

# Walter Reed Cardiovascular Center



## A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

### Commentary

Marina N. Vernalis, DO FACC

The “CONSULT” menu on CHCS is here. We are screening referrals to ensure the patient receives the appropriate appointment (Cardiologist, stress test, Holter, ECHO, pacer). Bugs are still being worked out.

Most **ECHO reports** are available on ICDB under the patient’s name on the left side toolbar – “**HEALTHeFORCES**” → “**Cardiology Reports**”.

We remain available for e-mail, phone or page consultations for all of our providers throughout the NCA/NARMC. Many consult questions can be answered via this method, which eliminates any inconvenience the patient may experience coming to DC. Utilize the provided contact information for patient diagnostic or treatment questions. Or call 202-782-3832/3833 and ask to speak with the “E-DOC” or page 202-356-1111 x107-3311.

Walter Reed Cardiology is directly handling all inpatient transfers from outside facilities. **Page 202-356-1111 x107-3384 to speak with the Cardiology Fellow on call -24/7.**

Our website is available at [www.wrampc.amedd.army.mil](http://www.wrampc.amedd.army.mil). Go to Clinical Departments → Medicine → Cardiology.

### Cardiovascular Update

Daniel E. Simpson, MD FACC

*Public-Access Defibrillation and Survival after Out-of-Hospital Cardiac Arrest\**

**Background:** Survival following out-of-hospital cardiac arrest is poor. Automatic external defibrillators (AEDs) have been investigated with trained first responders but not with laypersons.

**Methods:** Prospective, community-based, randomly assigned trial of 993 community units with 19,000 laypersons trained in CPR alone or in CPR and in the use of AEDs. The community units were apartment complexes and public areas like shopping centers and large office buildings.

**Results:** The baseline characteristics of the units and the volunteers were similar as were the demographics of the patients treated. The CPR/AED group had a higher rate of survival to discharge for patients with “treated arrest of cardiac cause” (23% - 30 of 128) compared to CPR only (14% - 15 of 107; P=0.03). Eighty-five percent of these arrests occurred in public facilities and there were only 2 survivors in residential complexes. There were no inappropriate shocks.

**Conclusion:** In a structured response system, training laypersons in CPR and in the use of AEDs can improve the rate of survival to discharge after out-of-hospital cardiac arrest in public locations.

**Comments:** Early defibrillation has been demonstrated to improve outcome. The cost effectiveness remains controversial. A high density, public area for AED placement is likely the optimal location.

\*N Eng J Med 2004;351:637-46.

[www.nejm.org](http://www.nejm.org)

### Guideline Review

Daniel E Simpson, MD FACC

*Screening for Coronary Heart Disease: Recommendation Statement (US Preventive Services Task Force –USPSTF)\**

ECG, ETT and EBCT are easy to order and to complete. However, the benefit obtained from the results must be put in context of the risk of the procedure.

**Grade A** – Good evidence that service improves health outcomes with benefit >> harm

**Grade B** – Fair evidence that service improves health outcomes with benefit > harm

**Grade C** – Fair evidence that service improves health outcomes but benefit:harm ratio too close for general recommendation

**Grade D** – Fair evidence that service ineffective or harm > benefit

**Grade I** – Evidence is lacking, poor quality or conflicting so that benefit versus harm cannot be determined

**Grade D – Low risk, asymptomatic adults**

Published in the April 6<sup>th</sup> edition of the Annals of Internal Medicine, the USPSTF clinical guidelines recommended against screening low risk, asymptomatic adults (< 10% 10-year risk by the Framingham Risk Score) with ECG, exercise treadmill test (ETT) or EBCT. False positives tests are likely to cause harm “including unnecessary invasive procedures, over treatment and labeling”.

**Grade I – Not low risk, asymptomatic adults**

They found insufficient evidence “for or against routine screening with ECG, ETT, or EBCT” in patients at ≥ 10% 10-year risk. USPSTF could not determine the magnitude of benefit versus the harms from false-positive tests.

\*Ann Intern Med. 2004;140:569-572.

[www.annals.org](http://www.annals.org)

**Cardiovascular Trials at WRAMC**

**CARDIASTAR**

PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology

Questions/Referrals: Please contact Daniel Simpson

**OPTIMIZE-HF**

Assessment of inpatients with CHF and/or LV dysfunction to determine if guideline treatment is appropriately implemented

Questions/Referrals: Please contact Stephen Welka