

FROM THE JOURNALS

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Health care system delay and heart failure in patients with ST-segment elevation myocardial infarction treated with primary percutaneous coronary intervention: Follow-up of population-based medical registry dataTerkleson, JT et al., *Ann Int Med* 2011; 155:361-367

In patients with a STEMI, delay between contact with a health care system and initiation of reperfusion therapy (a system delay) is associated with increased mortality but data on the associated risk of CHF among survivors is limited. This historical follow-up study used a population based medical registry to assess the risk for CHF admissions or related outpatient visits in patients treated with PTCI within 12 hours of symptom onset and who had a system delay of 6 hours or less. System delays of 60 minutes or less had a long term risk of readmission for or outpatient management for CHF of 10.1% compared to 14.1% for those with delays of 181-360 minutes. The results add further evidence of the benefit of early PTCI in patients with a STEMI. Associated costs were not assessed but likely were markedly increased and deserve further study.

Off-label use of recombinant factor VIIa in US Hospitals: Analysis of hospital recordsLogan, AC et al., *Ann Int Med* 2011; 154:516-522

Recombinant factor VIIa is approved for the treatment of bleeding in patients who have hemophilia with inhibitors but has been applied to a wide range of off-label indications. This retrospective data base analysis reviewed 12,644 hospitalizations for patients who received factor VIIa to determine reasons for use of this product.

From 2000-2008, off-label use of factor VIIa in academic and non-academic hospitals increased more than 140 fold. Adult and pediatric cardiovascular surgery, body and brain trauma and intracranial hemorrhage were the most common indications for its use. In conclusion, off-label use of factor VIIa in the hospital setting far exceeds its use for approved indications. This pattern raises concern about the use of factor VIIa in conditions for which strong supporting evidence is lacking.

Interventions to reduce 30-day re-hospitalization. A systemic reviewHansen, LO, *Ann Int Med* 2011; 155:521-528

About one in five Medicare fee-for-service patients discharged from the hospital is re-hospitalized within 30 days. Beginning in 2013, hospitals with high-risk standardized readmission rates will be subject to a Medicare reimbursement penalty. This study reviewed the literature to evaluate studies aimed at reducing re-hospitalization within 30 days of discharge. Forty-three articles covered 12 distinct interventions; pre-discharge interventions included patient education, medication reconciliation, discharge planning and pre-discharge scheduling of followup visits while post-discharge interventions included followup phone calls, patient activated hotlines, direct communication with the ambulatory provider, ambulatory provider followup and post-discharge home visits. Bridging interventions included transition coaches, provider continuity across the inpatient and outpatient settings and patient-centered discharge instruction. This comprehensive literature review points to the lack of information to support definitive action plans and concluded that no single intervention alone was regularly associated with a reduced risk for 30 day re-hospitalization.

Synopsis of the National Institute for Health and Clinical Excellence Guidelines on management of transient loss of consciousness

Cooper, PN et al., Ann Int Med 2011; 155: 543-549

Transient loss of consciousness is common and often leads to an incorrect diagnosis, unnecessary investigation or inappropriate subspecialist referral. In August, 2010, the National Institute of Health and Clinical Excellence published guidelines that addressed the initial assessment and the most appropriate specialist referral for persons who have experienced transient loss of consciousness. The Synopsis describes the principal recommendations concerning these issues.

The recommendations include:

Persons with uncomplicated faint, situational syncope or orthostatic hypotension should receive electrocardiography but do not otherwise require immediate additional investigation or specialist referral.

Persons with features that suggest epilepsy should be referred to a Neurologist for further evaluation.

Brief seizure-like activity is often associated with syncope from any cause and should not be accepted as a sign of epilepsy.

Persons with a suspected cardiac cause for their transient loss of consciousness or persons for whom a cause cannot be determined after an appropriate initial assessment should be referred to a Cardiologist for additional evaluation.

This article deserves a full read since the subject is complicated and decision-making in the course of its workup is often challenging for the clinician.

ID CORNER

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INFECTIVE ENDOCARDITIS—DIAGNOSIS, TREATMENT AND MANAGEMENT OF COMPLICATIONS

These Guidelines are not new but I have found them to be very useful in the management of patients with infective endocarditis and refer to them often as an Infectious Disease consultant.

Baddour, LM et al., Infective Endocarditis—Diagnosis, Antimicrobial Therapy and Management of Complications, AHA Scientific Statement, Circulation 2005; III:e394-e433

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