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Announcing the Results of the Guidelines Applied in Practice Initiatives

Nonostante il proliferare di linee guida atte ad unificare il comportamento dei cardiologi c'è l'evidenza, nella pratica clinica, di un grosso gap fra le raccomandazioni delle linee guida e ciò che il cardiologo effettivamente fa. Recentemente, l'American College of Cardiology (ACC) ha sviluppato un piano per aumentare l'adesione dei cardiologi alle linee guida ed nell'anno in corso è prevista la valutazione dei risultati di questa campagna di informazione. Riportiamo dal web i primi commenti.

"We've shown that we can make guidelines come alive in practice," said Kim Eagle, MD, of the University of Michigan, and principal investigator of the Guidelines Applied in Practice (GAP) Project. Dr. Eagle also chairs the ACC/American Heart Association (AHA) Task Force on Performance Measures. Yesterday, at a special presentation here in Orlando, Dr. Eagle announced the initial results of the first GAP Project.

With the [ACC/AHA guideline on acute myocardial infarction](#) as its first target, the College came together in a unique collaboration with the Southeast Michigan Quality Forum Cardiovascular Subgroup of the [Greater Detroit Area Health Council](#) and the [Michigan Peer Review Organization](#). Together they developed materials designed to make it easier for hospitals to put the guideline's recommendations into practice. Dr. Eagle then assessed the materials' impact on the care received by more than 800 acute myocardial infarction patients in 10 hospitals in the Detroit area.

The results were striking, Dr. Eagle told the audience. "For virtually all of the key quality indicators we were interested in, we saw either a positive trend or a significant improvement in adherence," he said. Take smoking-cessation counseling, for example. Before the GAP initiative, only 42 percent of patients' charts revealed evidence that

smokers had been advised to stop smoking. After the project, that figure jumped to 65 percent.

The results were especially impressive for Medicare patients, Dr. Eagle noted. Before GAP, for instance, only 63 percent of Medicare patients received beta blockers within 24 hours of arriving at the hospital; afterward, that figure rose to 73 percent. Similarly, the percentage of patients receiving aspirin within 24 hours rose from 76 percent to 87 percent. The percent of patients who were prescribed aspirin on discharge from the hospital rose from 82 percent to 92 percent.

The key to all of these improvements, explained Dr. Eagle, lies in the "toolkit" developed by the GAP collaborators. The materials included a pocket guideline for physicians, a clinical pathway for nurses, standard orders, chart stickers, and hospital-specific performance charts. Patients received educational materials and signed customized discharge "contracts" outlining their plans for medication use, dietary and lifestyle changes, and medical follow up.

"This may be one of the first quality-improvement initiatives where patients played a big role," said Dr. Eagle. "The doctor, nurse, and patient are the triangle of care."

Now the ACC's GAP Steering Committee hopes to expand the project, Dr. Eagle reported. Possibilities include taking the acute myocardial infarction project statewide in Michigan and developing new projects based on other guidelines. The College also hopes to put the "toolkit" on its Web site for use in other hospitals. "The whole idea is to share as much as we can so that others can take advantage of part or all of this program in their own hospitals," said Dr. Eagle.



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Acute Myocardial Infarction—GAP Project in Michigan

GAP Intervention Components

1. Partnership between ACC, Michigan Peer Review Organization, and the Greater Detroit Health Council
2. Ten participating hospitals from Southeast Michigan
3. Tool kit
4. Opinion leaders

Internal: Commitment of hospital leadership, cardiology and project leader (or physician/nurse team)

External: Physician/nurse team from outside participating hospital

5. Time line: Rapid cycle implementation
6. Performance measures
7. Data abstraction
8. Data analysis

Tool Kit

The tool kit consists of seven pieces based on the 1999 Update of the ACC/AHA Guidelines for the Management of Patients with Acute Myocardial Infarction. Templates were developed by the Project Team in collaboration with the guideline committee and provided to participating hospitals. The

hospitals were given the freedom to select which tools they would use. They were also given the flexibility to customize the tools to accommodate the unique conditions at their institutions. The AMI-GAP Project logo, created specifically for the project, could be used on the templates that were not modified. Institution logos could be used on any tools.

Templates of tools:

1. Critical Pathway
2. Pocket Guide/Pocket Card
3. Heart Attack Discharge Form
4. Patient Flight Plan
5. Chart Stickers
6. Hospital Performance

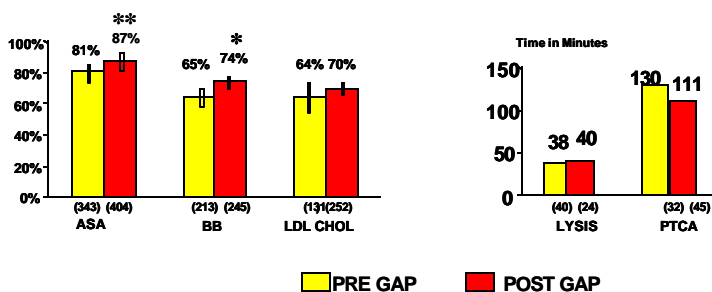
Preliminary Results

This presentation is from the ACC Annual Scientific Session in Orlando, FL given by Kim A. Eagle, M.D., F.A.C.C. on Monday, March 19, 2001.

Ongoing Activities

Analysis of data continues with the assessment of project im-

From GAP Results: Early Indicators



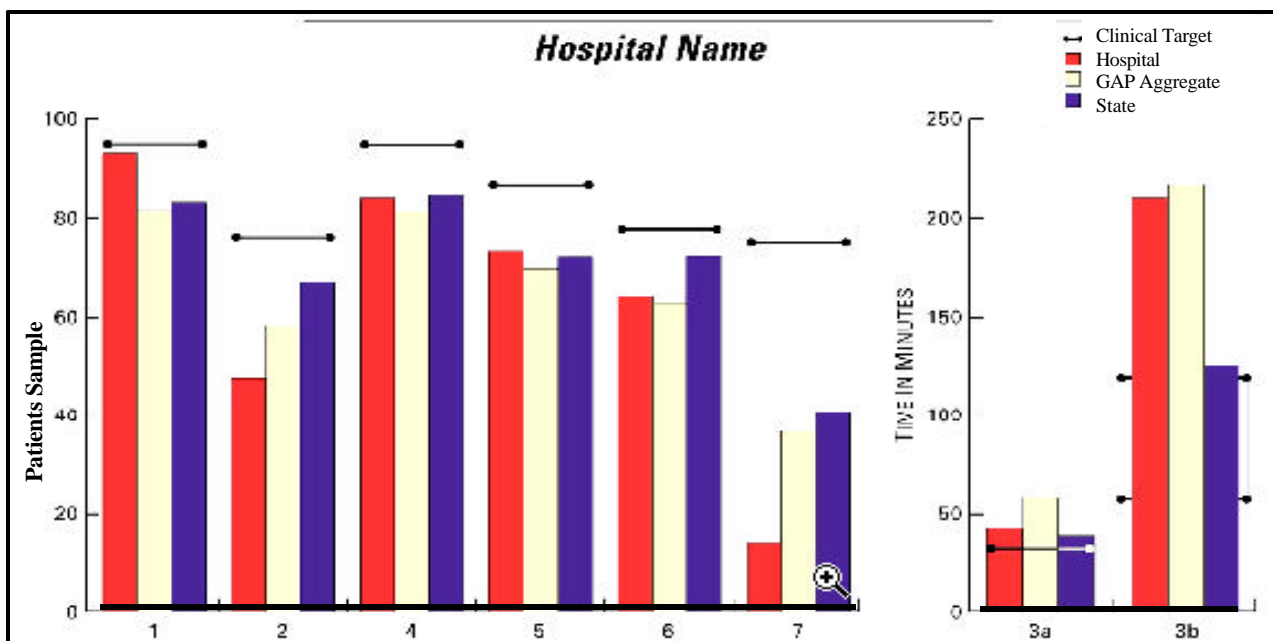
* p < 0.05

** p < 0.01

Other activities include an analysis of rate variation according to tool and hospital use, as well as a performance assessment of GAP-hospitals compared to non-GAP hospitals. A

qualitative assessment of the utilization of the tool kit and barriers to implementation is also planned.

**ACUTE MYOCARDIAL INFARCTION
QUALITY INDICATOR: PERFORMANCE “TARGET”**



- 1. ASPIRIN WITHIN 24 HOURS
- 2. BETA BLOCKER WITHIN 24 HOURS
- 4. ASPIRIN AT DISCHARGE

- 5. BETA BLOCKER AT DISCHARGE
- 6. ACE INHIBITOR AT DISCHARGE
- 7. SMOKING CESSATION COUNSULING

- 3a. MEDIAN TIME TO THROMBOLYSIS
- 3b. MEDIAN TIME TO PTCA



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Major Events and Findings from ACC 2001

ACC Opening Media Briefing

News Conference: 8:15-9 a.m., EST, Sunday, March 18

(ORLANDO, FLA.)—Don't miss the annual preview of the ACC Annual Scientific Session on Sunday, March 18, at 8:15 a.m. in the ACC News Conference Room, room 311 E-F, of the Orange County Convention Center.

ACC President Dr. George Beller, ACC 2001 Program Chair Dr. John DiMarco, and ACC 2001 Program Co-chair Dr. Sanjiv Kaul, all of the University of Virginia, Charlottesville, will lead this year's discussion. They will be joined by program committee members Dr. Sharon Hunt, Stanford University Medical Center; Dr. Eric Williams, Indiana University School of Medicine, Indianapolis; John Miller, Indiana University School of Medicine; and Dr. Jeffrey Popma, Brigham and Women's Hospital, Boston.

The panel will provide a brief overview of the program, highlighting the hottest and most novel research to be presented during the four-day meeting. They will focus on the latest research in cutting-edge areas, such as technological advances, innovations in disease detection and management, and key issues and medical trends, while directing you to important symposia, late-breaking clinical trial sessions, and oral and poster presentations.

Which is the best option—medical therapy, angioplasty, stents, or surgery?

News Conference: 10:30-11:15 a.m., EST, Sunday, March 18

(ORLANDO, FLA.)—Three studies to be presented at the American College of Cardiology 50th Annual Scientific Session, March 18-21, 2001, explore some of the foremost questions in the arena of coronary revascularization, that is, the use of drugs, balloons, stents, or bypass surgery in patients with coronary disease in an attempt to restore normal blood flow to heart muscle. One of the studies compares the two most common treatments for recurrent lesions within coronary stents already placed in heart vessels. Two other trials compare different available treatment approaches in patients with narrowings in two or more heart vessels, so-called multivessel coronary disease. A news conference on the three studies is scheduled for Sunday, March 18, at 10:30 a.m.

In-stent restenosis, or the growth of scar-like tissue within a stent several months after its implantation in a blood vessel, is most often treated with inflation of an angioplasty balloon or by insertion of a new stent. A randomized comparison of the two approaches, conducted at 24 institutions in Spain and Portugal, was designed to show which, if either, may be the better treatment. In the "Restenosis Intra-Stent: Balloon Angioplasty vs. Elective Stenting" (RIBS) trial (#22-1), 450 patients with stented but renarrowed heart vessels were randomly assigned to repeat therapy with either angioplasty balloons or additional stenting. Dr. Fernando Alfonso, of Universitario San Carlos in Madrid, will report six-month outcomes data. (Original presentation on March 18, 8:45 a.m.)

The other trials featured at the news conference compare available treatments for patients with symptoms due to multivessel coronary disease, whose optimal management remains controversial.

In the "Stent or Surgery" (SoS) trial (#22-7), nearly 1,000 such patients who were eligible for either stenting or bypass surgery were randomly assigned to undergo one or the other treatment and were followed for up to four years. The trial's investigators are comparing the rates of such major clinical events as death, heart attack, and development of chest pain associated with the two treatment approaches. Early preliminary findings suggested a possible advantage for bypass surgery. However, more conclusive results from patient follow up out to one year will be presented by Dr. Rodney Stables, of the Royal Liverpool University Hospital and the Cardiothoracic Centre, Liverpool, United Kingdom. (Original presentation on March 18, 9:22 a.m.)

Treatment with medications alone for patients with multivessel coronary disease was included in a three-way comparison with stenting and bypass surgery in the "Medicine, Angioplasty, or Surgery Study" (MASS-II). Preliminary findings from the study's 1,086 patients who were randomly assigned to one of the three treatments suggest that drug therapy alone may be as good a treatment strategy as coronary bypass surgery, at least in the short term. Dr. Whady Hueb, of the Heart Institute at the University of Sao Paulo, Brazil, will present findings from the MASS-II trial (#22-9). (Original presentation on March 18, 9:34 a.m.)

Moderator: Dr. David Faxon, University of Chicago

Clinical trials examine a novel pacing technique to prevent atrial fibrillation and radiation for in-stent restenosis
News Conference: 11:30 a.m.-12:15 p.m., EST, Sunday, March 18

(ORLANDO, FLA.)—Three late-breaking clinical trials—one in electrophysiology and two in interventional cardiology—being presented at the American College of Cardiology 50th Annual Scientific Session in Orlando, Fla., March 18-21, 2001, will reveal new information about preventing a life-threatening heartbeat irregularity as well as using the new technique of radiation to prevent vessel reclosure after stenting. These important, new treatment options are the subject of a news conference on March 18 at 11:30 a.m.

ness of such antiarrhythmic drugs in suppressing atrial fibrillation episodes.

One of the largest prospective, randomized studies of these issues—called the "Dual-Site Atrial Pacing for Prevention of Atrial Fibrillation" trial (DAPPAF, #61-5)—has found that a specific, nonstandard atrial pacing strategy prolonged the interval between episodes of drug-resistant atrial fibrillation better than did other standard atrial pacing methods.

"This trial for the first time establishes a synergistic relationship between an atrial pacing technique and antiarrhythmic therapy in patients with drug-refractory atrial fibrillation," said Dr. Sanjeev Saksena, who is director of the Cardiovascular Institute at the Atlantic Health System, Millburn, N.J., and professor of medicine at Robert Wood Johnson School of Medicine.

"It shows that dual-site right atrial pacing suppresses the atrial fibrillation that breaks through despite drug therapy," said Dr. Saksena, "allowing patients who would otherwise be considered treatment failures to maintain control of their arrhythmia." (Original presentation on March 18, 9:15 a.m.)

The lengths of vein or artery surgically implanted to bypass blood flow around narrowings in the major heart vessels can also start to close off from disease. Such restenosis or re-narrowing in bypass grafts can be treated with coronary stents, but the risk that recurrent lesions will grow within those stents is frustratingly high. Now, a radiation therapy technique that has been approved for the treatment of in-stent restenosis in native heart vessels has been tested for effectiveness in bypass grafts.

In the "Washington Radiation for In-Stent Restenosis Trial for Saphenous Vein Grafts" (SVG-WRIST, #22-11), 120 patients with recurrent, diffuse narrowings in stented bypass grafts were randomly assigned to undergo the radiation treatment, called brachytherapy, or a sham brachytherapy procedure that served as a placebo. The radiotherapy source consisted of a string of pellets containing iridium-192, an emitter of gamma radiation. The seed string is inserted through a catheter and temporarily positioned within the restenotic stented bypass graft. Dr. Ron Waksman, of the Washington Hospital Center in Washington, D.C., will present preliminary results of the trial.

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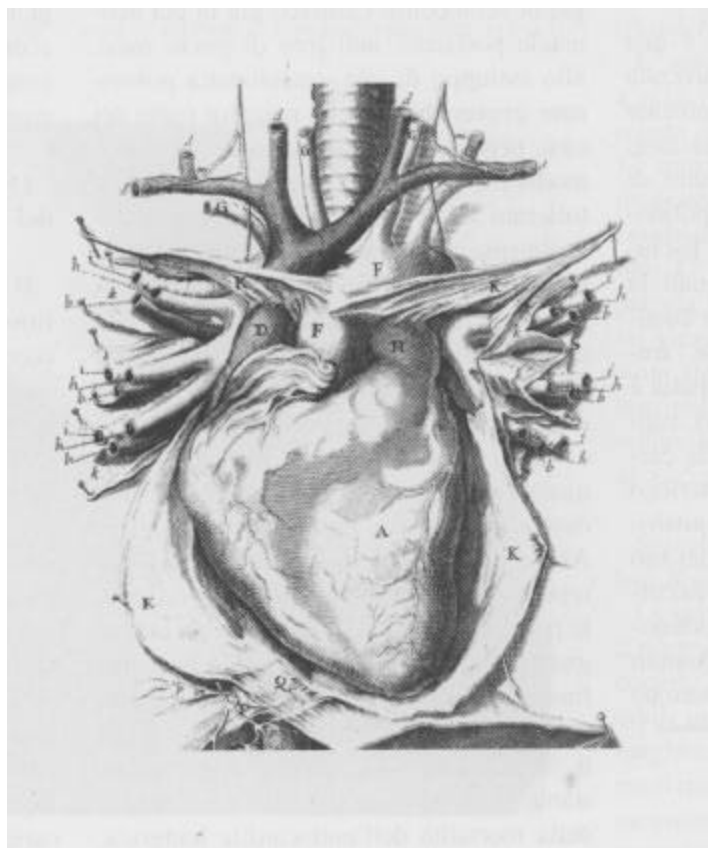
previously placed in native coronary arteries. (Original presentation on March 18, 9:46 a.m.)

But it is unknown whether radiation therapy will also prevent renarrowing of coronary lesions that are being stented for the first time. That may change with the reporting of the "Beta-Cath System Trial" (#22-3), which has tested the effectiveness of brachytherapy in patients with narrowings in either previously treated or yet untreated heart vessels.

"This is the only trial in the world with sufficient statistical power to test the potential for radiation therapy for treating coronary lesions that have not previously been stented," said

Women's Hospital, Boston. (Original presentation on March 18, 8:58 a.m.)

Moderators: Dr. Douglas Zipes, ACC president-elect, Indiana University School of Medicine, Indianapolis, and Dr. David Holmes, Jr., Mayo Clinic, Rochester, Minn.



Dr. Richard E. Kuntz.

If the study shows brachytherapy to reduce the risk of renarrowing after first stenting procedures as well as later ones, then "it could extend the radiation treatment to the broader population of patients with new lesions," said Dr. Kuntz, who is with the Division of Clinical Biometrics at Brigham and