Two different examples of a **COVID-free** and **COVID-suspected** team preparation for a primary PCI
- Ideally, **two separate cathlabs** but, if not available, apply strict cleaning operations after an emergency case (protocols available)

Two sections of a cardiology ward

Open:
Avoid non urgent exams: gastro, colon, pneumo, etc

Isolated:
Organise specific pathways

NO VISITOR ALLOWED

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How to Deal with the Disease after the ER

- **Asymptomatic and negative patients with cardiac pathologies** are sent to the cardiology ward for usual care
- **Positive patients with mild symptoms** are sent home in isolation
- **Positive patients needing respiratory care** are sent to COVID areas
- **Positive patients needing non-interventional cardiac care** go to COVID areas where dedicated cardiologists for COVID areas consult if needed. These cardiologists do not work at the cardiology ward during the period of exposure and, before returning, need to present a negative swab

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Cardiovascular Pathologies that Should not be Postponed

Levels of priority for treatment

- **Level 1**
  - Patients admitted through the ER
  - Severely symptomatic CAD patients with rest angina or angina on minimal effort
  - TAVR if: syncope, declining EF, high gradients (mean gradient >60 mm Hg or peak velocity >5 m/s), worsening symptoms, low-flow low gradient with DI <0.25, concomitant CAD, recent hospitalisation for AS
  - Pace-maker and ICD implantation
  - MitraClip: acute MR, hypotension requiring MCS, worsening EF, symptoms on minimal effort or at rest, recent hospitalisation for heart failure
  - Peripheral interventions with threatened limb or critical limb ischemia
- **Level 2**
  - PFO with recent stroke or recurrent stroke
  - Less symptomatic coronary, structural and peripheral cases
  - Pre-cardiac surgery
- **Level 3**
  - Stable patients
  - All elective procedures recommence
  - Research cases

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Shifting Conventional Surgical Indications to Endovascular Options

Verona's experience - Oct 20 – Dec 15 (2020)

- TAVI cases: 41, including 15 low-risk cases (generally sent to surgery)
- LM PCI: 9
- 3-VD PCI: 16

↳ Clinical outcome: no patient required mechanical ventilation or ICU care

↳ All patients were discharged within 2 and 5 days

↳ Cardiac surgery limited to emergency cases not doable by endovascular procedures
(aortic dissection, mitral surgery, endocarditis, complex CABG, and urgent cardiac transplant)

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Call Center Cardiologico "Emergenza COVID"

Toll-free number for telephonic consultations
Patients can talk to their cardiologists with a direct line from Monday to Friday 8:30-13.30

Zoom consultations
GPs can consult hospital cardiologist upon registration and appointment to discuss about their patients who cannot be sent to the hospital.
Monday to Friday from 13:00 to 17:00.

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Mass Media Communication by National Societies

Mass media to reach patients and decision-makers

Scientific societies to issue general appeals (institutional approach) and press releases that can then be disseminated locally using regional/local mass media

ANSAcheck
Notizia d'origine certificata

GISE
Società Italiana di Cardiologia Interventistica

SOCIETÀ ITALIANA DI CARDIOLOGIA

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Thank You!