

CHF DISEASE MANAGEMENT™

The Complete Congestive Heart Failure Resource

INSIDE

- **End of cardiomyoplasty:**
Medtronic says too much competition, not enough patients 16
- **Diuretics at home:**
Teach your patients the basics of managing this drug therapy while watching potassium 16
- **Are your patients OK with K?** Here are foods rich in potassium 17
- **Depression:**
Stop the creeping complication 18
- **Caregiver handout** 20
- **How spirituality can help depressed patients** 21
- **CHF resources for physicians, patients** 22

**FEBRUARY
1999**

**VOL. 2, NO. 2
(pages 13-24)**

American Health Consultants® is
A Medical Economics Company

Researchers seek more bridges to cross with mechanical pumps

Will left-ventricular assist devices span from CHF to recovery?

The day is coming, researchers say, when mechanical pumps will offer CHF patients a range of options for improvement and recovery.

Refinements continue to be made in using left-ventricular assist devices (LVADs) as a bridge to transplantation. But investigators now want to find out how they can offer the devices to more patients — such as those who are not transplant candidates because of their advanced age or degree of heart disease.

And today's tantalizing but rare cases of patients being weaned from their LVADs hint at a time in the future where doctors can use a pump to let a failing heart rest and heal until it can work well on its own again.

Getting to these goals, and crossing what some doctors call “a bridge too far,” means pushing the limits of the technology and running the trials. Investigators are optimistic.

“You might decide that today's pumps are not right for you and your patients,” says **Mehmet C. Oz, MD**, an LVAD researcher and cardiothoracic surgeon at Columbia-Presbyterian Medical Center in New York City.

“But with the advances being made, you should see a pump that's

KEY POINTS

- Left-ventricular assist devices (LVADs) are considered bridges to transplantation.
- Researchers are working to make LVADs available to patients who are not eligible for transplantation.
- In rare instances, patients using an LVAD regain heart performance and can undergo explantation, but researchers are just beginning to understand cardiac remodeling and damage on the cellular level and whether or not it can be reversed.

right for you within a decade,” he explains.

Buying patients more time as they await transplantation is a huge niche for LVADs to fill. Recent published reports determine only 2,500 organs are available each year to some 60,000 patients who need them or some type of mechanical help. And in 1996, more than 10% of the transplantation candidates died waiting for a new heart.

What about those not up for transplants?

Oz says doctors should be thinking about when LVADs may be appropriate for their patients today, whether or not they're on the transplant list.

“The first rule of thumb is that no one should die of heart failure without being considered for heart pumps.” That doesn't mean giving one to every patient, Oz notes, but rather, thinking about how a patient can be treated with an LVAD after traditional therapies are ruled out with a line of questioning such as the following:

- 1. Does the patient have a problem that can be repaired, such as aortic or mitral valve disease or an aneurism?**
- 2. If there isn't a physical defect that can be targeted for repair, can the patient's heart failure be controlled with medication?**
- 3. If medication cannot keep the patient's condition stable, could transplantation be implemented to reverse the patient's declining cardiovascular performance?** (In this case, a heart pump can help sustain the patient until a permanent organ becomes available.)
- 4. If the patient is not a transplantation candidate, could an LVAD be used?** (Today, patients can be part of the clinical trial testing the devices when other options are not appropriate or can no longer be helpful by themselves.)

This last consideration may not sit well with some doctors, who may feel that if a patient is not up to the surgery and recovery from transplantation, he or she would not benefit from using an LVAD.

But Oz says his team is learning how LVADs can be helpful to these patients. The researchers have a \$7 million government grant for their REMATCH study (Randomized Evaluation of Mechanical Assistance for the Treatment of Congestive Heart failure). Oz says patients have to apply to participate in the study, but for those who are not transplant eligible, an LVAD may provide a treatment option.

How long on an LVAD?

Two end points in heart pump therapy are crystal clear:

- transplantation;
- infection requiring removal.

In other cases, knowing when to stop using the LVAD is not as certain. Oz says there will be a growing number of patients not going on to transplant who will continue with their device, incorporating other treatments such as surgery and drug therapy to improve their heart performance.

And researchers also are looking at the chances of using the LVAD to help the patient's own heart recover enough to work on its own. This role is called a bridge to recovery.

In 1997, German investigators reported in *Circulation* (1997; 96:542-549) that they were able to wean a third of their 17 patients from their LVADs.

“We haven't been able to reproduce their results,” Oz says. In a recent article in *Circulation* (1998; 98:2,383-2,389), his team reported a retrospective study and an explanation evaluation that used exercise tolerance as an indicator of success.

The team found that among 111 LVAD recipients being bridged for transplants since 1991, only five were explanted. In three of these instances,

COMING IN FUTURE MONTHS

■ Five effective strategies for reducing readmissions

■ Prioritizing and managing comorbidities

■ Cost-effectively integrating new pharmacological therapies into a CHF program

■ The dos and don'ts of telemedicine and CHF

■ How to encourage your CHF patients to stay as active as possible

the devices were removed because of infection. The other two patients had their LVADS removed because they were not going on to transplantation: one after 186 days and another after two years.

Of these five explant cases, two died three months after explantation. Two patients needed reimplantation after being without them — one after two years, the other after 170 days. The fifth patient was still alive in class I CHF after 15 months without the device.

In the second part of the study, 39 recent LVAD recipients were considered for explantation, according to how well they could exercise with their LVAD output reduced to 20 cycles per minute. Seven of the 39 patients were able to exercise at this rate of assistance and still keep stable hemodynamics. One was able to be explanted.

Oz says the Germans' success may be due to the way

Europeans wean their patients off the LVAD three months after implantation. The practice may be a good idea because researchers still have a lot

to learn about how the heart responds to its mechanical helper and how long the partnership should last.

It's possible that patients reach a point where the heart pump no longer works well with the compromised heart. A device could even cause atrophy in the heart muscle, depending on its synchrony with the ventricle as it contracts and relaxes.

More research is needed, Oz says, to determine how long a patient should use the heart pump, whether or not weaning should begin, and how weaning should be done.

Right now, he says his team does not implant LVADs with the intention of weaning patients off of them. Nearly all the heart pumps used now are bridges to transplantation. Oz notes he recently had a case where a patient had a massive heart attack and an LVAD was used as part of his overall treatment, but those situations are not as common.

Other physicians see three standard uses for an

LVAD, including helping patients who suddenly run into trouble, says **Ross Zimmer**, MD, a Philadelphia cardiologist with the joint heart failure program at Presbyterian Medical Center and the Hospital of the University of Pennsylvania.

These uses are:

- A device can sometimes help patients who suffer complications during surgery.
- An LVAD is used as a transplantation bridge (the most common use).
- LVADs are used in a clinical trial.

Research will bring more uses for device

The editors commenting on Oz's study in *Circulation* note they hoped clinicians would one day be able to assess how a failing heart has been damaged on a cellular level — and whether the damage is reversible. This would give clinicians an indication of which hearts may go on to heal if given some mechanical assistance.

Oz says it would be even more helpful to understand the cellular changes of the heart so they can be reversed long before treatments like heart pumps are needed. Answers may come from looking at how patients may not be metabolizing free fatty acids or calcium properly. Harvesting heart tissue from deceased CHF patients could allow scientists to probe the mitochondria and hunt for missing or defective genes, which could lead to a whole new arsenal of cardiovascular genetic therapies.

Until that point, doctors say LVADs have a role in treating CHF.

"I hope that as [LVADs] become more common, they are developed not just as a bridge but as an alternative to transplant," says **Jim Fitzpatrick**, MD, clinical assistant professor of medicine in the division of cardiology at Thomas Jefferson Medical Center in Philadelphia. "The economics are staggering."

He says last year, Jefferson implanted two LVADs into CHF patients as bridges to transplantation. The site is not a transplantation center, so the patients continued with treatment at other centers to get new hearts.

And patients can find some reassurance when they learn that LVADs can help during the wait for a heart, says Zimmer: "It's nice psychologically for patients to know that it's there."

Editor's note: For more information about the LVAD study and to learn how to become involved, call (888) REMATCH. ■

Medtronic leaves CHF treatment to other devices

Cardiomyoplasty study ends

Citing too much competition from the successes of other implantable devices and a dwindling patient enrollment, Medtronic ended its cardiomyoplasty study in October.

The Minneapolis-based medical technology firm makes an experimental pacemaker used in the procedure. The technique uses one of the patient's own latissimus dorsi muscles as a wrap for the heart. There, it is "trained" to respond to electric pacing, beating with the heart in an attempt to improve cardiac performance.

Continued support for patients

"We'll continue to make replacement devices available to patients who need them," says Medtronic spokeswoman **Jessica Stoltenberg**. She says 750 CHF patients have undergone cardiomyoplasty since the procedure began trials in the early 1990s.

Stoltenberg says the program was successful, but with the rise of technologies such as left-ventricular assist devices, patient enrollment in their trials continued to decline. (See related cover story.)

"We've pretty much closed it down," says **William Anderson**, MD, attending and associate professor of cardiothoracic surgery at Deborah Heart and Lung Center in Browns Mills, NJ. "Patients are not being funneled in."

In 1994, Deborah planned to do 20 cardiomyoplasty procedures a year for three years. The clinical trial, which followed a previous one to determine feasibility, called for performing the procedure in 600 patients in 10 centers across the country.

Deborah was able, however, to recruit only two patients. One was randomized to cardiomyoplasty; the other was treated with drug therapy.

Anderson says that beside the success of other techniques, it was difficult to win support from cardiologists. There was a significant amount of morbidity involved, he says, because the patients need a "huge" incision to remove the muscle from the back so it can be wrapped around the heart and sewn in place.

The procedure usually takes six hours to complete. The electronic implant then is used to

condition the wrapped muscle so it does not become fatigued and then paces it to beat with the heart.

Anderson says the modest results didn't help sell the procedure. "Patients do improve, but it's not a night-and-day change."

Other researchers have reported that their small sample of patients also improved, but the benefits were likely to be due to the way the muscular wrap constricted the heart to prevent some of the typical chamber remodeling and not because the muscle was electrically paced to beat. (See *Circulation* 1995; 91:2,314-2,318, and 1997; 96:3,665-3,671.) ■

Your patients can regulate their diuretics at home

The key is giving them clear instructions

Can your patients regulate their diuretics according to their daily weigh-in? It takes some specific instruction about what they should do every day and how to react when they are gaining weight from fluid retention. But doctors say what patients know how to do at home can do a lot to keep a handle on their condition.

"I think it's an important part of managing the disease," says **Jay N. Cohn**, MD, professor of medicine at the University of Minnesota in

KEY POINTS

- Patients can learn to regulate their diuretics at home if they receive clear instructions on how to maintain the ideal body weight determined by the physician.
- Home diuretic regulation requires the physician to know how well the drug works in each particular patient so both the appropriate daily medication and the restorative agent can be prescribed.
- Some physicians may prefer to use metolazone for the restorative diuretic, instead of extra doses of the daily loop diuretic.

Are your patients OK with K?

Here is a list of foods and their potassium content in milligrams. Patients on diuretic therapy may find it helpful to know what foods they should be eating to help keep their potassium at a healthy level.

"A good rule to remember is that most fruits and vegetables are good sources of potassium," says **Kathleen Zelman, RD**, a spokeswoman for the American Dietetics Association in Alexandria, VA. But don't forget about other sources. Haddock, she says, provides 340 mg per 3 ounce serving. Three ounces of turkey contribute 255 mg more. And for patients who would like to eat a half-cup's worth, okra adds as much potassium as that serving of poultry. Even a large bell pepper provides 90 mg.

Zelman says there is no recommended daily allowance for the element, but most people need 2,000 mg to 3,500 mg a day.

Patients should still be careful about what they add to their food, as salt, butter, sugar, and other condiments may complicate the management of their condition.

♥ ¼ cup of dried apricots (about eight apricot halves)	448
♥ Medium-sized banana	396
♥ Cantaloupe (100 g serving)	309
♥ ¼ cup of pitted dates	290
♥ Two figs	232
♥ One nectarine	288
♥ One orange	181
♥ ¼ cup of pitted prunes	317
♥ Raisins (100 g serving)	751
♥ Winter butternut squash (100 g serving)	284
♥ One medium sweet potato	396
♥ One tomato	273

(See box on resources, p. 22, for the U.S. Department of Agriculture's on-line lists of nutritive values of food.)

Source: U.S. Department of Agriculture, Washington, DC.

Minneapolis and author of an article on the management of chronic heart failure (*N Engl J Med* 1996; 335:490-498).

"The day-to-day management of the diuretic is something patients can do at home," he says. "That tends to keep people out of the hospital, before they begin to decompensate. Anyone can be educated about his disease and how to manage his medication," says Cohn. "It's just like diabetic patients can be taught to regulate their insulin."

Self-regulation begins by establishing the patient's ideal body weight. Cohn says the ideal weight is where the patient is stable and has normal central venous pressure. "That is the weight you want to maintain," he says.

Then, give the patients simple instructions on what to do if they find they have gained two or more pounds since they weighed themselves the previous day. Usually it means taking more medication. "Often, patients have what's called a 'kicker,'" Cohn says. That's the extra medication taken to address the weight gain from fluid retention. When patients are taking a daily loop diuretic, their doctors may instruct them to take an extra one when their weight increases, until the ideal weight is restored.

Keep medication routines simple

When the weight goes down again, the patient may not remember to go back to the original dosage. For this reason, it may be easier for the patient to remember to keep the daily loop diuretic constant and use a different medication as the kicker.

"I find it is easier to use metolazone intermittently, rather than change the loop diuretic, but that is an individual decision," Cohn says. He adds that it works like a thiazide, at a different level of diuresis. The kicker is taken until the patient returns to the ideal weight, then only the regular daily plan is followed again. Patients continue to take their daily diuretic as well, unless told otherwise by the physician.

Also, when choosing the diuretic, make sure you understand how it affects that particular patient and how much it takes to get the responses you're looking for, says **Jim Fitzpatrick, MD**, clinical assistant professor of cardiology at Thomas Jefferson Medical Center in Philadelphia.

This is true for both the daily dose and the kicker, he says. That way, doctors know the daily dose should be effective and the response diuretic

will be able to start working on the extra fluid retention.

Fitzpatrick says he knows many patients who have been able to do this home regulation. He notes that some patients like to have a contact person to call at the doctor's office, such as a telemanager or a nurse practitioner, just to confirm they are doing the right thing. "They'll say, 'Here's what I weigh, and here's what I plan to do.'"

Cohn says doctors can cut down on those types of calls by giving the patients clear information and instructions during the office visit. Patients will know they are doing the right thing because it was discussed during the appointment.

What helps even more is to have the instructions written out so they don't have to commit it all to memory and call when they forget what to do. Then, by making daily weighing a part of the morning routine before getting dressed, at the same time of the day, they become comfortable with it. Deciding the diuretics to take for the day becomes as routine as the weigh-in.

More points to remember

Cohn and Fitzpatrick advise physicians to remember the following points:

□ "When you have a patient with sodium retention, it is important to check serum electrolytes and renal function each month or every other month," Cohn says.

□ When patients take the kicker, remember that potassium levels may drop. If they take a supplement to maintain potassium, they may need to increase that, too, or eat more fruit if they are maintaining levels with diet alone. Cohn says one banana, for example, has about 10 milliequivalents of potassium, about the same as a potassium supplement.

Potassium regulation is "a very individualized" thing, he says, therefore maintenance and response strategies must be tailored to each patient. (See **related box on potassium-rich foods, p. 17.**)

Patients may also lose potassium if they have diarrhea or have been vomiting, so instructions should cover these situations as well.

□ Prepare the patient before starting the self-regulation regimen, says Fitzpatrick. The physician should make sure the patient is educated about the condition and is motivated to take some responsibility with the daily management of the disease.

□ Remember to get a sense of how compliant

the patient will be and how the diuretics will affect each particular patient.

(For more information on patient compliance, see related stories, *CHF Disease Management*, January 1999, pp. 8-12.) ■

Be on the lookout for depression

Don't let it creep up on your patients

It usually doesn't appear all at once, and there may not be a clear starting point where symptoms begin. But once it shows up, depression can unravel the gains you make with your CHF patients.

With treatment plans depending so much on the patients remaining motivated — to keep up with drug therapy, appointments, and tasks such as daily weighing — depression can undo a lot of the control you're trying to get over their condition.

"The disease creeps up on people," says **Sue P. Heiney**, PhD, RN, CS, FAAN, a certified specialist in psychiatric nursing at the University of South Carolina in Columbia. "It's not like dealing with an MI, where there is a clear-cut event that puts a patient in crisis."

Heiney, who specializes in working with cancer patients, says she often lectures on depression for clinicians treating patients with heart failure because of the similarities with how patients deal with lasting illness and how depression can develop.

Patients who undergo surgery face an increased risk of depression, whether they are recovering from a valve replacement, cardiac bypass, or even transplantation. And depression can develop in

KEY POINTS

- Depression is a common complication in treating patients with cardiac problems.
- Experts urge recognizing symptoms of depression, asking about quality of life issues, and initiating treatment.
- Psychotherapy or counseling alone is not enough to treat most cases of depression. Antidepressant medication is needed.

Go the distance with depression treatment

Patients may require long-term treatment

Clinicians who help patients with the disease say there's more to the story than recognition of symptoms, following up with an evaluation for depression, and initiating treatment according to established clinical guidelines.

"If depression is recognized, one of the most important problems is that it's not treated adequately," says **Mary Amanda Dew**, PhD, a professor of psychiatry in the cardiothoracic division of the University of Pittsburgh Medical Center.

Dew says patients may be given antidepressant therapy and may be responding well to it, but treatment doesn't last long enough.

"Patients may be given medication for a short period," she says. "But research shows using medication for a longer term may be better."

2 or 3 years of treatment may be needed

Primary care physicians may not keep patients on drug therapy as long as a psychiatrist would, she says, noting that often maintenance therapy for two or three years can be beneficial. Others add that the generalist can do a lot to keep patients on the right track.

"A lot of primary care physicians are quite skilled at treating depression," says **Jeffrey E. Kelsey**, MD, PhD, assistant professor of medicine and director of the Mood and Anxiety Disease Clinical Trials Program at Emory University's department of psychiatry and behavior in Atlanta. ■

patients who have been dealing with CHF only. What's needed, say experts, is to look for the situations that can lead to depression, find out if the signs are there, then go ahead and treat it.

But don't wait for one signal to jump out at you as though someone flipped on the depression switch. CHF patients show the gradual symptoms

much the way other patients do.

"It's simple to assess, but it just gets ignored," Heiney says. "We often get so wrapped up with assessing symptoms and disease management that we miss the quality-of-life issues."

"Patients come in to get an EKG, a check of medical symptoms, heart symptoms — but doctors just need to know that the risk of depression is there," says **Jim Fitzpatrick**, MD, clinical assistant professor of medicine in the division of cardiology at Thomas Jefferson Medical Center in Philadelphia.

He says half of the patients that have had heart surgery show signs of depression. "In patients with heart failure, they may have had surgery for valvular repair or a bypass. After those surgeries they are in a high-risk group."

It is helpful to recognize that just being a heart patient is a roller coaster ride of emotions for most people.

"They've been sick. There was the anticipation of surgery. They go have it done. Then they still don't feel well. They made it through, but instead of having a sense of relief, depression sets in," Fitzpatrick says.

The same pattern is true for patients who undergo transplantation, says **Mary Amanda Dew**, PhD, who is a professor of psychiatry at the University of Pittsburgh Medical Center.

Before the transplant, there is a lot of stress for patients and their families. "Nobody is really sure if they are going to make it," she says. "People live in this limbo of not going to know what's going to happen. It goes on and on."

Reality hits after surgery

Dew, who works with cardiovascular patients, says she has studied depression in heart transplant patients for 10 years. The emotions can continue to work on the patient after surgery, especially after the patient's relief that he or she survived the procedure wears off.

"After the transplant, there is disappointment. We've found that people come down off of a honeymoon period," she says. "People aren't doing as well as they thought they would do."

And if the patients go on to develop depression, Dew says studies show they are more likely to develop complications like cardiac allograft disease.

"That's something seen across the board," she

(Continued on page 21)

Household Caregiver Handout

says, noting it worsens the health status of transplant recipients and bypass patients alike. Complications have such a strong tie to depression, she says, that it is a powerful predictor of physical morbidity.

Heart failure symptoms can mask some indications of depression. For example, patients may have less energy and probably can't be as active as they were when they were healthy. Those changes in a person's life could in time lead to depression. But the signs that it's developing, such as fatigue or difficulty sleeping, may appear to be just from the CHF itself.

"Probably, the question to ask is, 'How is your disease right now affecting your quality of life?'" Heiney says. "Then listen for the responses you get."

Start looking for symptoms

If you begin to hear about vague pain, headaches, or sexual problems, start being suspicious. After some digging, you may determine a few of these symptoms are not indicating depression, but these are good places to start.

"Look if there are more complaints than usual," says **Jeffrey E. Kelsey, MD, PhD**, assistant professor of medicine and director of the Mood and Anxiety Disease Clinical Trials Program at Emory University's department of psychiatry and behavior in Atlanta. "Where we get a lot of hits are changes in sleep, appetite, energy, concentration, or feeling blue."

"Look for clusters of symptoms that are suddenly appearing," Dew says. They can be both somatic (such as eating and sleep habits) and cognitive, such as sudden difficulty in decision making, feelings of worthlessness, or thoughts that they or their families would be better off if they died. "Some people may show one type or the other," Dew says. "Look for both."

Kelsey notes that elderly people tend to complain more about physiological symptoms than psychological ones. But that doesn't mean that psychological ones aren't there. In these cases, it may help to talk with the patient's spouse or another family member to see if they have noticed problems such as increased irritability or changes in sleeping or eating habits.

(See handout for caregivers, p. 20.)

Fitzpatrick says he had a patient's wife come to him to ask what could be wrong with her husband. She said her husband seemed so down after his surgery.

Use patient's spirituality to fight depression

Take advantage of a patient's spirituality if you know it's important to them, says **Mary Amanda Dew, PhD**, professor of psychiatry at the University of Pittsburgh Medical Center in the cardiothoracic division.

Research shows a patient's faith can help buffer the emotional toll that chronic disease can take. In turn, the boost can lead to better outcomes. In addition, a patient's spirituality may also increase the number of contacts he or she has outside the home.

"Many times health care professionals are uncomfortable or don't want to impose their views on patients," she says. "But allowing patients to talk about it can be important."

Ask about religious affiliations

It may be as simple as asking patients during an office visit if they have any involvement with a religious group.

"It will be clear if a patient doesn't have it. But if they do, I think health care people can use that as another tool to keep involvement up," she says.

A patient involved with a church or synagogue may have friends there who can help to look after them, run errands, and just provide ways to stay involved in the community. They may tell you they can no longer attend services because of their condition, and that could be a clue to look out for depression.

Patients may mention, in passing, that they have people praying for them and that may be just the entry point needed to get patients to tell you more. ■

The patient went through the surgery well and made no complaints himself. His wife, however, told Fitzpatrick he wasn't sleeping well. He also had lost his appetite and had anhedonia, or no sense of pleasure in anything. With that information, Fitzpatrick started the patient on antidepressant medication, and he responded well.

(Continued on page 23)

CHF Resources for Your Review

On-line

Try the search engine from the Department of Health and Human Services at <http://www.healthfinder.gov>.

Typing “congestive heart failure” takes the user to more information, which you probably want to screen before giving to patients. Some publications it offers, such as *Congestive Heart Failure in the United States: A New Epidemic*, include some information that would be helpful to train office staff, pharmacists, and patient educators, but is written in frank ways that some patients may find upsetting. For example, *Congestive Heart Failure* states that half of CHF patients will be dead in five years, and it has chart legends that refer to “CHF patients discharged dead.”

Patients may get more use from the Web resource that appears, titled *Facts about Heart Failure*, which is a reprint from 1997. Patients can find topics displayed as commonly asked questions. This resource is written to address patients, directing them to do things such as report any side effects to their physicians. There is a drug list with medications and their common side effects, a glossary, and advice for making the most of a doctor visit. It may generate questions and concerns, however, as it does talk about topics such as increased risk of sudden death.

Nutrition information:

Try this Web site for comprehensive listings of the nutritional components of food: http://www.nal.usda.gov/fnic/cgi-bin/nut_search.pl. This Web site is produced by the U.S. Department of Agriculture. It works like a search engine. Just type in the food you want to study, note the size of the portion to consider, and get information such as fat content, vitamins, potassium, sodium, and other nutritional values.

Journals

A valuable resource is the article by **Jay N. Cohn, MD**, in the *New England Journal of Medicine* on drug therapy and CHF management. It's highly regarded by many sources appearing in *CHF Disease Management*. (See: Cohn, JN. Drug therapy: The management of chronic heart failure, *N Engl J Med* 1996; 335:490-498.) “It's still valid,” says Cohn, who offers advice on self-regulation of diuretics at home (**see related story, p. 16**).

Books

Success with Heart Failure: Help and Hope for Those With Congestive Heart Failure, is now available in paperback says author **Marc Silver, MD**, director of the heart failure institute at Christ Hospital in Oak Lawn, IL. (**For more information, see CM, January 1999, p. 1.**) He notes this book, which he co-wrote with Jay N. Cohn, MD, may be useful for patient education and is available through the Internet at Amazon.com.

Dew has one more note about the patient's household caregivers: Keep an eye on the patient's family. You may need to assess if they are showing signs of depression, too. If so, they may need to be directed to get help from their physicians.

"The caregiver and the patient tend to feed off of one another," she says. It's a big problem to your case when caregivers, who are usually under a lot of strain themselves, are the one who give the patient daily medication. "If they get depressed, they may not be able to do what they used to do."

(See related story on another factor doctors can use to help CHF patients, p. 21.)

If depression is not a result of the medicine the patient is receiving, medication and counseling can be prescribed.

Start with basic questions

So the physician is asking questions about quality of life, eating, sleeping, and overall mood — and a patient shows signs that depression could be a problem. "Chances are, you'll want to take a clinical history and evaluate specifically for depression," Heiney says.

The basics include asking about previous history with depression, suicide attempts (personal or family members), persistence of feeling down all day long and every day, and not enjoying their usual activities. Most doctors are familiar with this drill for patients who are not suffering chronic disease, but it is still valid to CHF patients as well.

"The yeses you get from these questions are a major red flag," she says. Then once the physician establishes the cause for depression and determines depression does exist, patients can be treated.

"Whenever you see signs of depression, go ahead and treat it," Kelsey advises. Some treatment begins at looking at the medication the patient is taking already. Some drugs can cause depression as a side effect, particularly ones that have a long half life and tend to accumulate in the body over time.

Examples of drugs that could cause problems are Benzodiazepines such as Valium, Dalmane

and Librium. If there are questions about drug interactions, it's a good idea to consult a pharmacist or a psychiatrist, he says.

"It used to be thought that beta-blockers could cause depression," Kelsey adds. "That's probably not the case." If depression is not a result of the medicine the patient is receiving, medication and counseling can be prescribed.

Heiney says the data show half of the patients who suffer from depression are treated effectively with antidepressants alone. The other half may need a combination of antidepressants and psychotherapy.

According to Dew, studies show, in most cases, that psychotherapy or support groups alone are not enough to fight depression. Medication is needed as well.

"Without that," Fitzpatrick adds, "treatment is not going to be as successful."

Dew notes patients usually can tolerate the newer medications, such as Paxil, because of their lower profile for causing side effects. The older medications, however, such as tricyclic

CHF Disease Management (ISSN# 1098-6014) is published monthly by American Health Consultants[®], 3525 Piedmont Road, Building Six, Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodical rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to CHF Disease Management, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291.
E-mail: custserv@ahcpub.com. World Wide Web:
www.ahcpub.com. Hours: 8:30-6:00 Monday-Thursday;
8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), \$259. Outside U.S., add \$30 per year, total prepaid in U.S. funds. One to nine additional copies, \$130 per year; 10 or more additional copies, \$78 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are \$43 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact Karen Wehye at American Health Consultants[®]. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5491.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Publisher: **Brenda Mooney**, (404) 262-5403,
(brenda.mooney@medec.com).

Executive Editor: **Park Morgan**, (404) 262-5460,
(park.morgan@medec.com).

Associate Managing Editor: **David Flegel**,
(404) 262-5537, (david.flegel@medec.com).

Production Editor: **Ann Duncan**.

Copyright © 1999 by American Health Consultants[®]. CHF Disease Management is a trademark of American Health Consultants[®]. The trademark CHF Disease Management is used herein under license. All rights reserved.

Editorial Questions

For questions or comments, call **David Flegel** at (404) 262-5537.

antidepressants such as Elavil (amitriptyline) often are contraindicated for heart patients.

In order to guide patients on where to go for support, Heiney points out, it's a good idea to know about what's going on in your particular area. Find the support groups and where patients can go for more information. Keep up on the hospital-hosted patient programs, the groups that meet there, and how to get your patients involved.

Search for support

Local chapters of national organizations such as the American Heart Association also can put patients in contact with information and support. She says the United Way agencies often act as a clearinghouse for information as well. Get on their mailing lists, too.

"A lot of people may not know they have help right at their own back door," Heiney adds.

Also, take a look at what is available on-line. If you go to <http://www.healthfinder.gov>, you can find a wealth of information. It's a search engine available through the Department of Health and Human Services. Type in "depression," and you will find clinical guides and general depression brochures that have been made available through the Internet. **(See list of helpful resources, p. 22.)**

The clinician's quick reference guide works through either an interactive table of contents or direct searching. The table of contents takes you to a list of options: purpose and scope, guideline highlights, a bibliography, and tables and figures. The entire guide can be downloaded.

Note that the guideline is written to address primary care settings in general and not specifically for CHF patients. Heiney notes, however, it is a good outline to have.

The healthfinder site also includes links to Web sites for organizations like the National Institute of Health's National Institute of Mental Health and the National Foundation for Depressive Illness Inc., in New York City.

If you direct patients to this search engine to get printouts of information, be aware that they may try to get some on their condition as well. Typing in "congestive heart failure" summons a lot of materials, but not all of it may be useful for patient information.

In fact, patients may be shocked at how bluntly death from heart failure can be described. A word (or two) of caution to them may be helpful. ■

EDITORIAL ADVISORY BOARD

Consulting Editor: J. Thomas Heywood, MD
Director, Cardiomyopathy Service
Director, Adult Transplant Service
Loma Linda (CA) University Medical Center

Jane M. Geraci, MD, MPH
Assistant Professor
Veterans Affairs Medical
Center
Baylor College of Medicine
Houston

George A. Mensah, MD,
FACP, FACC
Associate Professor of
Medicine
Section of Cardiology
Medical College of Georgia
Augusta, GA

Stephen S. Gottlieb, MD
Medicine/Division of
Cardiology
Assistant Professor of
Medicine
University of Maryland
Baltimore

Sharon L. Merritt, RN, MSN,
EdD
Associate Professor
College of Nursing
The University of Illinois
Chicago

Edward K. Kasper, MD
Cardiology Assistant
Professor
Johns Hopkins Hospital
Johns Hopkins University
Baltimore

Elizabeth Nolan, RN
University Hospital
Clinical Nurse Specialist
Heart Care Program and
Patient Care Services
University of Michigan
Ann Arbor

Roger J. Laham, MD
Division of Cardiology
Harvard Medical School
Beth Israel Deaconess
Medical Center
Boston

Tarik M. Ramahi, MD
Assistant Professor
Internal Medicine/
Cardiovascular Medicine
Director
Heart Failure and
Transplant Cardiology
Yale University
New Haven, CT

CE objectives

After reading the February issue of *CHF Disease Management*, the continuing education participant will be able to do the following:

- Recognize both standard and experimental uses of left-ventricular assist devices, or LVADs, to date.
- Initiate and maintain home regulation of diuretic use for appropriate patients.
- Understand underlying symptoms of depression in CHF patients and recognize the need to start treatment with antidepressant therapy or a combination of medication and psychotherapy.
- Use a search engine to find on-line information that could be helpful to both clinician and patient. ■