Cardiologists with different specialities from a variety of European countries describe which guideline has had the most impact on their clinical decision making and how much guidelines in general affect their everyday practice to Lindy van den Berghe, BMedSci, BM, BS.

Stefan James, MD, PhD, senior consultant cardiologist and director, Interventional Cardiology Department of Cardiology, Uppsala University Hospital and associate professor of cardiology, Uppsala Clinical Research Centre, Uppsala University, Uppsala, Sweden

"At the moment, the guidelines on myocardial revascularisation affect my clinical work the most. Their recommendations are discussed frequently during my daily practice. Important effects of the guidelines are the discussion they create and the evidence they provide for implementing new processes, such as the introduction of new treatment strategies. As an example, we have recently introduced ticagrelor for all patients with acute coronary syndrome."

Barbara J. M. Mulder, MD, PhD, professor of cardiology, Academic Medical Centre, Amsterdam, the Netherlands

"Clinical practice guidelines are important for cardiologists in the Netherlands. We usually adhere to the recommendations of the European Society of Cardiology. My specialisation in adult congenital heart disease means that the European Society of Cardiology guidelines on adult congenital heart disease are the most relevant guidelines for me. However, guidelines on pregnancy, infective endocarditis, aortic dissection, and sports participation also play an important role in my clinical decision making. During our weekly multidisciplinary meetings, these guidelines are often consulted."

"As past-president of the International Society of Adult Congenital Heart Disease, I am interested in comparing international guidelines. My specialisation in adult congenital heart disease means that the European Society of Cardiology guidelines on adult congenital heart disease are the most relevant guidelines for me. However, guidelines on pregnancy, infective endocarditis, aortic dissection, and sports participation also play an important role in my clinical decision making. During our weekly multidisciplinary meetings, these guidelines are often consulted.

"As past-president of the International Society of Adult Congenital Heart Disease, I am interested in comparing international guidelines. They emanate from different cultural, social, and legal backgrounds, and, although mostly similar, sometimes they suggest different approaches and clinical implications. For example, European recommendations on sports participation are more restrictive than American recommendations with regard to gene carriers."
No firm data support either position, and recommendations are currently based on what seems to be most reasonable in each region. In the near future, we should consider assembling updated recommendations applicable to the global cardiology community.”

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Jean-Jacques Monsuez, MD, PhD, and Jean-Yves Artigou, MD, PhD, Hôpitaux Universitaires de Paris Seine Saint-Denis, Paris, France

“Older age has been an independent predictor of lack of prescription of angiotensin converting enzyme inhibitors and/or β-blockers in patients with heart failure.1 Treatment of patients hospitalised for heart disease in the cardiovascular unit of the geriatric facility belonging to the university hospital (Hôpital René Muret) was therefore systematically revisited at admission to ascertain that patients received drugs as recommended by current guidelines appropriately. Using a combined approach based on requirements for both accreditation for hospitals and continuous medical education criteria for practitioners, we obtained substantial increases in patients with heart failure treated according to guidelines.2,3 During a 2-year period, the proportion of 218 elderly patients treated for heart failure receiving angiotensin converting enzyme inhibitors and β-blockers increased from 55% to 92% and 27% to 62%, respectively. Similarly, for patients with atrial fibrillation, appropriate anticoagulant therapy, as recommended by European Society of Cardiology, American Heart Association, and American College of Cardiology guidelines, increased from 34% to 72% during the study.

“According to the recent release of the 2012 guidelines for heart failure management of the European Society of Cardiology,4 the therapy checkup of older patients admitted for heart failure in our cardiogeriatric facility also now takes into account a baseline and follow-up assessment of heart rate to target a 70 per minute recommended rate.

“In our practice, guidelines have proved useful in optimising therapy in the subgroup of older patients with heart disease who are otherwise commonly undertreated.”

References
Zeljko Reiner, MD, PhD, FRCP (Lond), FESC, FACC, professor of internal medicine, director, University Hospital Center Zagreb, School of Medicine, University of Zagreb, head, Department of Internal Medicine, Zagreb, Croatia, president of the Croatian Atherosclerosis Society

“I am a preventive cardiologist, so the guidelines that have had the most impact on my clinical practice are the joint European guidelines on cardiovascular disease prevention.1 This is not only because I am a coauthor of these guidelines, but much more because they reflect an integrated approach consensus from the 9 most relevant European scientific bodies/societies concerning cardiovascular disease prevention. The systematic coronary risk evaluation: high and low cardiovascular risk (SCORE) charts based on gender, age, total cholesterol, systolic blood pressure, and smoking status, with relative risk chart, qualifiers, and instructions, which are used in these guidelines for an evidence-based risk estimation, a specific approach to cardiovascular disease risk in the young, stressing the importance of lifestyle counselling, is another reason.

“The European Society of Cardiology/European Atherosclerosis Society guidelines for the management of dyslipidaemias, published in 2011, had a similar impact on my work.2 One reason is because I cochaired the writing group, but a stronger reason is because these were the first European guidelines dealing exclusively with dyslipidaemias. Familial dyslipidaemias, dietary supplements and functional foods active on plasma lipids, recommendations on the management of dyslipidaemias in different clinical settings (eg, percutaneous coronary interventions, renal disease, aortic aneurysm, HIV infection), lipid-lowering drug combinations and management of dyslipidaemias in children are not addressed in the joint European guidelines, but they are important for preventive cardiologists in their everyday practice.”

References

Oyvind Ellingsen, MD, PhD, specialist of internal medicine, professor of cellular cardiology, Faculty of Medicine, NTNU, Norwegian University of Science and Technology, consultant, Department of Cardiology, St. Olavs Hospital, Trondheim, Norway

“Supported by the highest level of evidence for exercise in heart failure, the guideline helped us convince colleagues and internal review boards that it was justified and safe to move on with a larger multicentre trial comparing high and moderate intensity of exercise in heart failure.3 I realised that guidelines are a great tool to determine when a change in practice is warranted, and we all felt grateful to Kenneth Dickstein, MD, PhD (see http://circ.ahajournals.org/content/119/16/f91), and the other members of the task force who had done the work, sifting and evaluating the current evidence in the literature.”

References
“The guidelines, elaborated by the European Society of Cardiology, the American College of Cardiology, the American Heart Association, and the Heart Rhythm Society are excellent and relevant, and they impact on our clinical practice. In our daily practice, we think that the most impactful are European Society of Cardiology guidelines for the management of atrial fibrillation published in 2010.1 The prescription of oral anticoagulation guided firstly by thromboembolic risk stratification by the score CHA2DS2-VASc (congestive heart failure, hypertension, age ≥75 [doubled], diabetes mellitus, stroke [doubled], vascular disease, age 65–74, and sex category [female]) and secondly by bleeding risk score calculated by the HAS-BLED (hypertension, abnormal renal/liver function, stroke, bleeding history or predisposition, labile international normalised ratio, elderly [≥65 years of age], drugs/alcohol concomitantly) seems to be more frequent than in the past. The strategy for rhythm control is no longer opposed to the strategy of rate control; they are complementary. The choice for rhythm control strategy is well guided by the European Heart Rhythm Association score of atrial fibrillation-related symptoms.

“In my department, I have made all guidelines that deal with heart diseases necessitating urgent management (eg, acute coronary syndrome, pulmonary embolism, atrial fibrillation, acute heart failure) available to young residents and fellows and we regularly discuss them with our fellows and try to adapt them to our daily practice.”

Reference
Milan A. Nedeljkovic, MD, PhD, FESC, FACC, professor of internal medicine/cardiology, University School of Medicine, director, Outpatient Clinic, University Cardiology Clinic, Clinical Centre of Serbia, president, Cardiology Society of Serbia, vice-president, Serbian Heart Foundation, and president elect, Working Group on Interventional Cardiology of Cardiology Society of Serbia

“The growing epidemic of cardiovascular disease worldwide accounts for ≈50% of deaths in Europe, and Serbia’s health system is working to keep pace and reduce the general burden and effects of this modern plague. Eastern countries are generally more threatened than well-developed western countries and have higher rates of morbidity and mortality from cardiovascular disease. However, with this increased awareness, came beneficial action, like the Stent for Life Initiative (see http://circ.ahajournals.org/content/125/5/i25), which was set up in 2009 by a few excellent doctors and good friends above all, among whom was also present Professor Miodrag Ostojic, MD, PhD, at the time president of the National Cardiology Society of Serbia. That initiative, together with 2010 European Society of Cardiology guidelines for myocardial revascularisation,1 in which Professor Ostojic took part as a task force member, changed the momentum in favour of patients, especially in my country.

“Recent wars and sociopolitical disturbances in Serbia affected the development of health system. Since 2009, we have set up more cath labs (20 in 6 cities), carried out more primary percutaneous coronary interventions/million inhabitants (from <200 to ≈500 in 2011 with a Stent for Life Initiative goal of 600/million), and have generally better health system organisation with reduced total ischaemic time and more effective antiplatelet agents, resulting in lower patient mortality and morbidity. The firm guidance from the Stent for Life Initiative and the European Society of Cardiology guidelines and our compliance with them is the right path to follow.”

Reference


Nuno Cardim, MD, PhD, FESC, FACC, professor of cardiology, Nova Medical School, Lisbon, senior staff cardiologist, head, Cardiac Imaging Department, head, Hypertrophic Cardiomyopathy Centre, Hospital da Luz and Corclinica, Lisbon, Portugal.

“In this era of evidence-based medicine, guidelines have become part of our lives. However, although they are essential, useful, and necessary tools, they are not perfect. They are often not based on ‘real-world’ populations, the evidence on which they are based is seldom excellent, and the interpretation of trial results depends on the opinions of those who wrote them.

“We must not forget that medicine in general and cardiology in particular is much more than a science. It is also an art, and sometimes there is still room for clinical-based medicine. No guidelines supersede a tailored individualised approach, taking into account the clinical opinion of experts based on years and years of experience. Guidelines are not the law and should be applied according to circumstances, not slavishly.

“A good example seems to be the 2009 European Society of Cardiology guidelines on endocarditis,1 specifically the prevention section. According to these guidelines, the number of patients in whom antibiotic prophylaxis is recommended decreased dramatically, causing some controversy on the issue with the cardiology population divided into guidelines followers and nonfollowers. Only the future will tell us who is right and who is wrong and whether these guidelines should be followed.”

Reference

Ernst R. Rietzschel, MD, PhD, primary investigator, Asklepios Study, assistant professor, Ghent University, Departments of Cardiovascular Diseases and Public Health, cardiologist, Ghent University Hospital, Ghent, Belgium

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Photograph courtesy of Dr Rietzschel.

Photograph courtesy of Dr Torella.

“The 2 guidelines that have the most profound impact on my clinical practice are the 2012 European guidelines on cardiovascular disease prevention in clinical practice and the strategic American Heart Association document “Defining and Setting National Goals for Cardiovascular Health Promotion and Disease Reduction.”

“These prevention guidelines not only affect far more individuals than any other guideline, but they are equally important in my research work. In an effort to continuously ensure that our longitudinal Asklepios cohort receives an optimal contemporary treatment, we implement these guidelines in a far more systematic manner than is usually the case in clinical practice. As such, we are quickly confronted by their strengths and delicate balance, but also their inherent limitations and unknowns. The latter are triggers for further research. Ultimately, in clinical practice, we need to remember that guidelines are not law, they are guidance.”

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