Sociedad Española de Cardiología

Continuo CV.
Desde la Cardiopatía Isquémica
a la Insuficiencia Cardiaca.

IC Crónica: Caso Clínico

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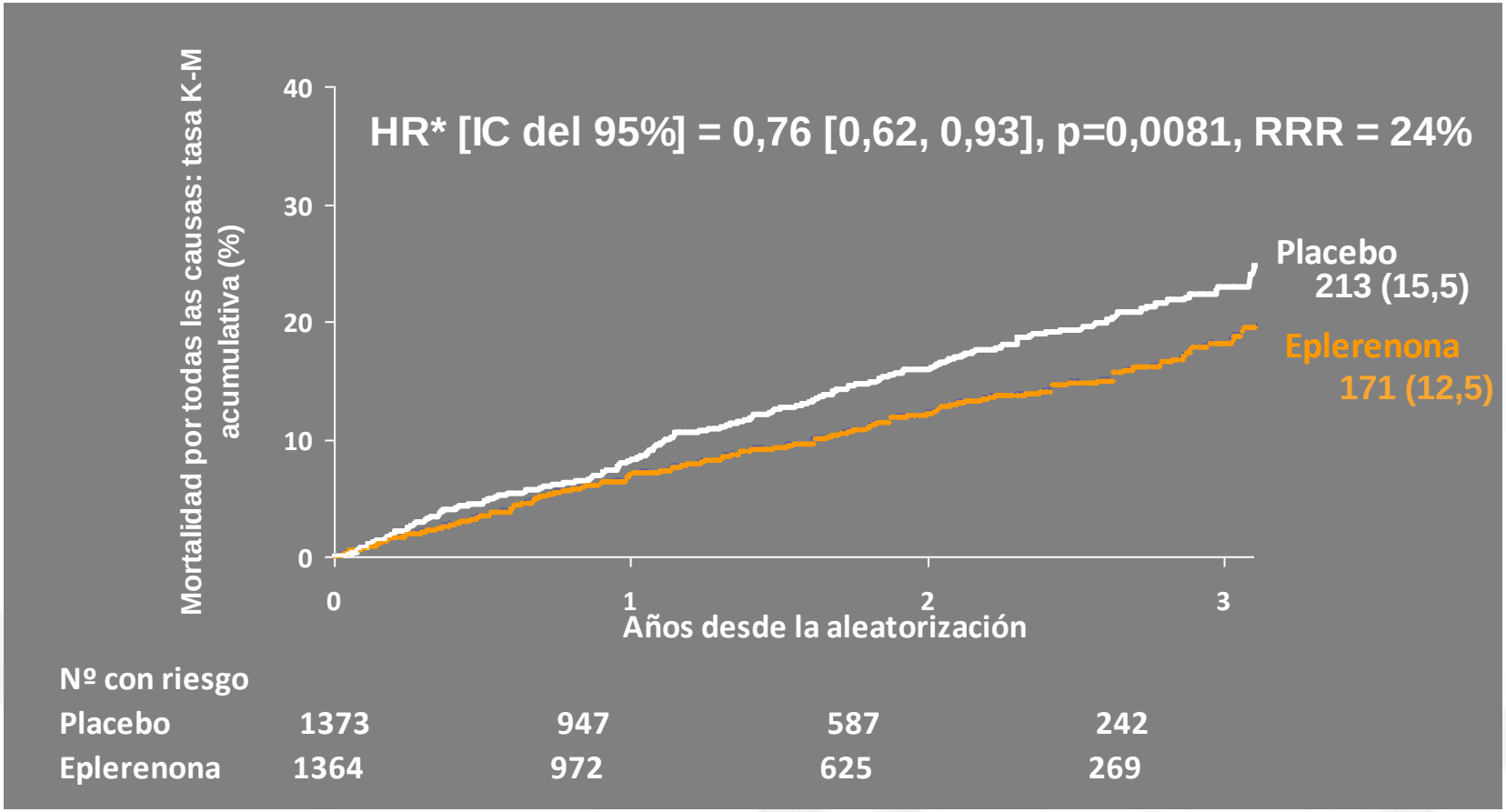
Antecedentes

- **Mujer de 76 años**
- **FRCV: No**
- **Hª Cardiológica: MCD con coronarias N en ingreso por IC hace 1 año (FEVI 35%, también hace un mes),CF II/IV**
- **AP: Qx Ca de mama a los 61 años, remisión completa.**
- **TTo: Carvedilol 25mg, Lisinopril 20mg, Furosemida 80mg**

¿Echa en falta algún fármaco?

ICC CF II/IV: Mortalidad



*No ajustada HR, 0.78; 0.64, 0.95; p=0.01

Zannad F et al. N Engl J Med 2011;364:11-21

Situación Actual: 24/12/2012

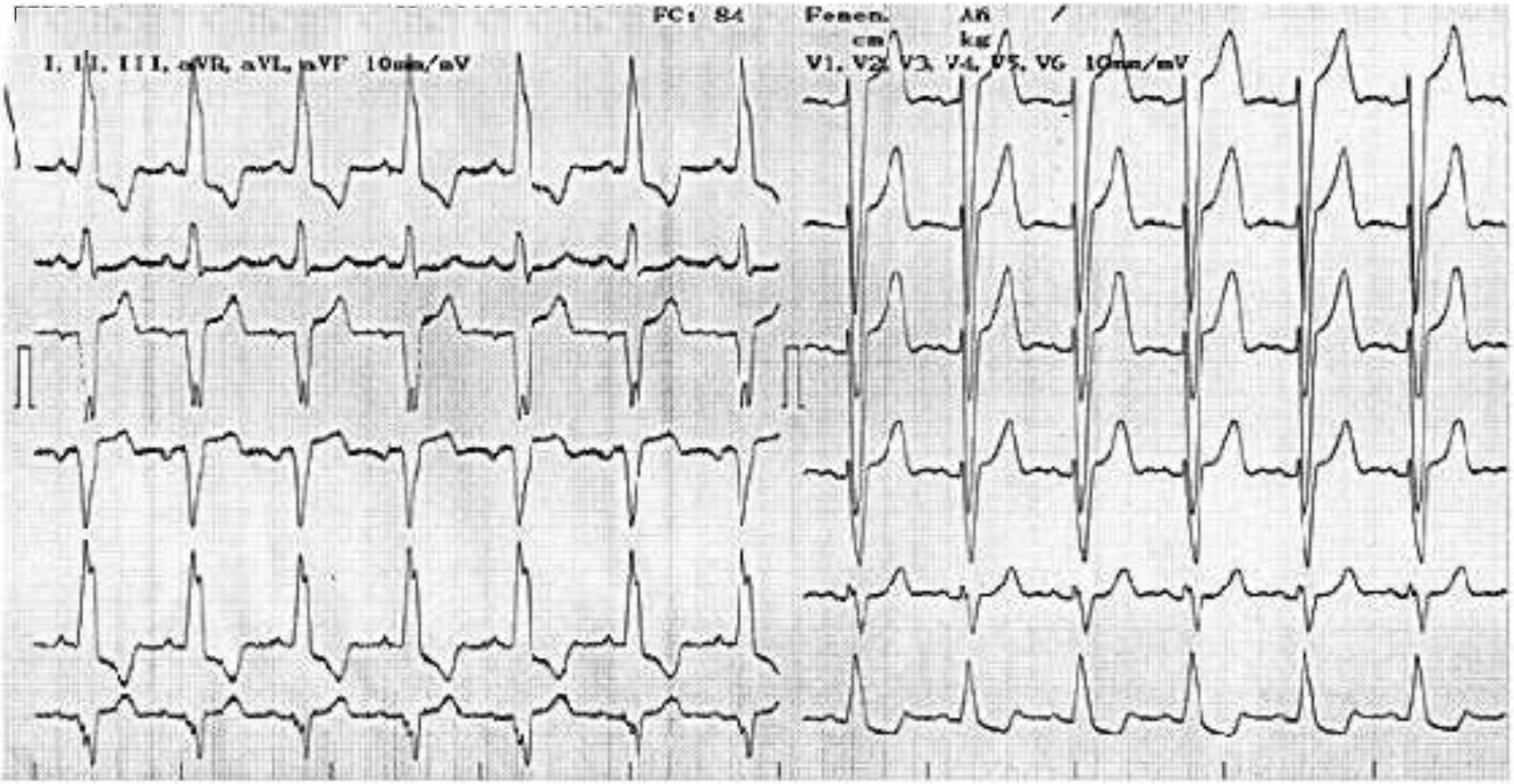
- **Disnea progresiva hasta clase III en relación con incumplimiento dietético (consumo sal) y terapéutico (olvido furosemida)**

- **EF: TA: 110/75, FC 84 lpm, PVY ligeramente elevada, AC: rítmica, no soplos, AP: crepitantes bibasales, ABD: N, EEII: edemas maleolares bilaterales**

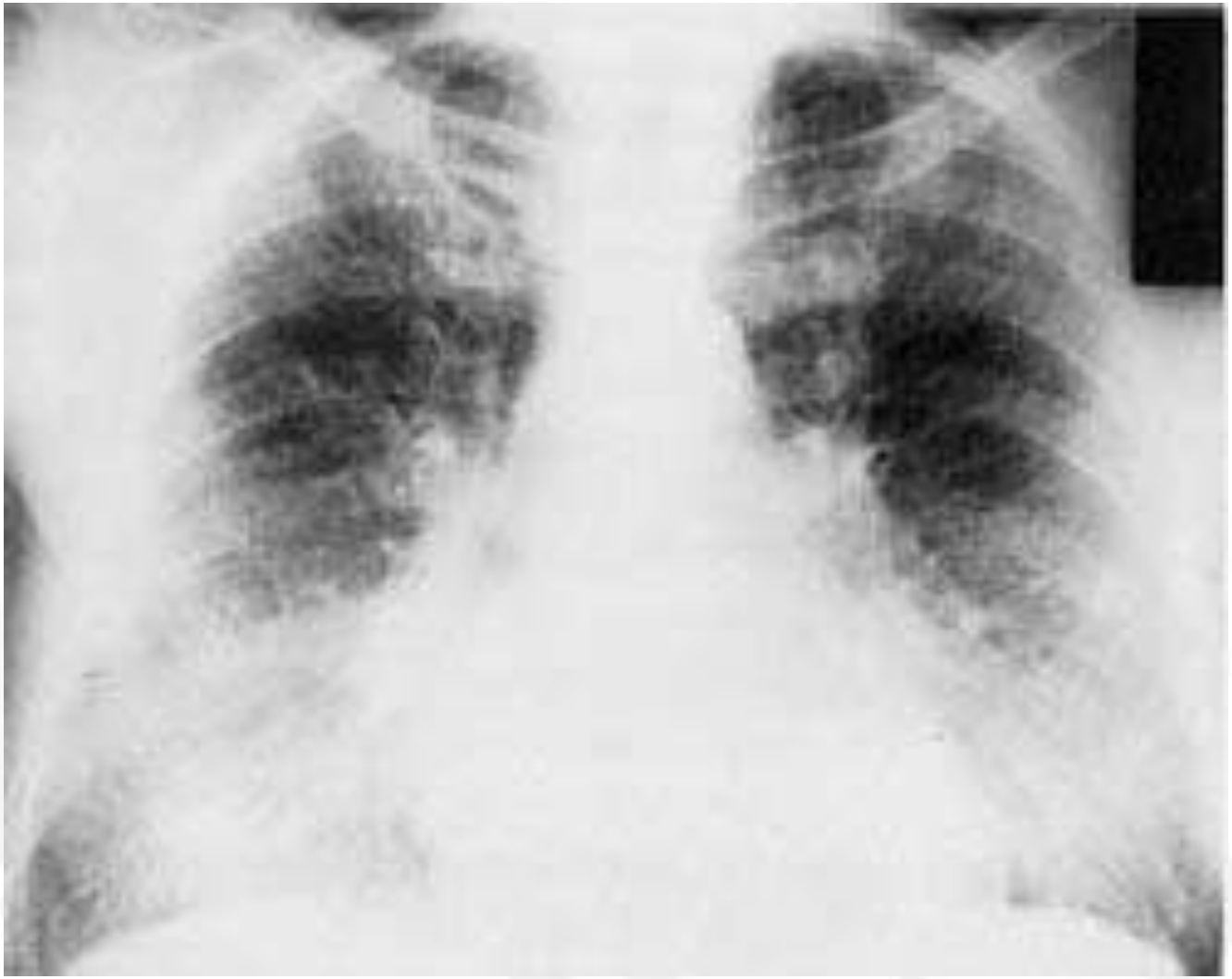
- **ECG, Rx Tórax y Analítica: Creatinina= 1,0 mg/dl Glucosa= 109 mg/dl; BNP: 1400 pg/ml, hemograma N**

ECG

RS a 84 lpm. BCRI, QRS 140 ms



Rx Tórax



¿Ubicación?

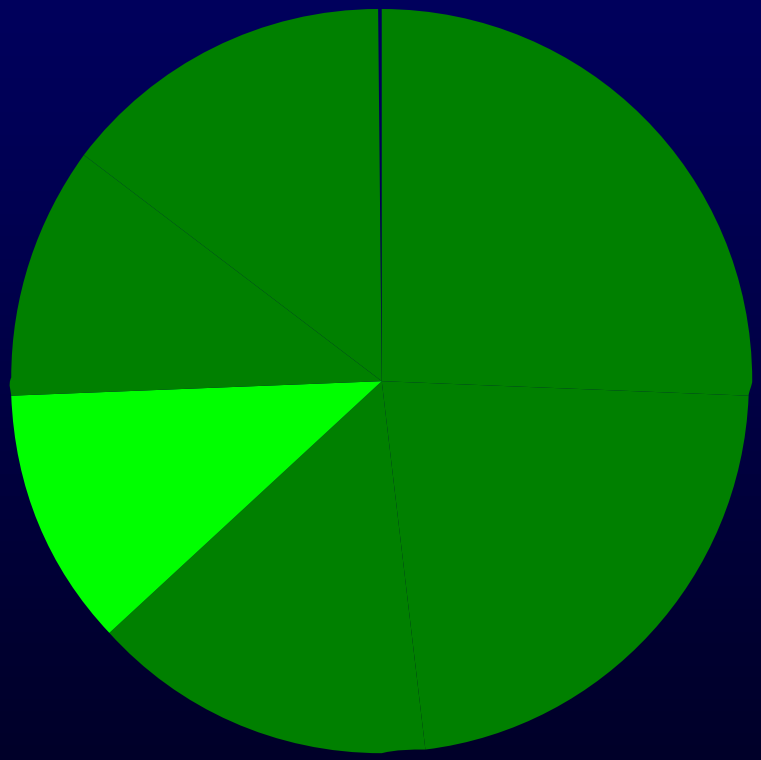
Urgencias: 120 mg furosemida → diuresis 1100 ml a las 3 h

1. **Ingreso.** ←
2. **Estancia 24h en urgencias y ver evolución.**
3. **Alta.**

¿Qué hacemos con el BB?

1. Retirar
2. Bajar dosis
3. Mantener dosis ←

Motivo de retirada de carvedilol durante ingreso



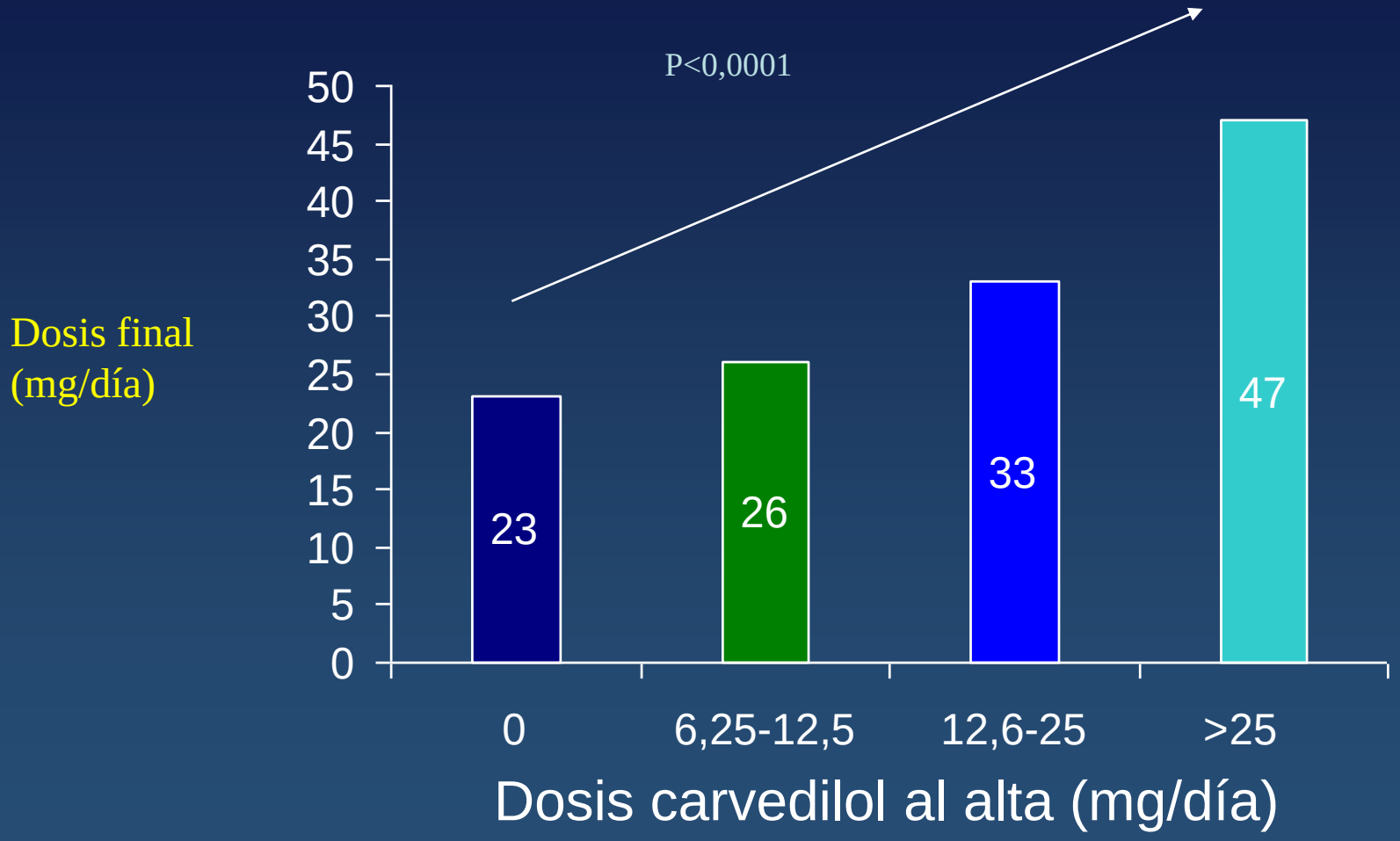
11%

- Bradicardia
- Hipotensión
- Empeoramiento EPOC
- Empeoramiento IC
- Espasmo coronario
- Otros

Martínez-Sellés J Heart Lung Transplant 2008

Dosis de carvedilol al final del seguimento

Media 32,4±22,2 mg/día 162 pts (41%) ≥ 50 mg/día



Martínez-Sellés J Cardiovasc Med 2010

A las 48 horas:

- **Eupneica, sin datos de congestión, CF II/IV**
- **ECG sin cambios (RS a 84 lpm. BCRI, QRS 140 ms)**
- **El hecho de que la pte betabloqueada siga a 84 lpm le parece…**

1. **Muy raro, probablemente no se tome el BB**
2. **Excepcional en un paciente con IC estabilizada**
3. **Indicativo de alto riesgo** ←

European Journal of Heart Failure
doi:10.1093/eurjhf/hfs026

Gender and survival in patients with heart failure: interactions with diabetes and aetiology. Results from the MAGGIC individual patient meta-analysis†

Manuel Martínez-Sellés[1*], Robert N. Doughty[2], Katrina Poppe[2], Gillian A. Whalley[3], Nilki Earle[2], Christophe Tribouilloy[4], John J.V. McMurray[5], Karl Swedberg[6], Lars Køber[7], Colin Berry[5], and Iain Squire[8], on behalf of the Meta-Analysis Global Group In Chronic Heart Failure (MAGGIC)

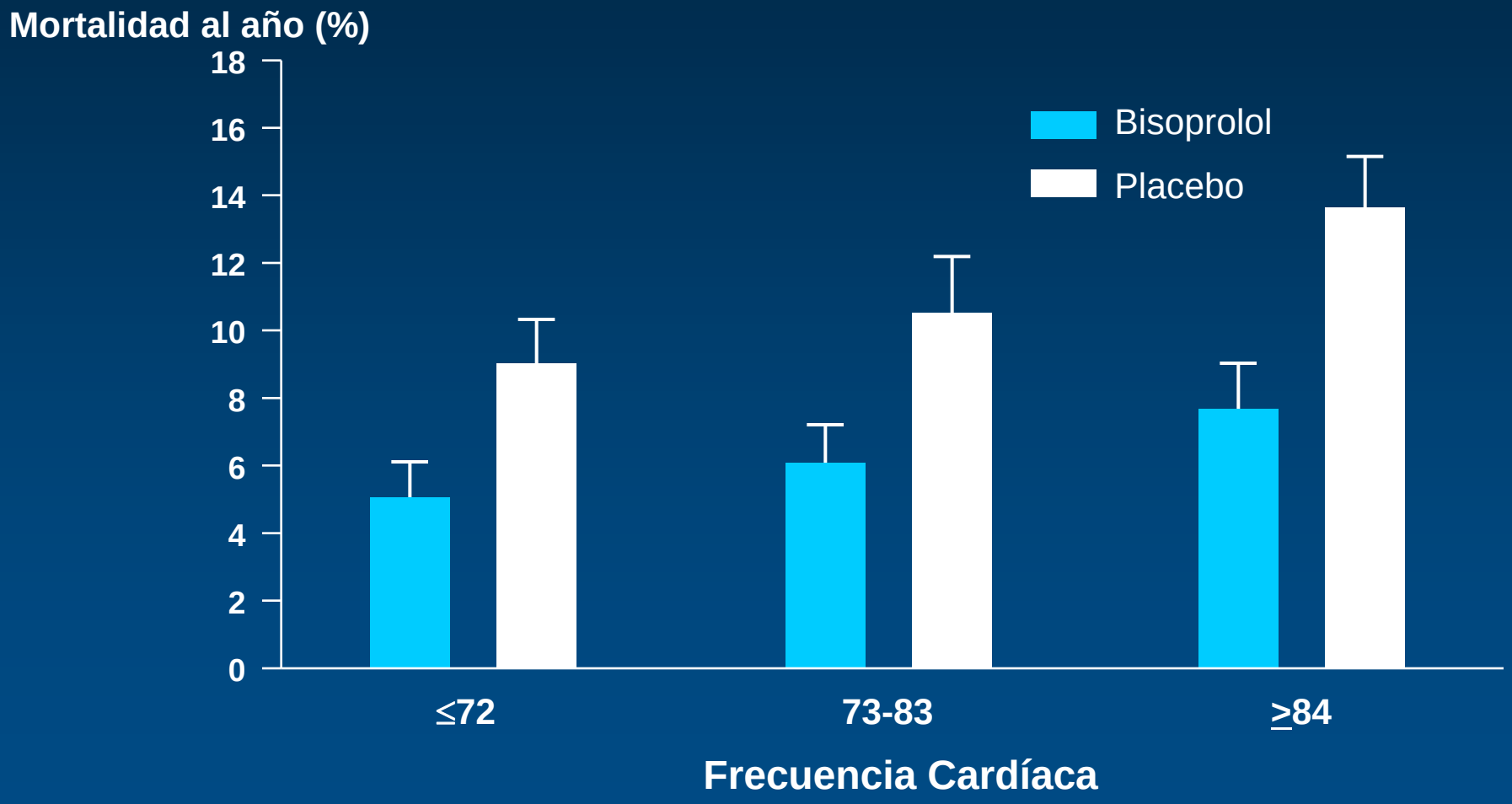
Table 1 Baseline characteristics of 41 949 patients included in 31 studies by gender

	Men	Women
Heart rate, b.p.m.	78.0 (17.5)	81.4 (19.6)

Eur J Heart Fail 2012

FC como predictor de mortalidad total en IC

The CIBIS-2 study (n=2539)

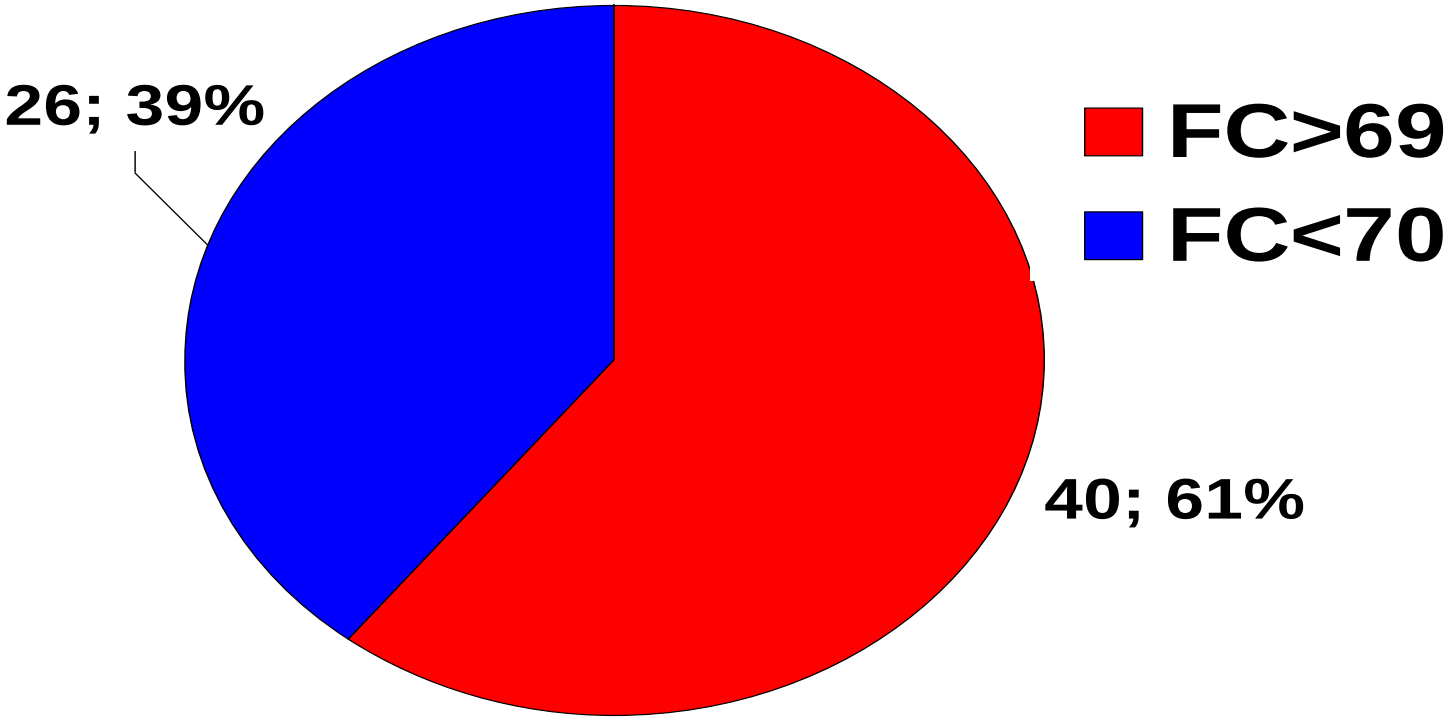


Lechat. *Circulation*. 2001.

EVIDEMTE

66 pts con MCD, RS y FEVI<30%

- Solo 1 pt (1,5%) sin BB, por bradicardia (FC 52 lpm)
- 61 (92,4%) carvedilol (dosis 33,8±19,1 mg)
- 4 (6,1%) bisoprolol (dosis 5,0±3,5 mg).



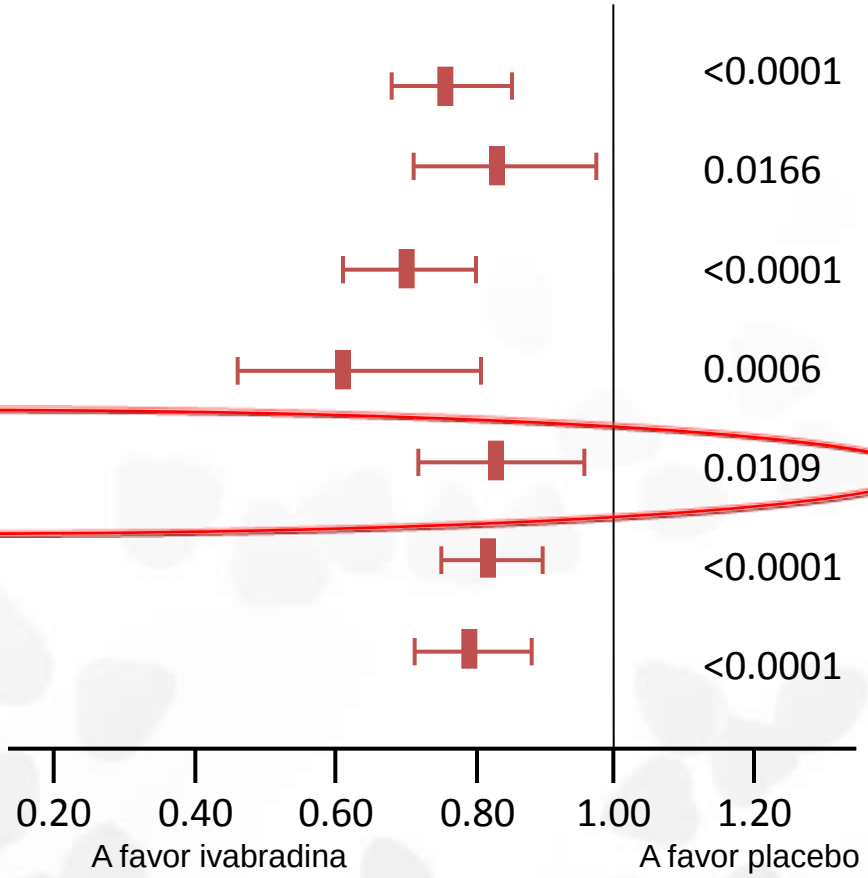
Martínez-Sellés REC 2011 (abs)

Antes del alta … ¿Qué hacemos?

1. Implantar MP-RSC
2. Implantar DAI-RSC
3. Introducir Ivabradina ←

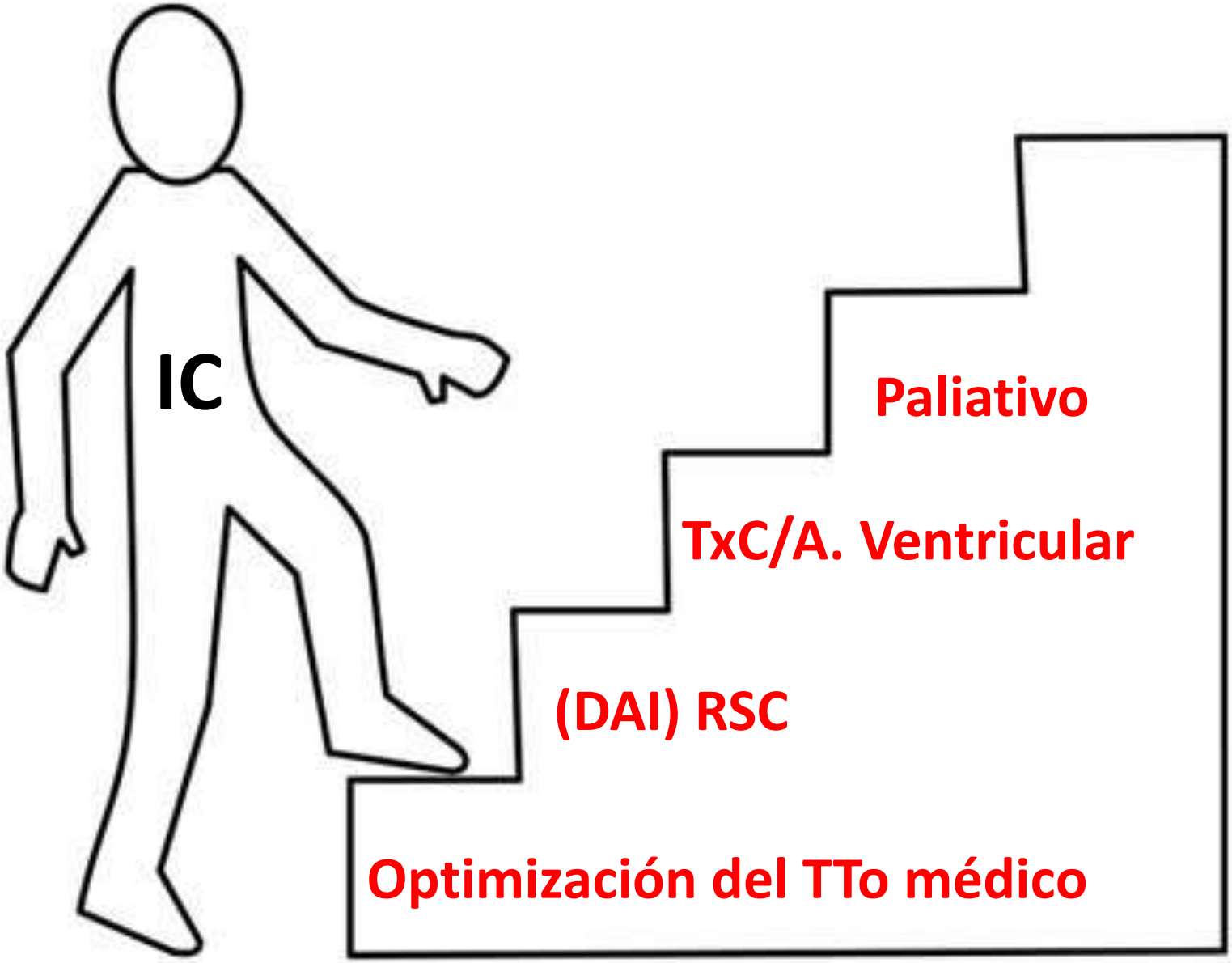
IC con FC≥75 lpm

	Hazard ratio	95% CI	*P*
Objetivo primario	0.76	0.68-0.85	<0.0001
Muerte CV	0.83	0.71-0.97	0.0166
Hospitalización por IC	0.70	0.61-0.80	<0.0001
Muerte por IC	0.61	0.46-0.81	0.0006
Mortalidad todas causas	0.83	0.72-0.96	0.0109
Hospitalización todas causas	0.82	0.75-0.90	<0.0001
Cualquier hospitalización CV	0.79	0.71-0.88	<0.0001



Böhm M, et al. *Clin Res Cardiol*.2012; 102:1-12.

IC Crónica: TTo Escalonado



TTo IC Sistólica: FEVI<50%

¡PUNTOS DE CORTE PARA TOMAR DECISIONES!

IECAs (y/o ARAII) y BB. Comorbilidades/desencadenantes

síntomas

Diuréticos e I. Aldosterona

No Síntomas

FEVI≤30%

FEVI>30%

Valorar DAI

No más TTo

síntomas

RS y FEVI≤35%

FA o FEVI>35%

FC<70

FC≥70

Ivabradina

síntomas

Valorar:TxC,2ª línea*,DAI,Paliativos,AV

*Hidralazina/NTG, digoxina, inotrópicos

(DAI) RSC

QRS≥150

QRS<130

Impact of QRS Duration on Clinical Event Reduction With Cardiac Resynchronization Therapy

Meta-analysis of Randomized Controlled Trials

Ilke Sipahi, MD; Thomas P. Carrigan, MD; Douglas Y. Rowland, PhD; Bruce S. Stambler, MD; James C. Fang, MD

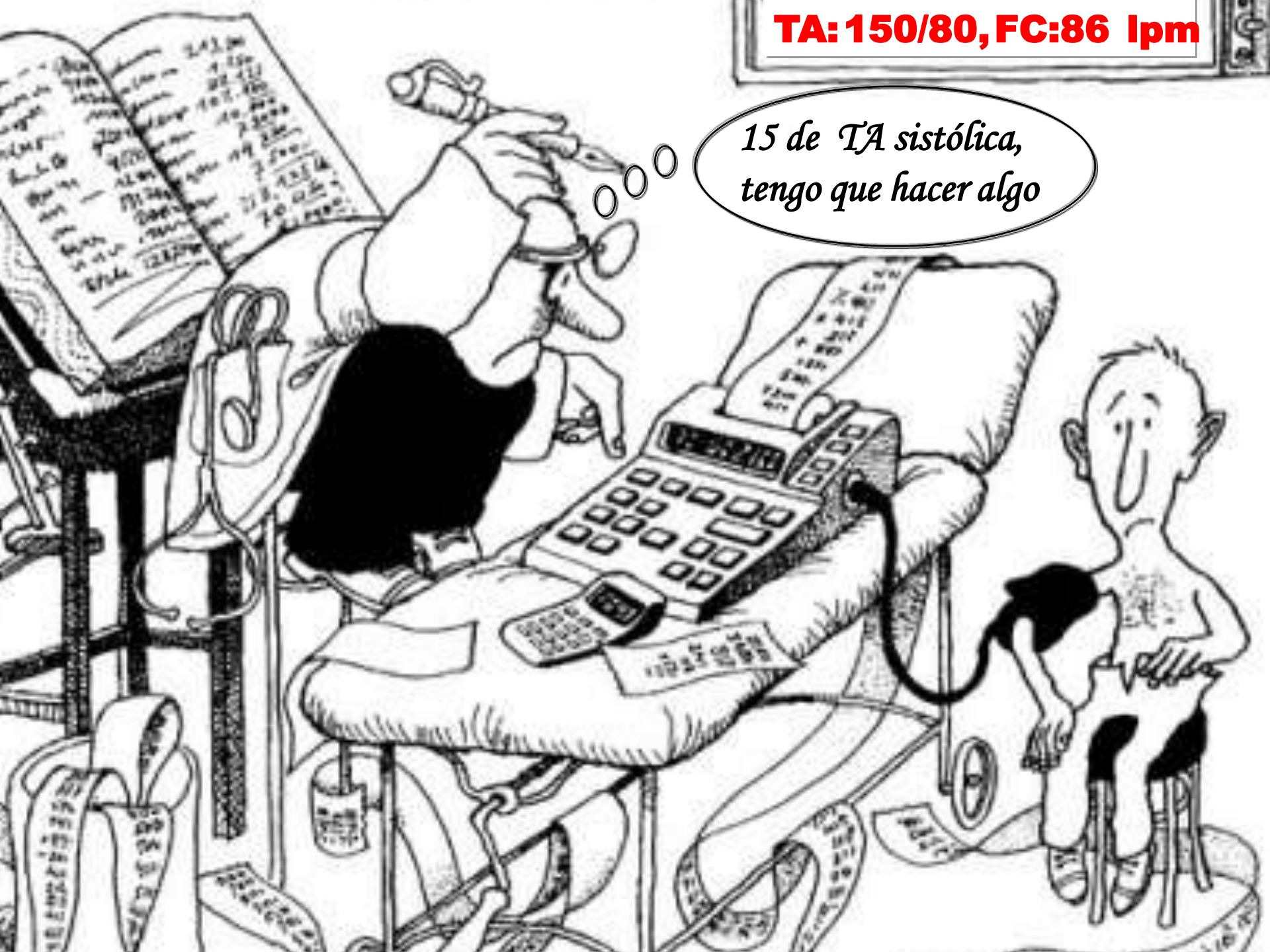
Background: Cardiac resynchronization therapy (CRT) is effective in reducing clinical events in patients with heart failure and prolonged QRS interval. Studies using surrogate measures and subgroup analysis of large trials suggest that only patients with severely prolonged QRS benefit from CRT. Our objective was to determine whether the effect of CRT on adverse clinical events (eg, death, hospitalizations) is different in patients with moderately (ie, 120-149 milliseconds) vs severely (ie, ≥150 milliseconds) prolonged QRS duration.

Methods: Searches of MEDLINE, SCOPUS, and Cochrane databases were conducted for randomized controlled CRT trials. Trials reporting clinical events according to different QRS ranges were identified. Five randomized trials fulfilling the inclusion criteria (total patients, n=5813) were included in the meta-analysis.

Results: In patients with severely prolonged QRS, there was a reduction in composite clinical events with CRT (risk ratio, 0.60; 95% confidence interval [CI], 0.53-0.67) ($P<.001$). In contrast, there was no benefit of CRT in patients with moderately prolonged QRS (RR, 0.95; 95% CI, 0.82-1.10) ($P=.49$), resulting in a significantly different impact of CRT in the 2 QRS groups ($P<.001$). There was a significant relationship between baseline QRS duration and risk ratio ($P<.001$) with benefit of CRT appearing at a QRS of approximately 150 milliseconds and above. The differential response of the 2 QRS groups was evident for all New York Heart Association classes.

Conclusions: Cardiac resynchronization therapy was effective in reducing adverse clinical events in patients with heart failure and a baseline QRS interval of 150 milliseconds or greater, but CRT did not reduce events in patients with a QRS of less than 150 milliseconds. These findings have implications for the selection of patients for CRT.

Arch Intern Med. 2011;171(16):1454-1462.
Published online June 13, 2011.
doi:10.1001/archinternmed.2011.247


TA: 150/80, FC:86 lpm
15 de TA sistólica, tengo que hacer algo