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HEART OF THE MATTER

Heart Failure Guidelines and the Elderly

A significant shift in recent years to treating heart failure with device implantation and surgery has made its way into clinical guidelines, published last month by the American College of Cardiology and the American Heart Association. The value of these therapies is most apparent in young patients with little concomitant disease and in whom the long-term risks and benefits can be measured in many symptom-free years.

The decision to implant a cardioverter-defibrillator in a young patient with an ejection fraction of 20% and with active ventricular ectopia is easy, as is the choice of mitral valve surgery in a similar patient with symptomatic heart failure. However, physicians using the heart failure-guideline update should appreciate that many of our heart failure patients to whom these guidelines will be applied are elderly. The summary article recommends and deems it "reasonable" to consider a wide range of therapies, including surgery and devices. But the full text, which includes the background discussions of the decision-making process, makes it clear that the authors struggled with the uni-

versality of their application to all ages and all persons. (Both articles are available at www.acc.org/clinical/statements.htm.)

There is concern that some elderly patients will be persuaded to accept these therapies as essential to survival, as they well may be. But at what cost to quality of survival? It is important to understand that these are indeed guidelines and not requirements. However, there are concerns that they will become imperatives for the measurement of quality, like β -blockers, aspirin, and ACE inhibitors, and thus fall into the gun sights of aggressive medical administrators who will penalize hospitals and doctors who do not comply. In the realm of quality improvement, variation is not appreciated.

Some questions can be raised about the class I recommendation for the use of biventricular pacing with patients with prolonged QRS intervals at a time when we are still learning about the physiology of the device, where the electrodes should be implanted, and which patients will benefit most. The results of those studies will determine who will receive the most benefit. This

information will be essential for cardiologists as they make their recommendations to individual patients. Similarly, the advisory class I for mitral valve replacement in "severe" mitral insufficiency in patients with asymptomatic left ventricular dysfunction is puzzling without a definition of severity and without any randomized clinical trial to support the procedure.

The application of these technical advances to elderly patients, who make up a large part of heart failure population, should be a concern of physicians. Some writing to this newspaper are worried that any deviation from the published guidelines will make them vulnerable to litigation. To those who have those concerns—and they are indeed real—I would suggest they read beyond the guideline summary and appreciate the gray zones that surround many of the recommendations. And the writing committee should try to bring its recommendations into a somewhat "grayer" reality of care and perhaps reemphasize the need for the physician's judgment in applying them. ■

DR. GOLDSTEIN, *medical editor of CARDIOLOGY NEWS, is professor of medicine at Wayne State University and division head, emeritus, of cardiovascular medicine at Henry Ford Hospital, Detroit.*

OCardiology News

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Editorial Offices 12230 Wilkins Ave., Rockville, MD 20852, 800-445-6975, cardiologynews@elsevier.com

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National Account Managers Sue Fagan,

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Barbara Napoli, 973-290-8224, b.napoli@elsevier.com;

Christy Tetterton, 973-290-

8231, c.tetterton@elsevier.com

Advertising Offices 60 Columbia Rd., Bldg. B,

Morristown, NJ 07960, 973-290-8200,

fax 973-290-8250

Classified Sales Manager Robin Cryan, 212-

633-3160, r.cryan@elsevier.com

Classified Advertising Offices 360 Park Ave.

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