

General Practitioner Symposium

— WEST MORETON — 2025 —



12:45pm – 1:25pm

Cardiology Update

Dr Johanne Neill



Symposium
organisers



West
Moreton
Health



Queensland
Government

Got a question?
LOG IT HERE:





WMHHS Cardiology update

2nd August 2025

Johanne Neill

Director of Cardiology

- Update on NEW Heart Foundation ACS guidelines
- WMHHS Cardiology services
- WMHHS Cardiology service of the future

New ACS guideline hub



Resources

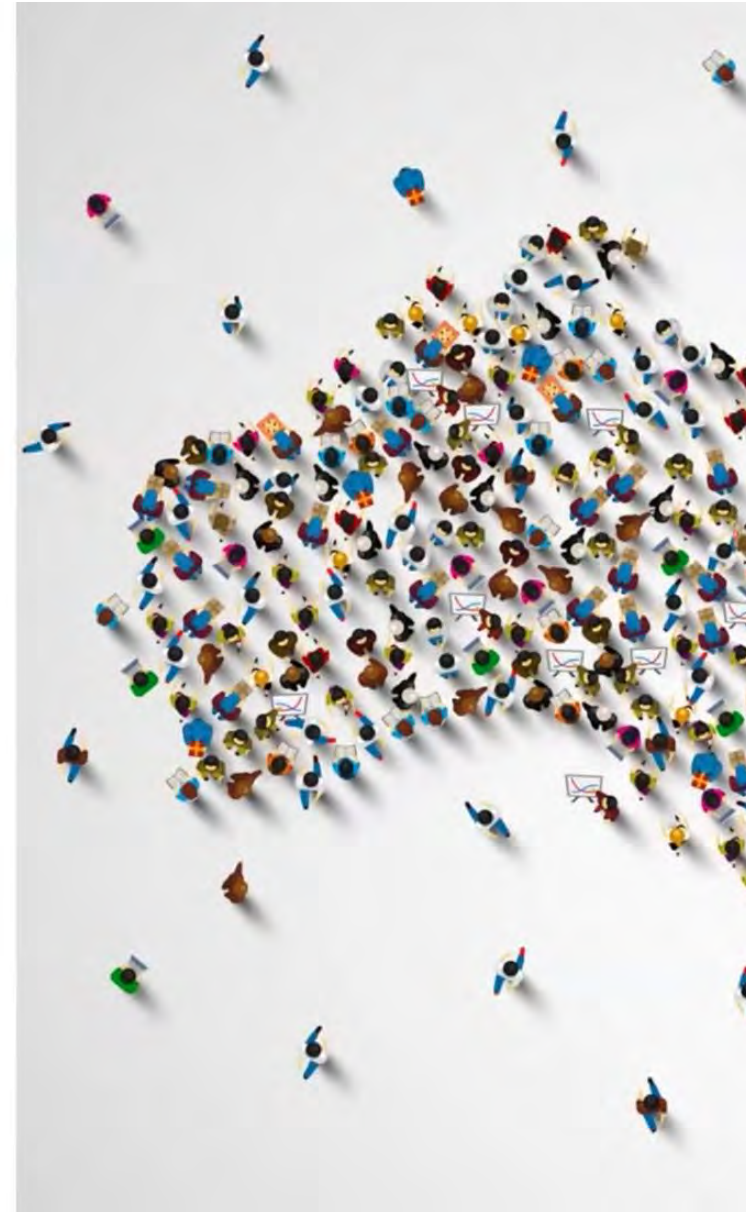


[heartfoundation.org.au/
for-professionals/acs-guideline](https://heartfoundation.org.au/for-professionals/acs-guideline)

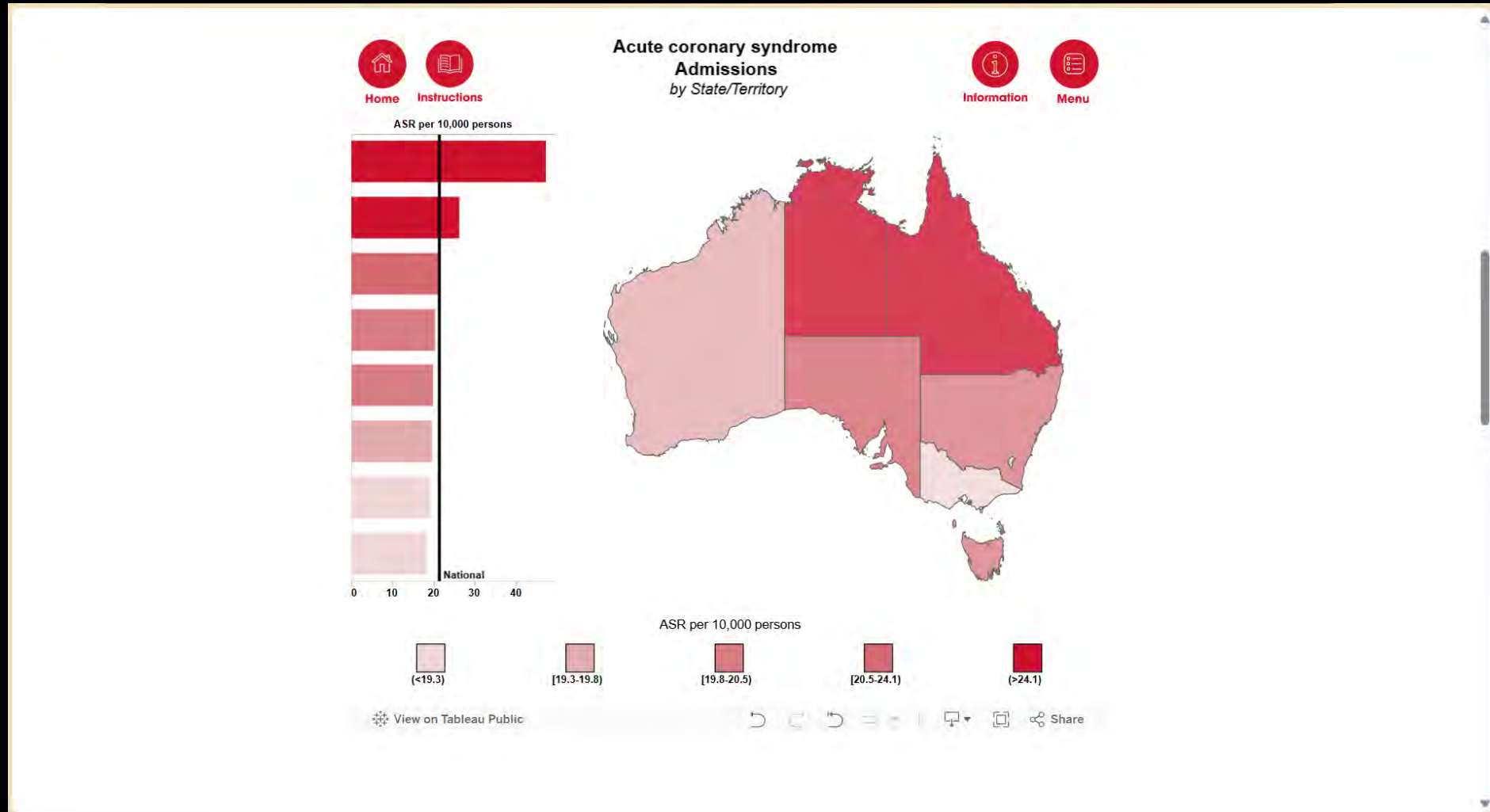


Impact of ACS in Australia

- Each year in Australia, there are over 57,000 acute coronary events among people aged 25 and over.
- This is equivalent to nearly 160 people every day, or one person every nine minutes.
- The impact of ACS varies across different population groups – women, First Nations peoples, people living in regional and remote areas, older people.

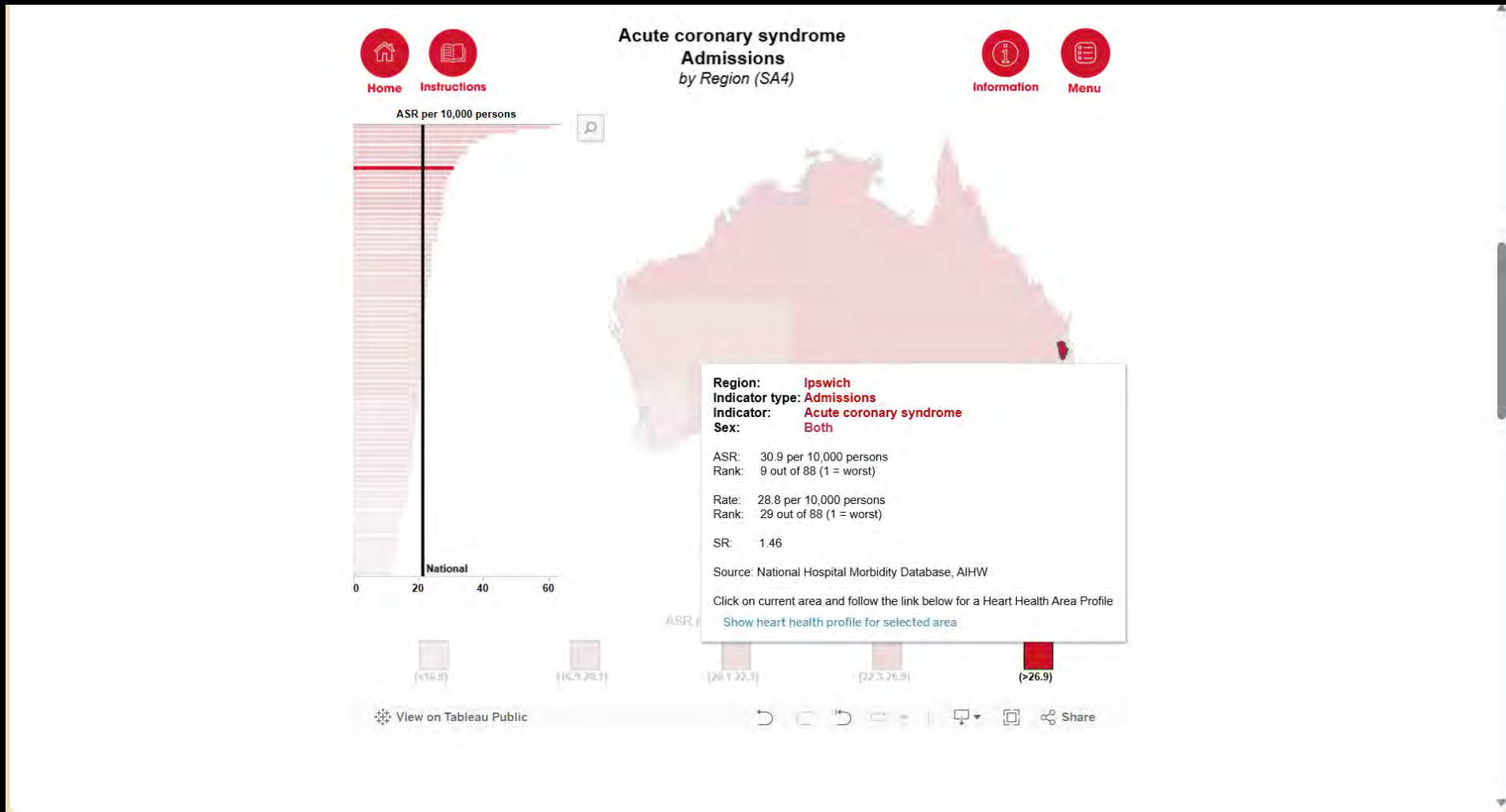


ACS QLD



Second only to NT for ACS admission rate

ACS Ipswich





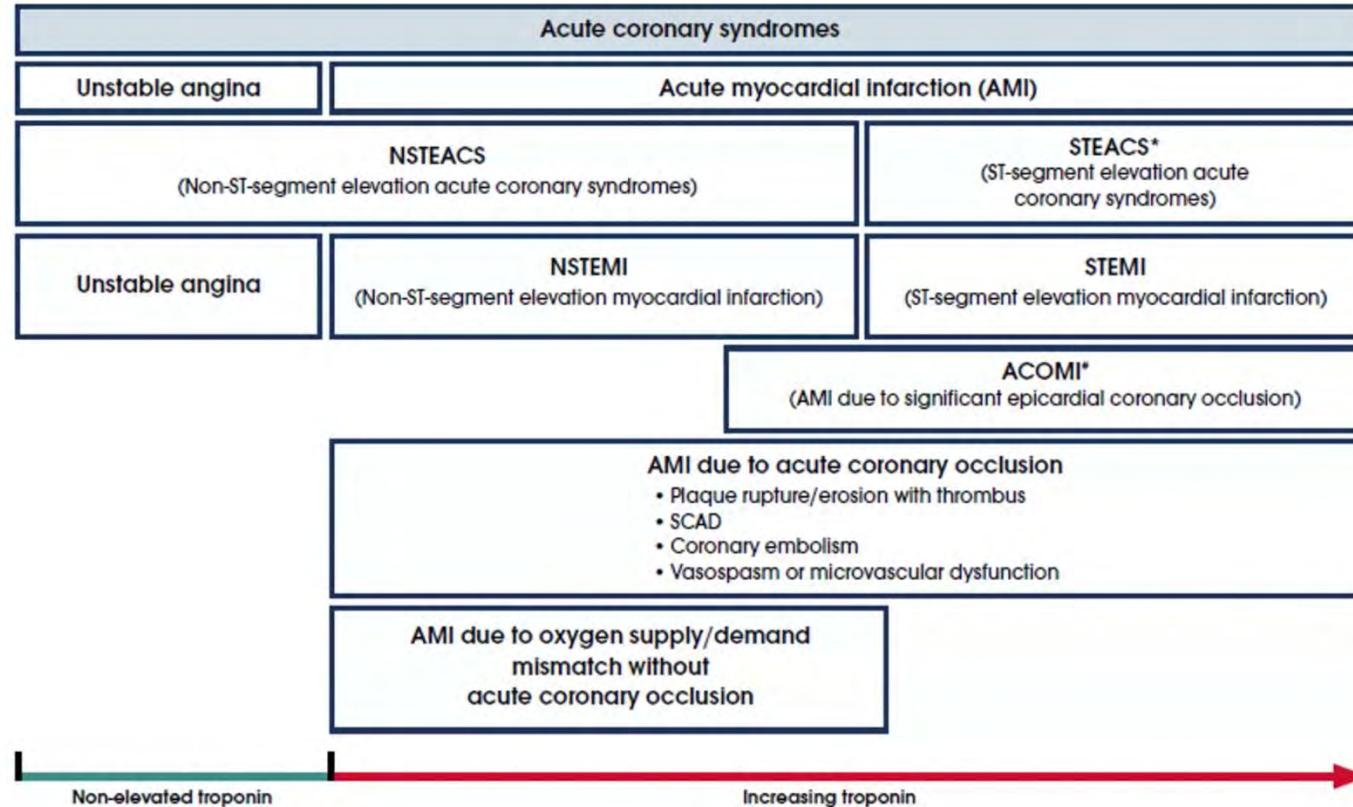
Assessment & Diagnosis

What's new?

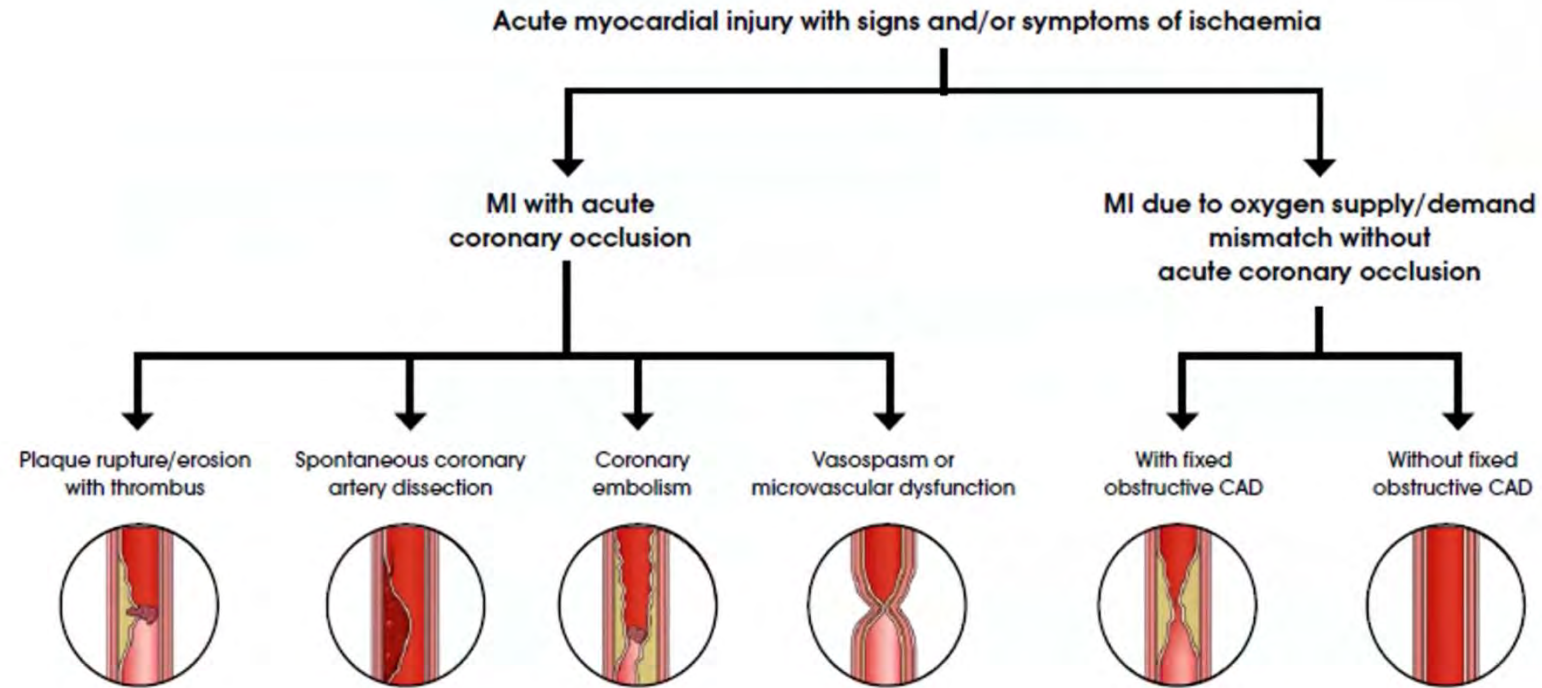
- New terminology
- Initial ECG assessment
- Biomarkers
- Risk assessment and clinical decision pathways for suspected ACS
- Further diagnostic testing for people with suspected ACS
- Role of rapid access chest pain clinics
- Primary care and regional and remote presentations



Classifications of conditions associated with ACS



Revised classification of MI

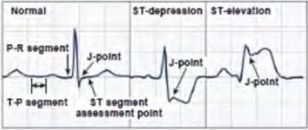
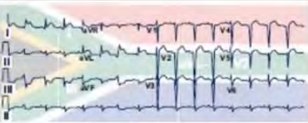

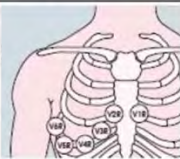

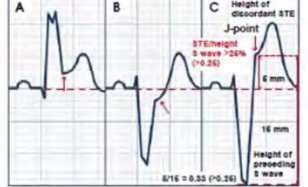


Note: Both types of MI may present with ECG changes of STEMI or NSTEMI.

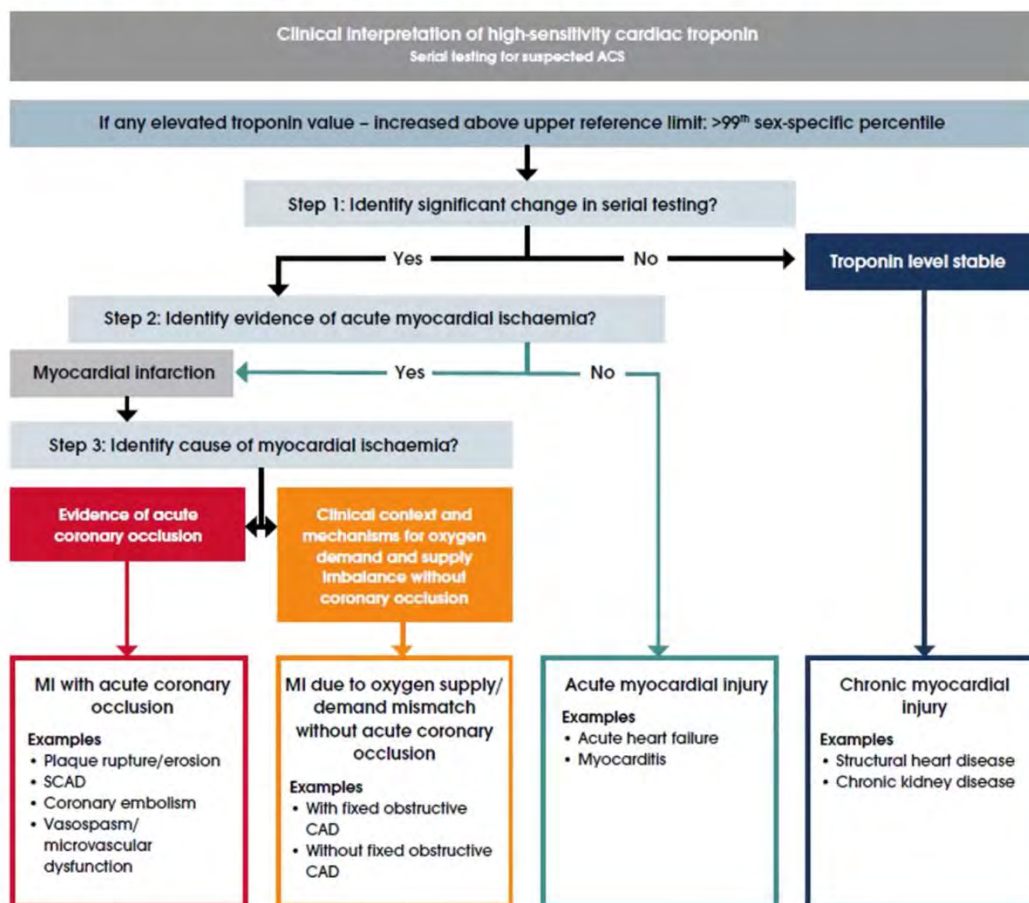


ECG findings of acute coronary occlusion MI (ACOMI)

- If ACOMI is not initially identified, the ECG should be further examined for features associated with higher likelihood of evolving to ACOMI or signs of myocardial ischaemia.
- Various ECG patterns of ACOMI beyond the traditional STE.
- Recognition of these patterns should prompt consideration of emergency reperfusion.
- Validated Modified Sgarbossa criteria improves diagnosis of STE in people with left bundle branch block (LBBB) or right ventricular pacing with 99% specificity and 80% sensitivity.

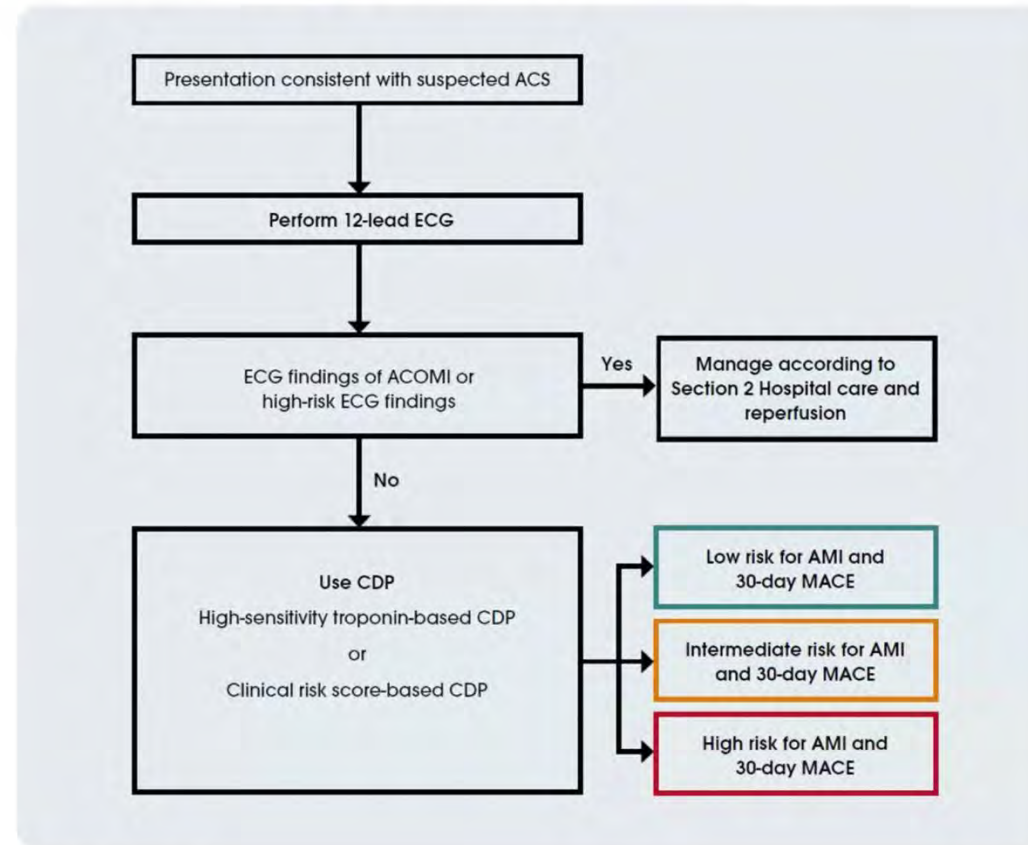
		and illustration	for clinical action
A. Regional STE with reciprocal STD	STE ≥ 1 mm at the J-point in two contiguous leads in all leads other than V2-4. V2-4 STE criteria: ≥ 1.5 mm in women ≥ 2 mm in men ≥ 40 years ≥ 2.5 mm in men < 40 years		Activate reperfusion pathway
B. High lateral MI	STE I, aVL, V2 STD III (+/- II, aVF) Subtle STE V5, V6 and reciprocal changes in aVF may be seen.		Activate reperfusion pathway
C. Posterior MI	Precordial STD ≥ 0.5 mm V1-3 Confirm with posterior leads (V7,8,9) with findings of STE: • ≥ 0.5 mm in women and men ≥ 40 years • ≥ 1 mm in men < 40 years	V7, 8, 9 supplementary lead placement 	Activate reperfusion pathway
D. Right ventricular MI	STE ≥ 0.5 mm in any right-sided chest lead (V3R-V6R), but particularly V4R. STE ≥ 1 mm in men < 30 years	Right precordial supplementary lead placement 	Activate reperfusion pathway
E. De Winter T waves	J-point depression with up-sloping ST segments and tall, prominent, symmetric T waves in precordial leads, with STE (≥ 0.5 mm) in aVR and an absence of STE in precordial leads.	V3 	Activate reperfusion pathway
F. Modified Sgarbossa criteria (LBBB or paced rhythm)	Any of the following: A) Concordant STE > 1 mm in leads with positive QRS complex B) Concordant STE ≥ 1 mm V1-3 C) STE ≥ 1 mm in one or more leads at the J-point which is proportionally discordant to the preceding S wave by $> 25\%$.		Activate reperfusion pathway

Interpreting high-sensitivity cTn results



- Ability to detect very low troponin values with accuracy ($\leq 10\%$ CV at 99th percentile).
- When evaluating changes (deltas) in troponin values, serial results from a single assay must be used.
- Identify if there is a stable or changing pattern associated with an elevated cTn.
- Comparable diagnostic accuracy between hs-cTnI and hs-cTnT.

Assessment process for suspected ACS



High-sensitivity troponin-based CDP

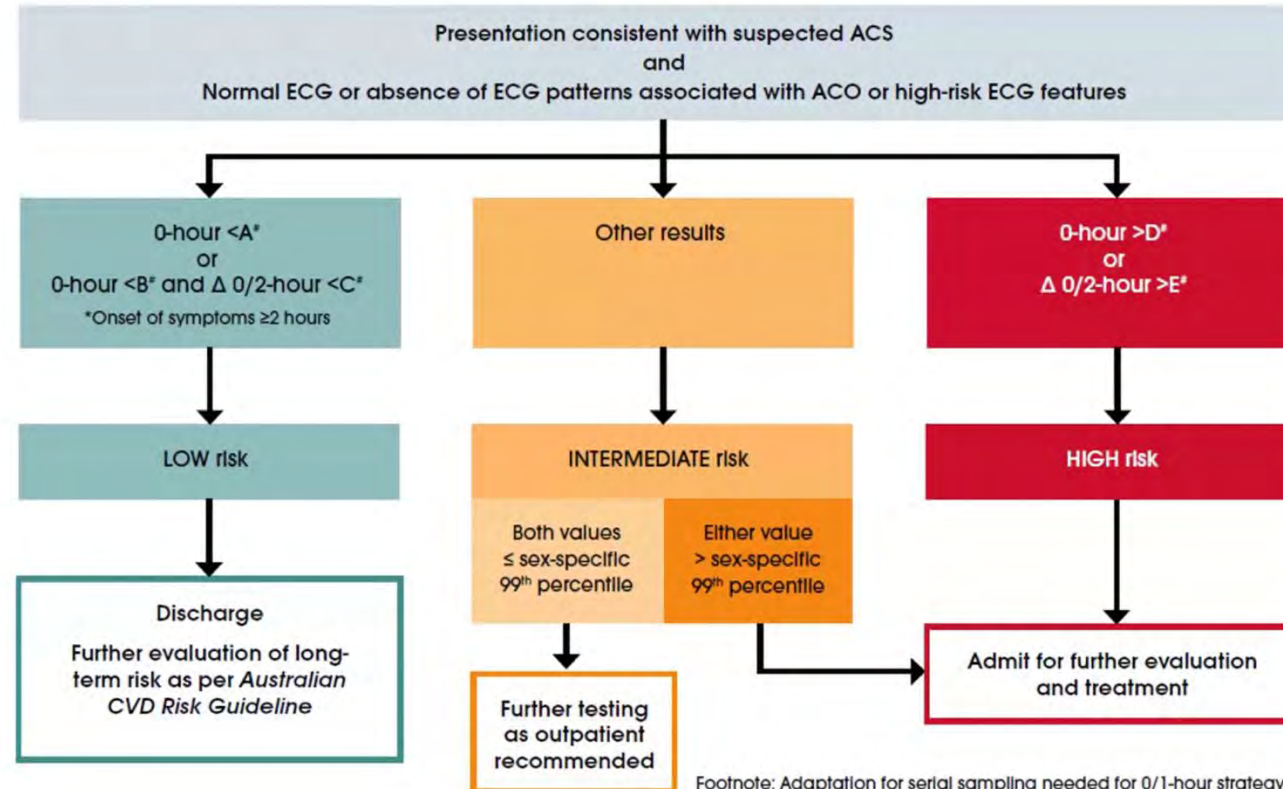
A high-sensitivity troponin-based clinical decision pathway is recommended, using: (Consensus)

- 0/1-hour or 0/2-hour strategy, or
- *High-sensitivity troponin in the evaluation of patients with acute coronary syndrome (High-STEACS) algorithm.*



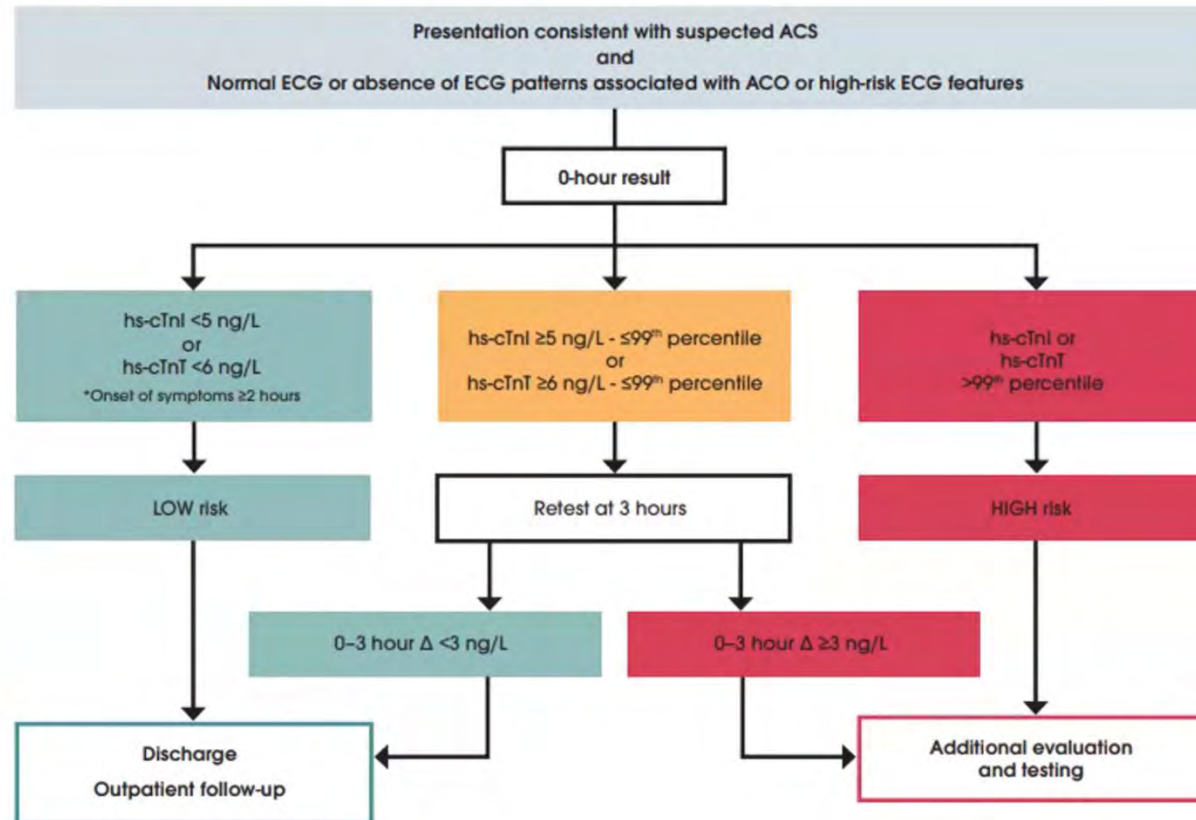
High-sensitivity troponin-based CDP: 0/2-hour testing

Assessment & Diagnosis



High-sensitivity troponin-based CDP: High-STEACS algorithm

Assessment & Diagnosis





Further diagnostic testing for people with suspected ACS

In people at low risk who remain symptom-free, further cardiac testing for CAD is not routinely required. (Consensus)

In people at intermediate risk (as defined by a validated CDP) with elevated troponin concentrations (>99th percentile), inpatient investigation is recommended. (GRADE SOR: Strong; COE: Moderate)

- Invasive cardiac testing is now an option to further stratify and assess risk beyond 30 days.

In people at intermediate risk without elevated troponin concentrations, consider outpatient investigation with non-invasive testing. (Consensus)



Role of rapid access chest pain clinics (RACPC)

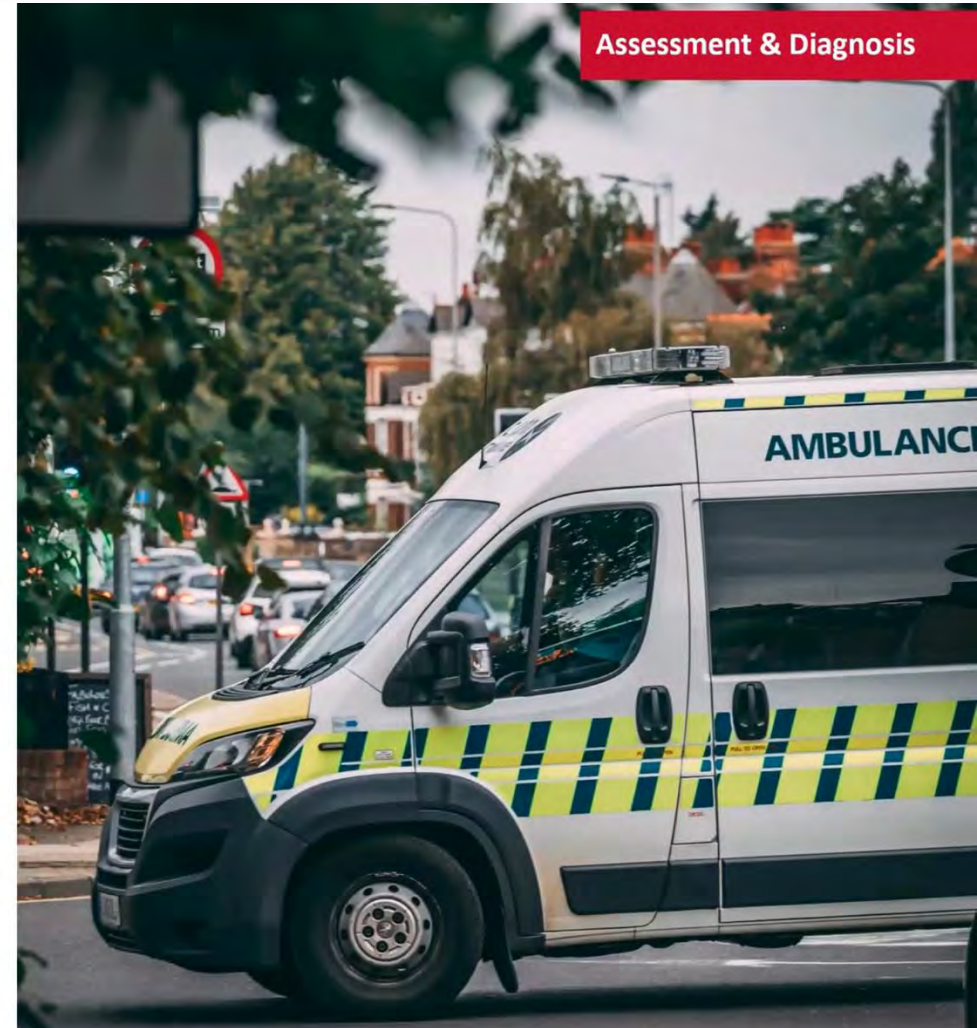
- RACPCs may assist with choice of further investigations including non-invasive testing or management in selected people discharged following an ACS. (Cho, French et al. 2023)
- **Benefits of RACPCs:** (Black, Cheng et al. 2019, Yu, Brazete et al. 2021, Kozor, Mooney et al. 2022)
 - more efficient access to testing and diagnosis
 - cost savings compared to hospital admission
 - greater patient satisfaction
 - equal or improved safety compared to traditional hospital-based care
 - reduced invasive investigations
 - lower rates of ED re-presentation.
- Access to these clinics should be prioritised for selected intermediate-risk people with cTn levels <99th percentile where protocolised assessment guidelines are not available.



Primary care and regional and remote presentations

Metropolitan health services should establish centralised support systems for regional and remote health services to facilitate: (GRADE SOR: Strong; COE: Low)

- prompt assistance with ECG interpretation and access to troponin results when on-site access is not available
- provision of clinical advice to healthcare professionals
- access to cardiac investigations if required.

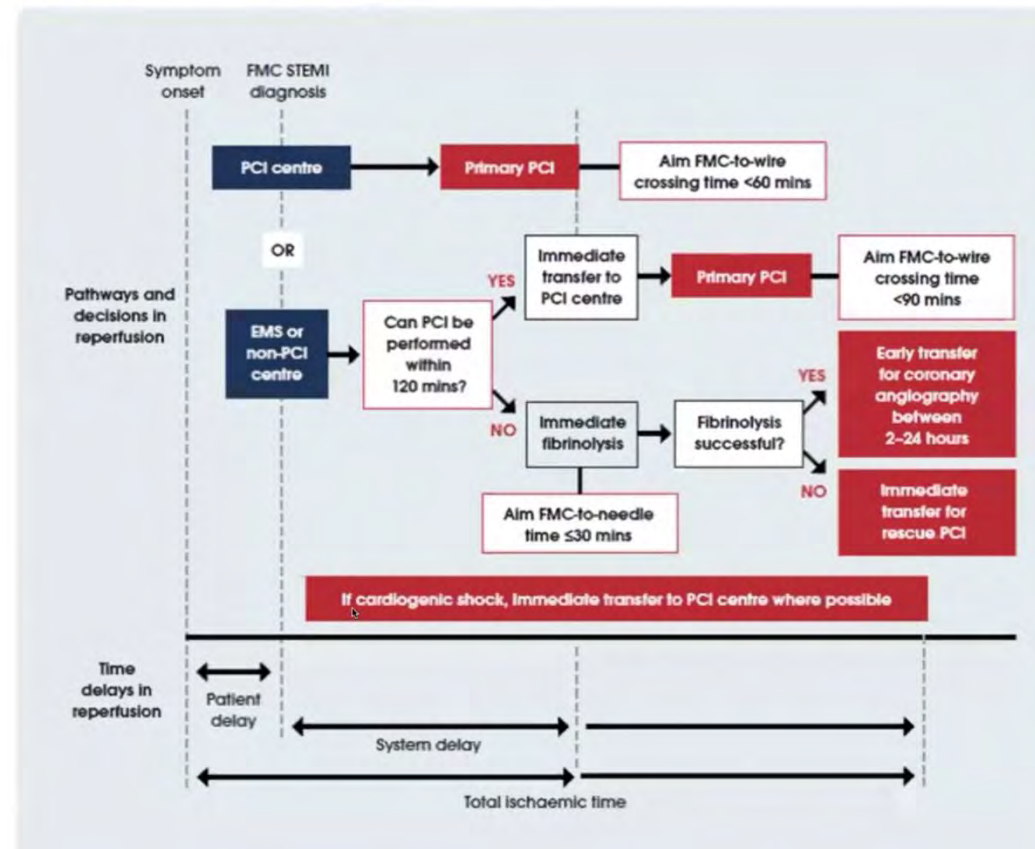


Hospital care and reperfusion

- Whats new?
- Acute STEMI management
- Acute NSTEMI management
- SCAD management
- Management of ACS with shock or cardiac arrest
- Management of ACS with multivessel disease
- Antiplatelet regimen

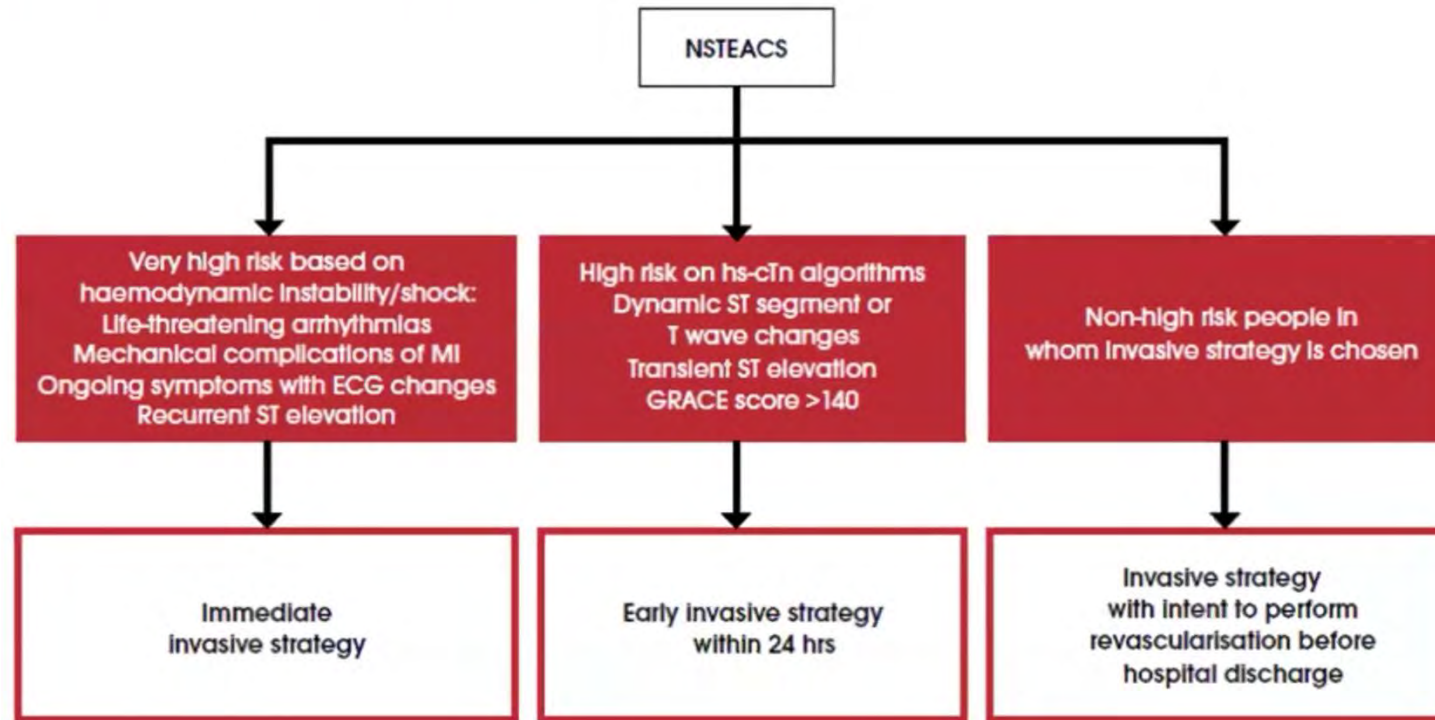
Acute management of STEMI: Choice & timing of reperfusion strategy

Hospital Care & Reperfusion



Acute management of NSTEMIACS: Timing of invasive management

Hospital Care & Reperfusion



Hospital Care & Reperfusion



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Acute management of NSTEMACS: Considerations for priority populations

Women

- Use radial-first approach and consider routine invasive strategy.
- ❖ Observational data show women less likely to receive an invasive strategy or radial access. (Stehli et al. 2021, Elgendy et al. 2016)

Older adults

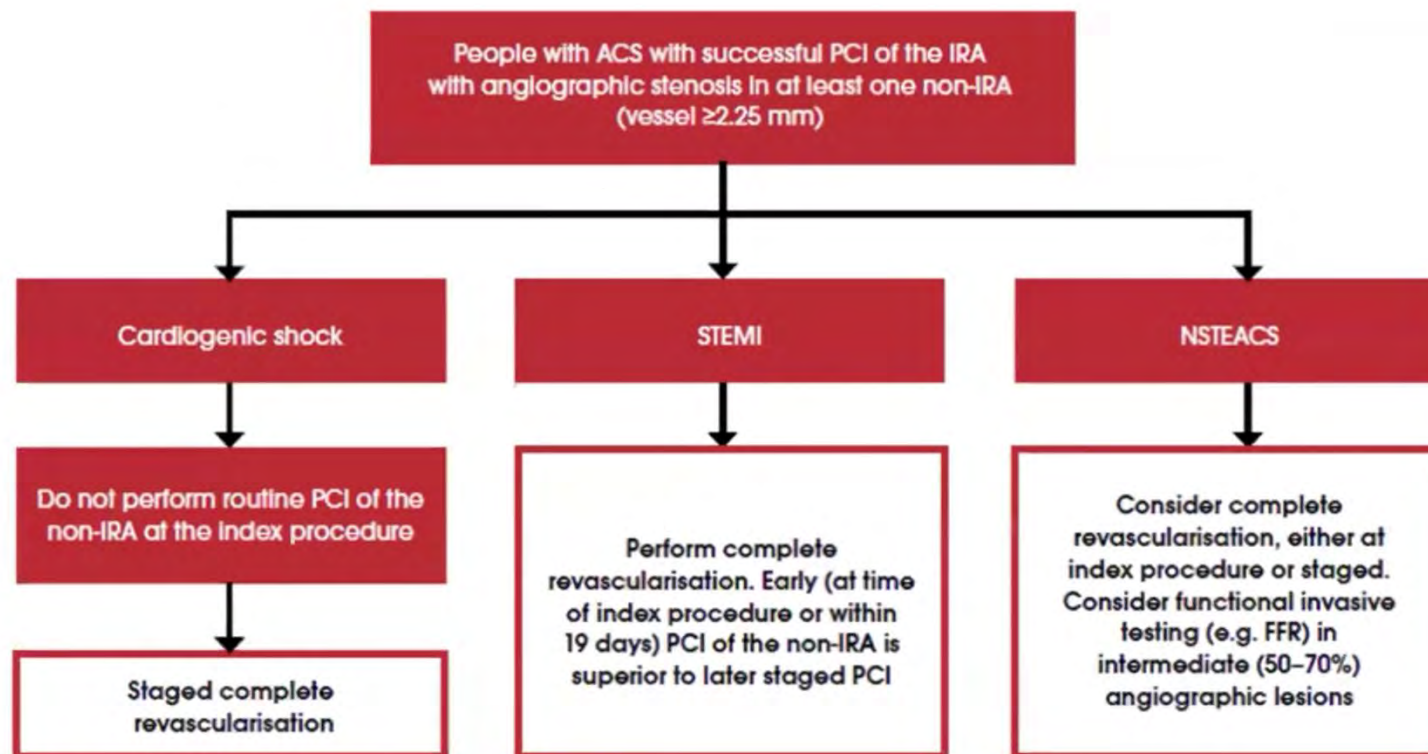
- Consider invasive strategy over initial conservative approach if no frailty, multimorbidity or cognitive dysfunction based on objective assessment.
- Individualise treatment decisions, balancing the potential for improved outcomes with the risks of complications, especially bleeding.

First Nations peoples

- Provide information about transfers or invasive management with assistance from First Nations health practitioners or Aboriginal liaison officers.
- Recognise barriers to equitable care.



Managing ACS with multivessel disease (MVD)



Pharmacotherapy in the acute phase



Hospital Care & Reperfusion

Antiplatelet therapy

In people with STEMI undergoing primary PCI and people with NSTEMI/UA undergoing a routine invasive strategy, give dual antiplatelet therapy with aspirin and a potent P2Y₁₂ inhibitor (ticagrelor or prasugrel). (GRADE SOR: Strong; COE: High)

- Preferred P2Y₁₂ inhibitors ticagrelor or prasugrel: more rapid onset of action, greater potency than clopidogrel.

Practice points for timing of P2Y₁₂ inhibitor administration:

- **STEMI:** Consider pretreatment with a P2Y₁₂ inhibitor.
 - ❖ P2Y₁₂ inhibitor given before angiography, compared to during or immediately after PCI did not reduce mortality or major bleeding. Subgroup analysis found pretreatment in the pre-hospital setting associated with reduced MI (RR 0.73, 95% CI 0.56–0.91, $p < 0.01$). (meta-analysis Gewehr, Carvalho et al. 2023)
- **NSTEMI/UA:** P2Y₁₂ inhibitors can be withheld until the coronary anatomy is known if coronary angiography can be performed within the time recommendations based on risk.
 - ❖ RCTs found pretreatment increased bleeding but not ischaemia – but trials were with prasugrel. (ACCOAST trial)
 - ❖ Observational evidence suggests similar results with ticagrelor and clopidogrel. (SWEDEHEART registry)
- **STEMI and NSTEMI:** Administration of P2Y₁₂ inhibitor after the coronary anatomy is known is reasonable when clinical suspicion of need for urgent cardiothoracic surgery e.g. left main ischaemia pattern on ECG.



Pharmacotherapy in the acute phase



Hospital Care & Reperfusion

Antiplatelet therapy

In people with ACS with concomitant non-valvular atrial fibrillation and CHA₂DS₂VA score >1, give aspirin and clopidogrel, together with a non-vitamin K oral anticoagulant. (GRADE SOR: Strong; COE: High)

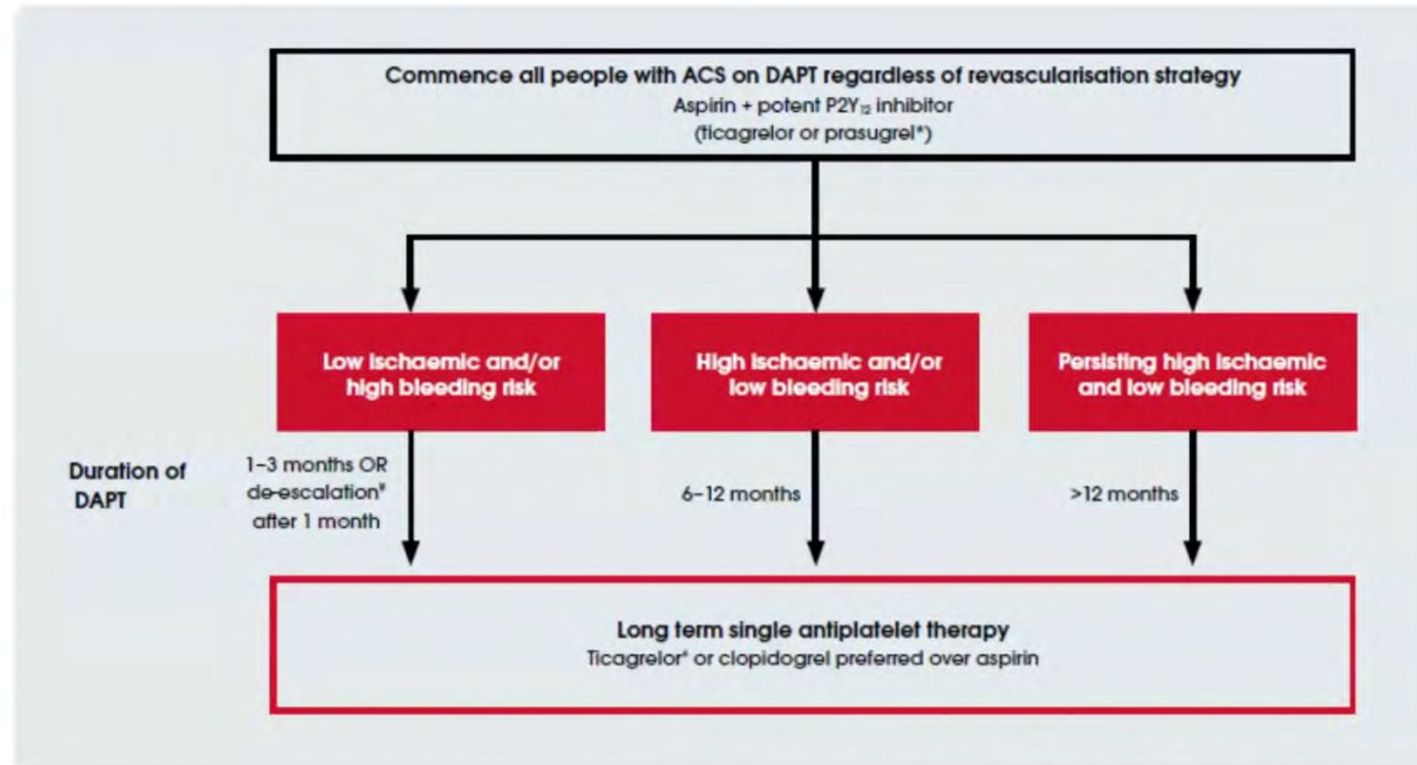
- After an initial period (1–4 weeks) of triple therapy (aspirin + P2Y₁₂ antagonist + OAC), lower bleeding rates seen with direct oral anticoagulants (DOACs) and clopidogrel compared to warfarin with continued DAPT. (PIONEER AF-PCI, RE-DUAL PCI, AUGUSTUS)



Antiplatelet therapy: DAPT duration



Recovery & Secondary
Prevention



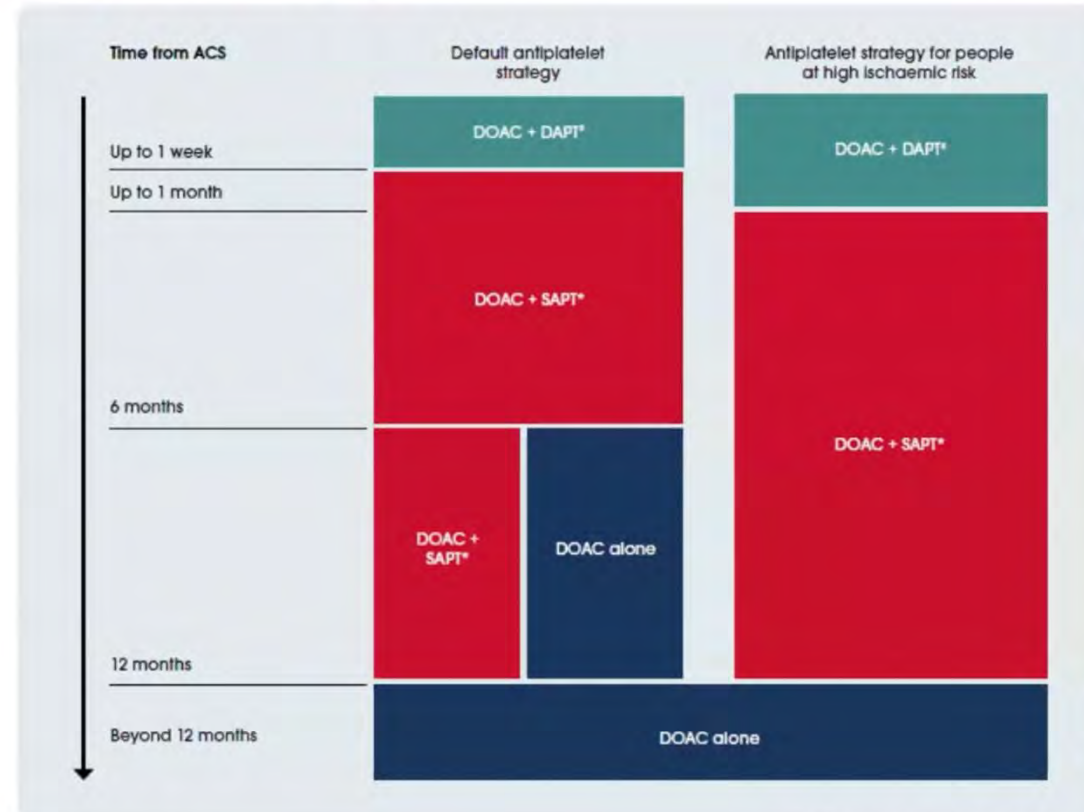
Recovery and secondary prevention

- Post ACS pharmacotherapy – DAPT, targets, colchicine
- Vaccination
- Patient centred cardiac rehab

Antiplatelet therapy: Long-term anticoagulation



Recovery & Secondary
Prevention



Lipid-modifying therapy



Recovery & Secondary
Prevention

In people with ACS, an initial target **LDL-C level of <1.4 mmol/L** and a **reduction of at least 50% from baseline** is recommended, with further benefit gained from treating to the lowest achievable level. (Consensus)

In people with ACS with a **suboptimal LDL-C level despite maximally tolerated statin therapy and ezetimibe**, give **PCSK9 inhibitors**. (GRADE SOR: Strong, COE: High)

- Reduced composite CV endpoint over a median follow-up of 2.8 years (HR 0.85 95% CI 0.78–0.93). (ODYSSEY trial)

Practice points:

- Initiate or continue high-potency statin therapy (e.g. atorvastatin or rosuvastatin) as early as possible during the ACS admission, irrespective of baseline LDL-C level.
- If already on lipid-lowering therapy prior to index ACS admission, consider intensifying existing lipid-lowering therapy.
- Re-assess total cholesterol and LDL-C levels approximately 4-6 weeks after initiating or intensifying treatment.
- For men <55 years and women <60 years with ACS, the Dutch Lipid Clinic Network score can guide the need for diagnostic genetic testing. If genetic predisposition confirmed, consider cascade testing, genetic counselling, and initiating statins in family members. (Watts et al. 2021)
- If TG level 1.5–5.6 mmol/L and LDL-C 1.0–2.6 mmol/L despite statin therapy, consider adding icosapent ethyl. (Bhatt et al. 2019) Current PBS criteria TG 1.7 mmol/L.



Other post-ACS pharmacotherapies

Renin-angiotensin antagonist therapies

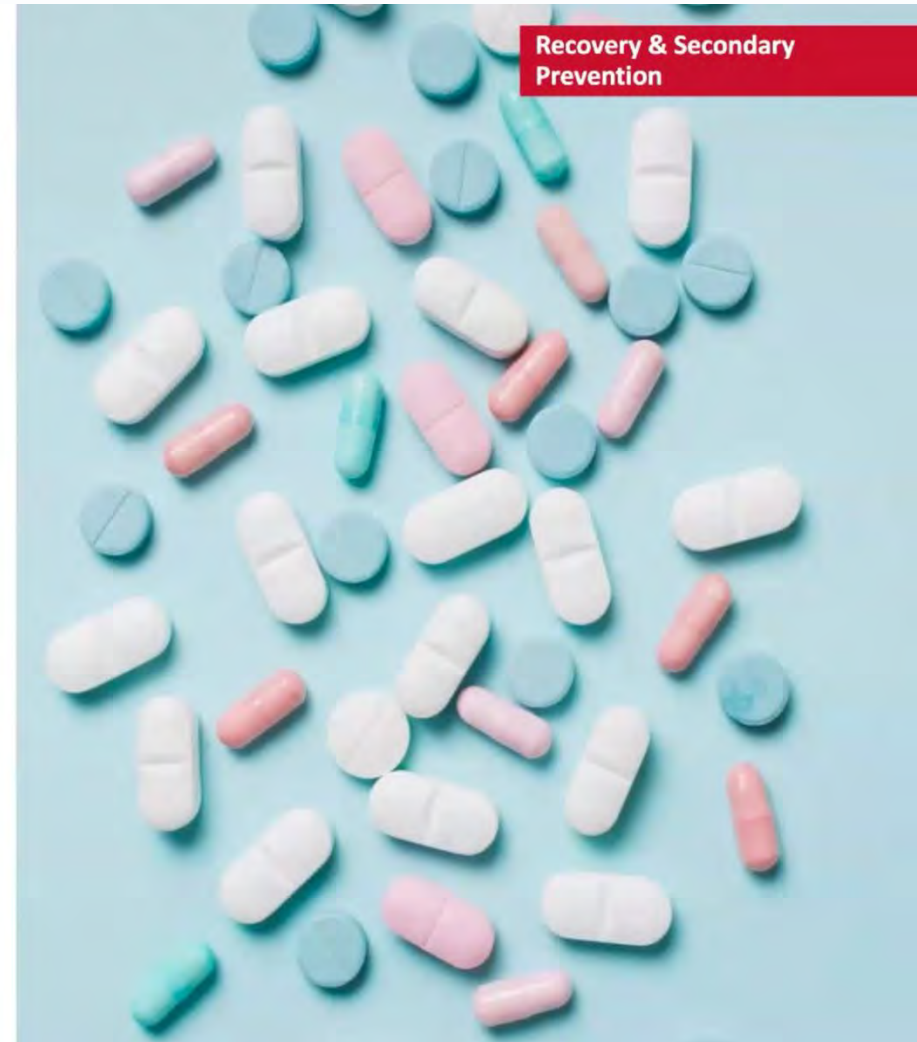
In people with ACS, use of an **angiotensin receptor–neprilysin inhibitor is not recommended**. (GRADE SOR: Strong; COE: High)

- PARADISE-MI trial (majority post-acute MI with LVEF $\leq 40\%$) assigned people to angiotensin receptor–neprilysin inhibitor or ACE inhibitor, showed no difference in CV death or incident heart failure at 22 months.

Colchicine therapy

In people with ACS, **consider initiating colchicine (0.5 mg daily) and continuing long-term unless contraindicated or colchicine-intolerant**. (GRADE SOR: Weak; COE: Moderate)

- Lower risk of coronary revascularisation and stroke, and no significant difference in mortality or MI. (meta-analysis Bao, Gu et al. 2022)
- No benefit on composite CV endpoint. (CLEAR trial)





Vaccination against influenza and other respiratory pathogens

In people with ACS, vaccinations for influenza and other respiratory pathogens are recommended. (Consensus)

- International RCT (n=2,571 people with STEMI or NSTEMI) found reduced primary composite outcome of all-cause death, MI, or stent thrombosis (HR 0.72, 95% CI 0.52–0.99) at 1 year follow-up. (Frobert, Gotberg et al. 2021)
- Meta-analysis of randomised trials and observational studies (n=240,000 people with CVD, median follow-up 19.5 months) found reduced risk of all-cause and cardiovascular mortality but not MI. (Yedlapati, Khan et al. 2021)

Practice points:

- People with CAD should receive influenza and pneumococcal vaccinations as per recommended schedules.
- ❖ Influenza vaccine can be safely administered within 72 hours of hospitalisation for AMI, including for an invasive coronary procedure. (Frobert, Gotberg et al. 2021)



Person-centred secondary prevention

For all people with ACS, provide advice on **lifestyle changes** such as healthy eating, regular physical activity, not smoking, limiting alcohol intake, and caring for mental health. (Consensus)

Practice points:

- Screen people with ACS for depression and other mental health conditions using validated tools and refer for appropriate mental health support as required.

For all people with ACS, implement strategies to optimise **adherence to preventive medicines**. (Consensus)

Practice points:

- Provide effective medicines education during hospital admission and at time of discharge.
- Implement practical strategies e.g. daily alerts/reminders, combining medicines where possible (fixed combination medicines), pharmacy-provided medicine packs.
- Consider post-discharge comprehensive medicine review.





Person-centred secondary prevention

For all people with ACS, refer to a multi-disciplinary exercise-based cardiac rehabilitation program prior to discharge. (GRADE SOR: Strong; COE: Moderate)

- Exercise-based CR associated with reductions in MI (RR 0.82, 95% CI 0.70–0.96) and all-cause hospital admission (RR 0.77, 95% CI 0.67–0.89). (meta-analysis Dibben, Faulkner et al. 2023)
- Key components of CR programs: cardiovascular risk factor management, exercise training and physical activity, nutritional advice, medicines education, mental health support.

Practice points:

- CR can be delivered in-person, remotely (e.g. telehealth) or via flexible CV risk management programs.
- Tailor CR programs, where possible, to meet the unique needs of groups with low attendance rates, including women, First Nations peoples and people from culturally and linguistically diverse communities.
- Consider use of digital health interventions e.g. reminders, SMS, mHealth apps, wearable devices.





TOPICS

RESOURCES

VIDEOS

CALCULATORS

PATIENT INFORMATION

Patient Information



PATIENT INFORMATION

Introduction to patient information



Calculators



Cardiac rehabilitation



Cardiac surgery



♥ Patient Information ^

- ♥ Introduction to patient information
- ♥ Calculators
- ♥ Cardiac rehabilitation
- ♥ Cardiac surgery
- ♥ Heart failure disease management
- ♥ Investigations, devices and procedures
- ♥ Lifestyle management
- ♥ Psychological help
- ♥ Support services within Australia

About the MyHeart MyLife patient support program

MyHeart MyLife

A free, tailored **12-week digital program** that delivers reliable heart health information, expert tips and practical tools to **support people living with coronary heart disease** to live healthier and happier lives.



Online dashboard with bite-sized articles and videos



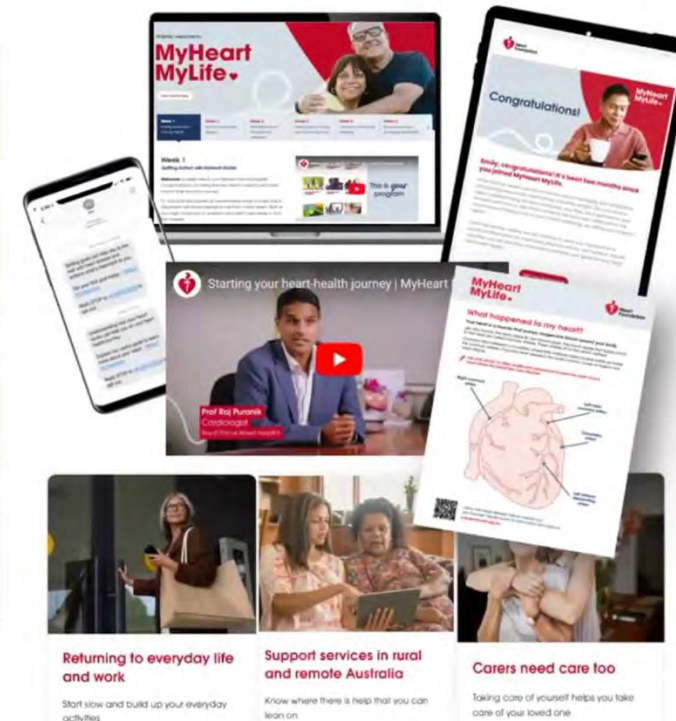
SMS and emails with practical tips



Downloadable resources



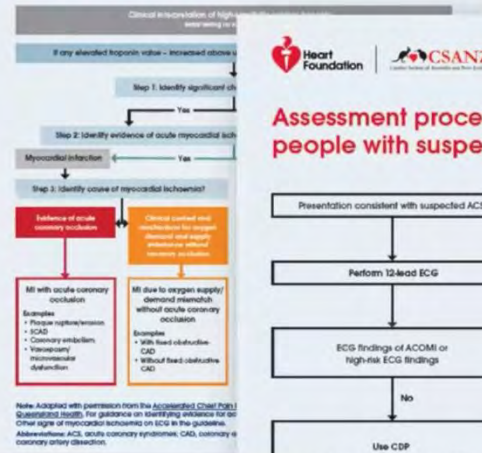
Access to the MyHeart MyLife online peer support community



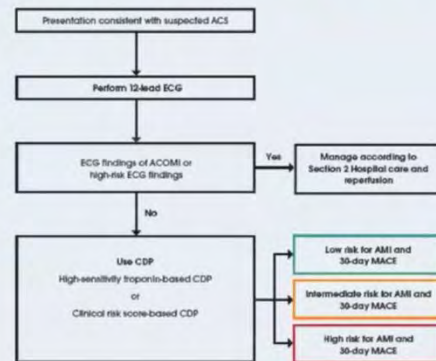
Quick reference guides for healthcare professionals

Resources

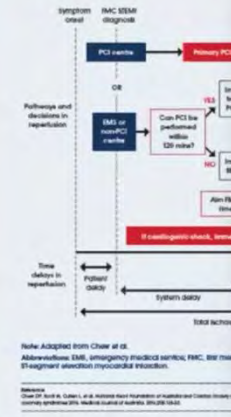
Clinical interpretation of high-sensitivity cardiac troponin results



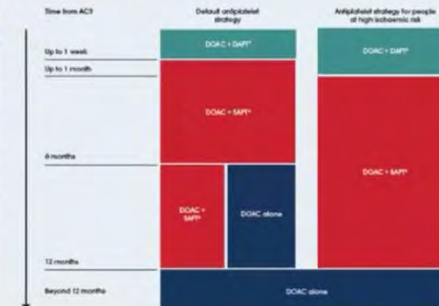
Assessment process for people with suspected ACS



Decision-making and organisation of reperfusion strategies within first 12 hours of medical contact



Recommended antiplatelet treatment strategies for people with ACS requiring long-term direct oral anticoagulant for atrial fibrillation



Implementing the new ACS guideline



Implementation

- **For patients/carers**
 - MyHeart MyLife – a support and education program for people living with heart disease and their carers, helping healthcare professionals to implement the 'Recovery and secondary prevention' recommendations for their patients.
- **Healthcare professionals**
 - Clinical education and more practical tools and resources in development.
- **Health system**
 - Support and advocacy for system-level implementation activities and alignment with national Acute Coronary Syndromes Clinical Care Standards.



LDL-cholesterol	Type 2 diabetes	Hypertension	Cigarettes	Overweight	Triglycerides
<1.4mmol/L	A1c ~7%	sBP ~120mmHg	Cessation	Aim healthy BMI ~21kg/m ²	~1.7mmol/L
Initial LDL <3 mmol/L maximally tolerated statin	Prioritise a regimen with SGLT-2i (especially with CKD) and/or GLP-1RA (especially with obesity)	Prioritise a regimen with ACE/ARB and consider combination therapy early	Consider nicotine replacement Champix or Zyban	150mins of moderate vigorous physical activity per week.	If TG>1.7mmol/L despite statin use, consider use of Omega 3 FA such as icosapent ethyl 2g BD
Initial LDL >3 mmol/L maximally tolerated statin and ezetimibe		Encouraging home blood pressure recording		Lifestyle interventions: time-restricted eating, intermittent fasting or meal replacements.	
Repeat LDL-C at (3 months and if not at target consider PCSK9 Inhibitor				Consider use of semaglutide to reduce adverse CV events	
4.Statin Intolerance: Consider bempedoic acid and ezetimibe					
If LDL > than 5 mmo/L or DLSC score > 4 initiate family cascade screening					

ANGINA ACTION PLAN



01



- ▶ If you are having angina symptoms, stop what you are doing and rest now
- ▶ Tell someone how you are feeling
- ▶ Take 1 puff of your GTN spray

02



- ▶ If you still have symptoms after 5 mins, take 1 more puff of your GTN spray

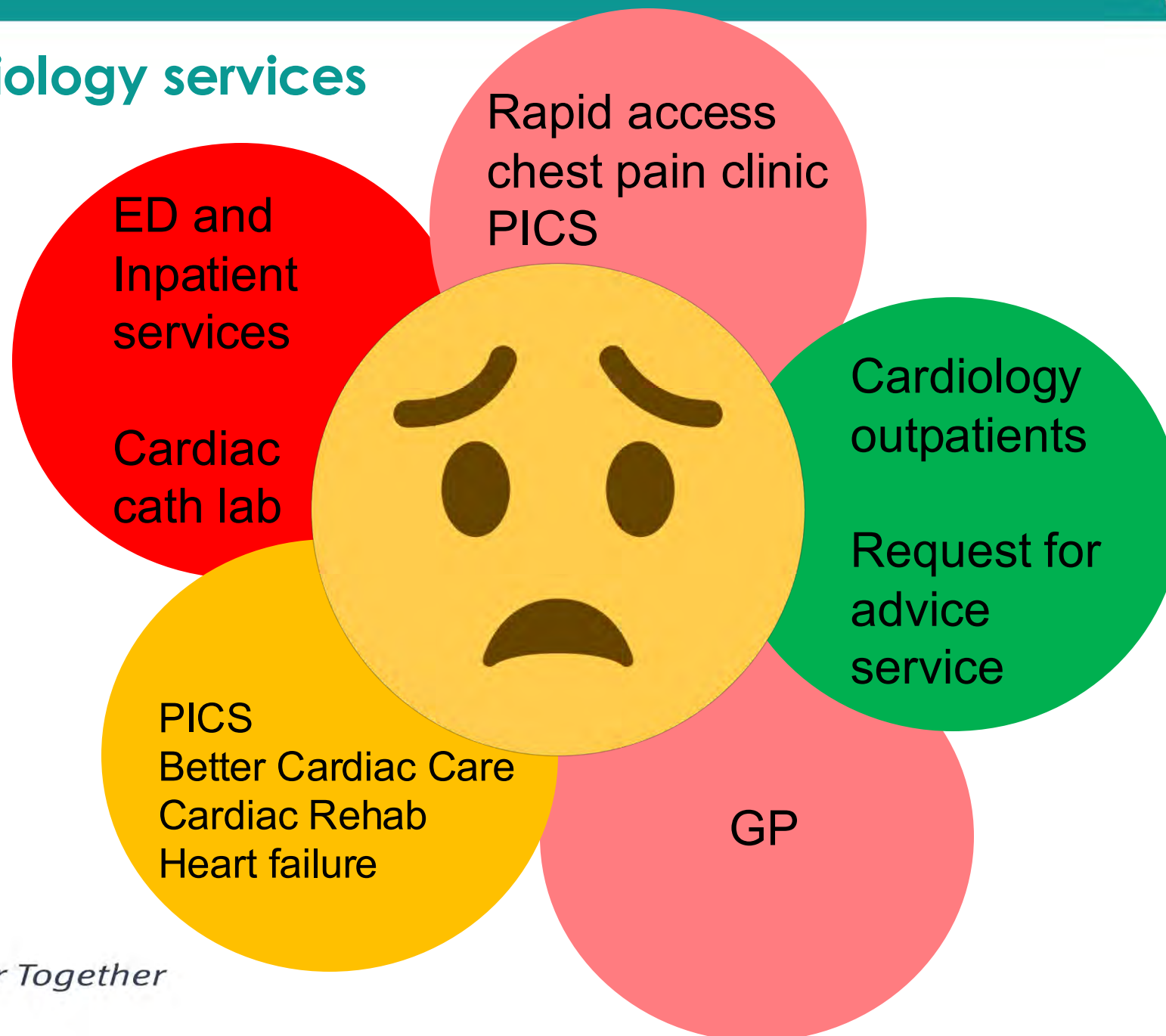
03

- ▶ If you still have symptoms after another 5 minutes, treat it as a heart attack - **dial 111 and ask for an ambulance**
- ▶ Chew an aspirin if advised by a paramedic

If your symptoms go away, you can resume your activities gently

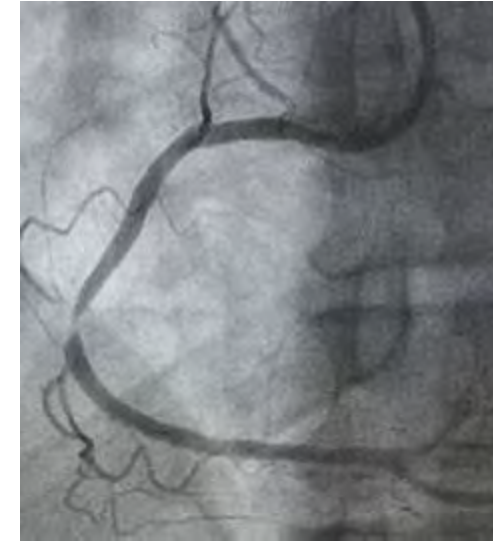
IMPORTANT - if your angina becomes more frequent, severe, lasts longer or happens when you are doing very little or resting, see your doctor in the next 24 hours

Cardiology services



In patient services

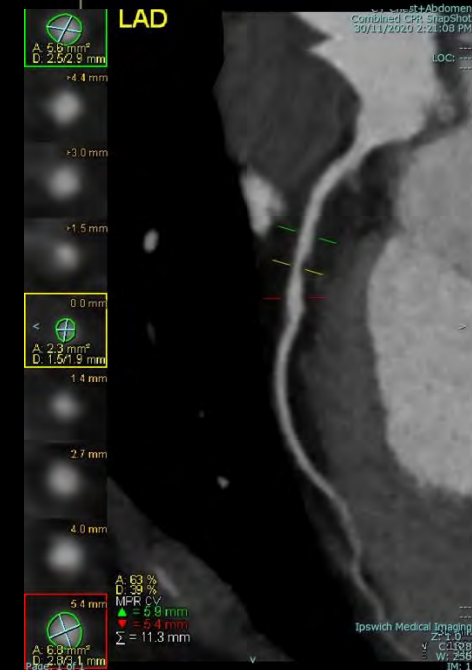
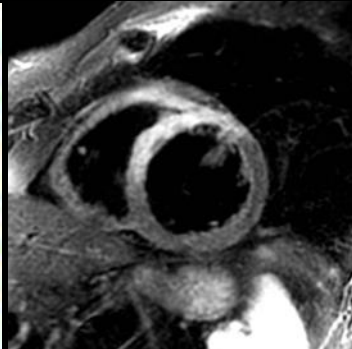
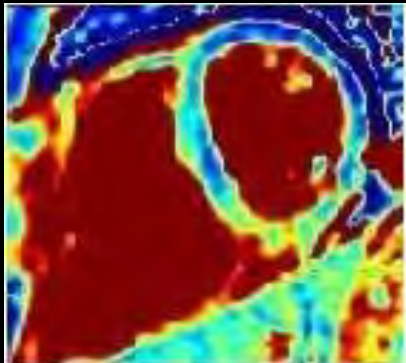
- 6 bed CCU
- 19 potential beds
- Cardiac cath lab – Mon, Wed, Friday since 2022 –
- >1500 cases treated closer to home
- Allied health inclusive of **specialist pharmacist**
- 4.5 FTE Consultant staff, training site for Cardiology advanced Trainees



Caring Better Together

Diagnostic services – Clinical measurements and Medical Imaging

- Echo
- Stress testing / stress Echo
- Holters
- CTCA
- CMRI



Rapid Access Chest Pain Clinic

- 12 years in Ipswich Hospital
- Intermediate risk patients discharged from ED
- GP referrals for stable but ischaemic sounding chest pain triaged by Cardiologist to CPAS
- Nurse lead OP model
- MDT with Cardiologist and Pharmacist to discuss optimal testing and management
- Letter to GP
- Referral - GPSR

Better Cardiac Care

CNC, Pharmacist and administrative support

Focussed on coordination of care particularly for vulnerable patients

Post discharge 30 day phone calls

Care navigation

Outreach service – Gatton, Boonah, Esk, IUIH

Goodna

Echo Gatton clinic

Contact for GPs and patients

ED alternatives

West MoretonHealth

Emergency Department alternative referral pathways

	Medical Rapid Access Clinic (MRAC) Monday to Friday 7.30 am – 3.30 pm	Preventative Integrated Care Service (PICS) Monday to Friday 7.30 am – 3.30 pm	Minor Injury and Illness Clinic 7 days a week 8 am – 10 pm	Hospital in the Home (HITH) 7 days a week 7 am – 7 pm
About this service	Refer patients who would normally be sent to the ED with medical pathology who would benefit from rapid specialist physician review but are otherwise stable to be managed in the community. Patients will be seen between 24-72 hours after the referral is accepted.	PICS provides rapid access (review within 24-48 hours) to intensive multi-disciplinary management delivered by a team of medical, nursing, and allied health clinicians, with a specific focus on supporting people with diabetes, cardiology, and respiratory chronic conditions to avoid a potential hospital presentation or admission.	The Minor Injury and Illness Clinic at Ripley Satellite Hospital provides urgent care. It is not an Emergency Department. If your patient requires an urgent ultrasound, CT or formal pathology, please refer them to the Emergency Department.	HITH provides acute care for patients with conditions requiring care equivalent to or a component of an acute hospital admission. HITH care includes home-based IV therapy for infections and fluid overload, warfarin and other medication titration, close monitoring of bloods or observations (including blood glucose), delirium monitoring and management, post-acute allied health intervention, post-acute wound care and long-term IV antibiotics. Patients will be admitted as inpatients during their care period with HITH and contacted daily and therefore Medicare billing is not permitted.
Eligibility	Phone to discuss patient before making referral	Phone to discuss patient before making referral	Phone to discuss patient before making referral	Phone to discuss patient before making referral
Telephone	3413 5868	CNC triage line: 0409 594 866	Triage nurse: 3436 3765	Intake line: 0418 177 831
Fax	3810 1253	3447 2893		
Exclusions	<ul style="list-style-type: none"> Unstable and undifferentiated patients best seen in the Emergency Department Age <16 Aggressive and agitated patients Pain Infections requiring isolation (Influenza, covid, TB) 	<ul style="list-style-type: none"> Clinically unstable requiring emergent/immediate assessment and management All residential aged care residents Age <16 years for patients 	<ul style="list-style-type: none"> Chest pain Difficulty breathing Decreased consciousness Sudden severe headache Severe abdominal pain Severe burns Late pregnancy complications Severely ill children 	<ul style="list-style-type: none"> Patient too unwell to stay home Patient not consenting to HITH care Patient requiring therapy not amenable to HITH (interventions > 12 hours per day, complex wound care, chronic wound care) Age < 15 Patient must reside in HITH catchment area (approx. 30 mins from Ipswich Hospital) or willing to attend HITH clinic in Ipswich Hospital

Preventative Integrated Care Service (PICS)

A community service that aims to reduce **avoidable admissions** and **re-admissions** in patients with **chronic diseases**, by:

- Confirming diagnosis and providing rapid access to sub-specialists
(*Consultants and NP's across **respiratory, cardiology and endocrinology***)
- Rapid assessment and intervention
- Treating exacerbations (*timely intensive **follow-up***)
- Identifying and treating co-morbidities
(*multidisciplinary approach across specialties*)
- Addressing psycho-social issues and optimising function
(*full suite of **senior allied health and nursing clinicians***)

...in a safe way

How does this work?

- 24-48 hours from triage to first contact
- Adults only (no paed)s – aim maximum 16 day episode of care
- Medical, nursing, allied health team
 - Physiotherapist, dietitian, pharmacist, occupational therapist, social work, podiatry.
- Standalone clinic at East Street (50m from Ipswich Hospital)
- Telehealth, remote biometric monitoring, home visiting services
- If referred as inpatient – must be sufficiently stable to be home without support for 24-48 hours
- Includes entire West Moreton Health catchment



Inclusion

Confirmed diagnosis of:

- Cardiovascular disease and risk factor management
- Heart failure – confirmed with one of:
 - ECHO with EF <50%, diastolic dysfunction, elevated RVSP >30, moderate/severe structural or valvular disease
- Atrial fibrillation/flutter
- *Cardiac exclusions*
- *Breathlessness at rest due to heart failure, or signs/ symptoms of pulmonary oedema*
- *Unstable*

Triage – 0409 594 866

Phone 3447 2744

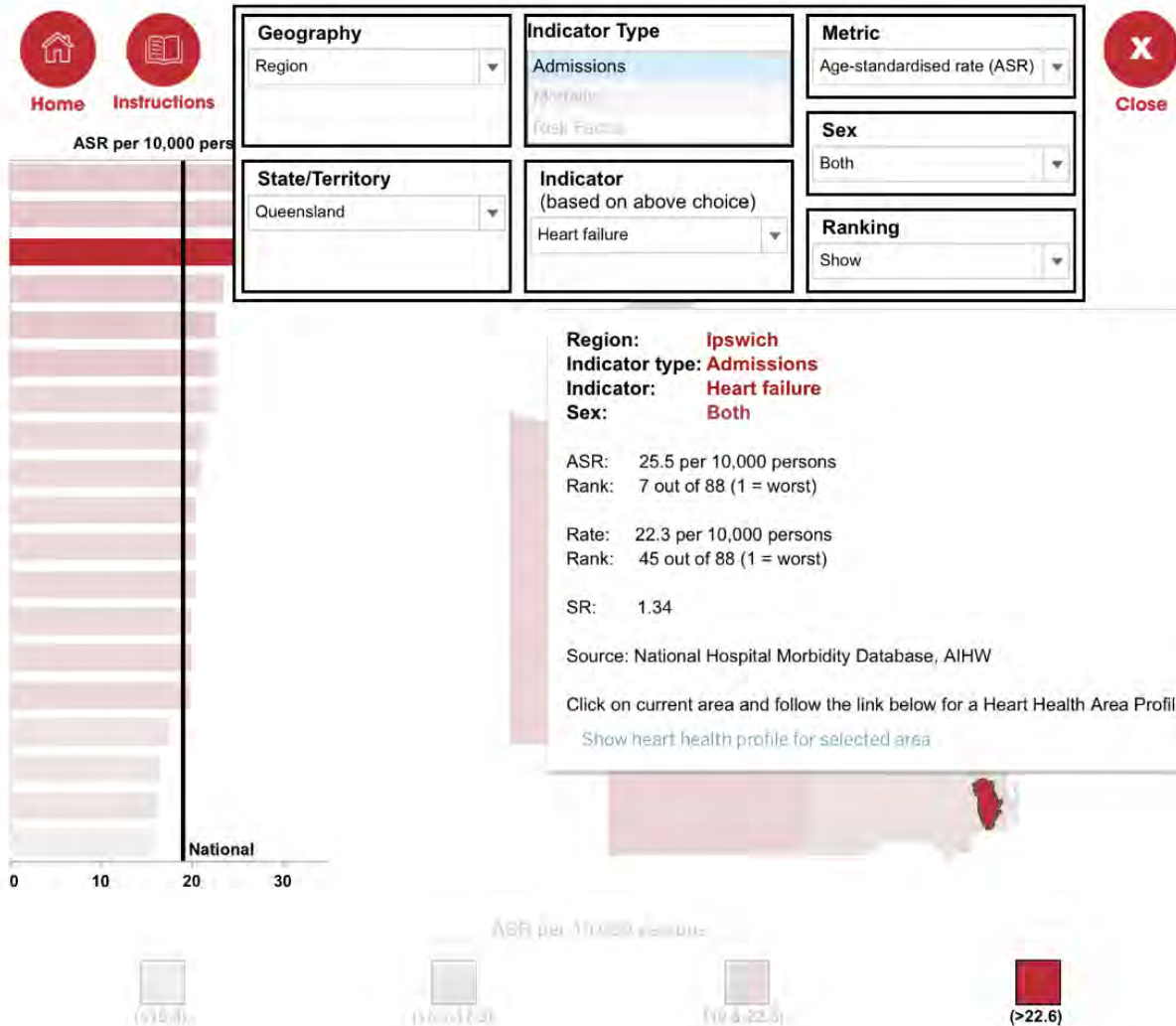


Caring Better Together

- WM_PICS@health.qld.gov.au

Interactive Australian Heart Maps

Compare heart health indicators across Australia



HEART FAILURE SERVICE

Exercise Program



Stay active. Stay healthy.
Strengthen your heart.

When:

Tuesdays & Thursdays

11:00 AM Session

12:45 PM Session

Where:

37 South Street,
Ipswich

Join our supervised 12-week exercise program designed to improve heart health, boost energy, and enhance your well-being.



Ipswich Heart Failure Service
07 3447 2866

Heart Failure service

- All patients over the age of 16 years with diagnosis of heart failure
- Case management – clinical nurse with access to Nurse practitioner and allied health staff, pharmacist, psychology, social work
- Gym
- Focus on self-management strategies
- Heart Health Hub

Referral

» WM_HFS@health.qld.gov.au

» 3447 2866 or 0439 663 420

Queensland Government

Heart Failure Fluid Action Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: ☐ M ☐ F ☐ I

Facility:

Patient information

This plan will guide you on how to fine-tune your dose of diuretic (fluid tablet) when your weight or other symptoms change.

Diuretic (fluid tablet) is: _____ One tablet = _____ mg

Daily fluid limit is: _____

Well (dry) weight range is: _____ kgs with no worsening of swelling or breathing

_____ tablet/s in the morning

Your usual fluid tablet dose:

(note number of diuretic tablets and time of day)

_____ tablet/s at lunch

_____ tablet/s (details)

Fluid overload (too much)	Dehydration
If your weight goes OVER _____ kg in _____ days	If your weight goes DOWN _____ kg in _____ days
AND / OR breathing is hard, or you have _____	And you feel thirsty or dizzy than usual,
your feet or legs, or _____	you have diarrhoea or vomiting
Take: _____ tablet/s in the _____	Take: _____ tablet/s in the morning
_____ tablet/s at lunch	_____ tablet/s at lunch
_____ tablet/s (other)	_____ tablet/s (other)

Return to your usual tablet dose when you are at your well (dry) weight again

If changes to your usual dose are needed for more than 3 days, please:

See your regular GP **OR**

Contact:

Tel: _____




Call 000 if your symptoms are severe

Prescriber name: _____

Signature: _____

Date: _____

Page 1 of 2

 <p>Queensland Government</p> <p align="center">Heart Failure Fluid Action Plan</p> <p>Facility: _____</p>	<p align="center">(Affix identification label here)</p> <p>URN: _____</p> <p>Family name: _____</p> <p>Given name(s): _____</p> <p>Address: _____</p> <p>Date of birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</p>
<p align="center">Fluid Watchers not Weight Watchers!</p>	
<p>When your heart doesn't pump properly, your body won't be able to keep fluid. This causes you to put on fluid weight. Remember that 1 kilogram = 1 kilogram.</p> <p>Keep track of your changes and weigh yourself every day.</p> <p> Weight yourself  Write down your weight</p> <p>Weight can change over time. There are many reasons for this including changes to your food intake or exercise. If your well (dry) weight has changed please see your doctor or nurse so they can adjust your plan.</p>	
<p align="center">Diuretics (fluid tablets)</p>	
<p>Medicines that help you lose fluid are called diuretics. Some people call them fluid tablets, water pills or by a brand name. The tablets take 30 minutes to work and make you pass urine for about 6 hours.</p> <p>Try taking your diuretics (fluid tablets) at the same time of day. You can sometimes delay or skip a dose to fit in with an outing but try not to do this too often.</p> <p>While fluid tablets help to manage your breathlessness and swelling, they will not improve your heart function. This means that not everyone needs a fluid tablet all the time. Fluid tablets can be increased, decreased, or even stopped as your weight or other symptoms change.</p> <p>Other instructions:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	

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Living well with heart failure

Information to help you feel better



Google Q health SGLT2i Heart Failure sick day plan

Queensland Health

Sodium-glucose co-transporter-2 (SGLT2) inhibitors for heart failure

Patient information

SGLT2 inhibitors, when used for heart failure, can help to keep you out of hospital and to live longer. The medicines work by relieving symptoms caused by fluid build-up, preventing further damage to the heart, and helping heart cells to work better. Dapagliflozin (Forxiga®) and Empagliflozin (Jardiance®) are types of SGLT2 inhibitors for heart failure.




Your SGLT2 inhibitor: (name/brand)

Possible side effects	Actions to take
Increased thirst, dry mouth, tiredness, and increased urination (more than usual).	Make sure you have enough fluid (within your fluid limits), and see your doctor if symptoms continue.
Thrush	Prevent infection* but if symptoms appear contact your doctor.
Genital area itch.	

*Prevent thrush infections by washing the genital area at least once a day (when showering) and always wear clean underpants.

Sick day rules, surgery and SGLT2 inhibitors

There is a rare risk of developing ketoacidosis (especially if you have diabetes). Ketoacidosis is when your blood becomes too acidic and is dangerous if left untreated. Symptoms include nausea, vomiting, dehydration, or difficulty breathing. To reduce the risk of ketoacidosis and severe dehydration, follow the sick day rules:

	STOP (temporarily) your SGLT2 inhibitor when you are unwell (vomiting, diarrhoea, fever) or not eating or drinking normally. If you have surgery planned, check with your doctor to see if you need to stop your SGLT2 inhibitor beforehand.
	Look out for symptoms of dehydration, passing more urine than usual and tiredness. Please see your doctor if you have these symptoms.
	Restart the SGLT2 inhibitor when you are feeling better and able to eat and drink normally for 24 to 48 hours.

Cardiac rehabilitation

- Patients who have had a recent MI (i.e. within 6 months)-ACS-NSTEMI/STEMI. Stable angina.
- Patients who have had a recent Cardiac Intervention e.g., PCI/Stent; CABG; Valvular surgery, open heart surgery
- Moderate to Severe CAD for medical management.
- Non obstructive CAD or mild CAD with a definite diagnosis of ACS.
- Focus on returning to pre-morbid activities- work, activity.
- Patients can be supported by Nurse practitioner for medication optimisation, risk factor management

CardiacRehabIpswich@health.qld.gov.au

3447 2860

- Murrumba Targan Djimbulung Service
 - Provides wrap-around health and well-being support to First Nations adults who live in West Moreton and experience chronic health issues, such as diabetes and ongoing heart and lung issues.
 - Improved engagement with outpatients
 - Expanding service. New clinic out of Laidley
 - Free exercise sessions at the Deadly Steps Together Gym
 - For more information, email WM_MTDS@health.qld.gov.au or call [3447 2717](tel:34472717).
-
- Health Pathways
 - Referral portal
 - <https://westmoreton.communityhealthpathways.org/>

LDL-cholesterol	Type 2 diabetes	Hypertension	Cigarettes	Overweight	Triglycerides
<1.4mmol/L	A1c ~7%	sBP ~120mmHg	Cessation	Aim healthy BMI ~21kg/m ²	~1.7mmol/L
Initial LDL <3 mmol/L maximally tolerated statin	Prioritise a regimen with SGLT-2i (especially with CKD) and/or GLP-1RA (especially with obesity)	Prioritise a regimen with ACE/ARB and consider combination therapy early	Consider nicotine replacement Champix or Zyban	150mins of moderate vigorous physical activity per week.	If TG>1.7mmol/L despite statin use, consider use of Omega 3 FA such as icosapent ethyl 2g BD
Initial LDL >3 mmol/L maximally tolerated statin and ezetimibe		Encouraging home blood pressure recording		Lifestyle interventions: time-restricted eating, intermittent fasting or meal replacements.	
Repeat LDL-C at (3 months and if not at target consider PCSK9 Inhibitor				Consider use of semaglutide to reduce adverse CV events	
4. Statin Intolerance: Consider bempedoic acid and ezetimibe					
If LDL > than 5 mmol/L or DLSC score > 4 initiate family cascade screening					



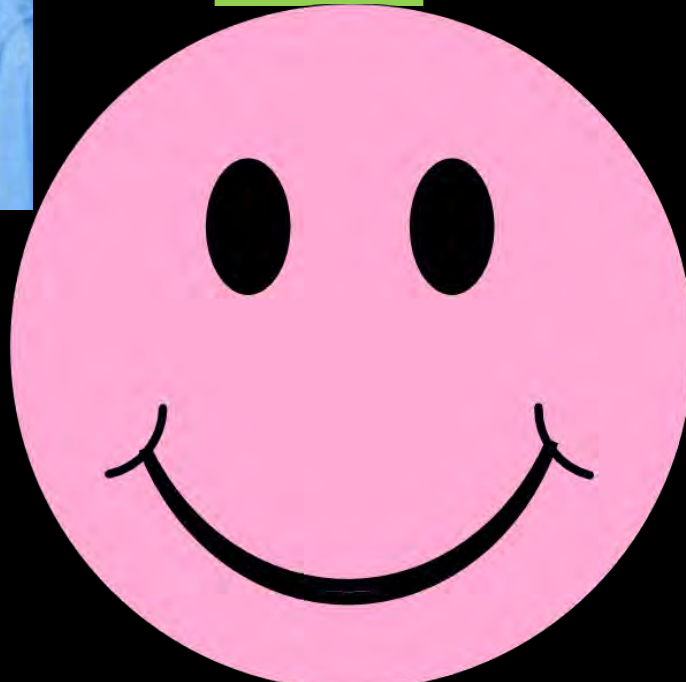
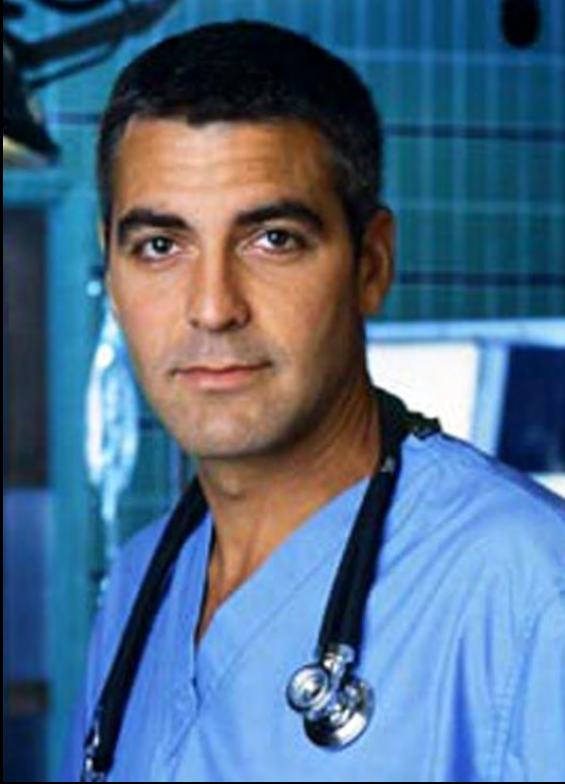
Outpatient Clinics

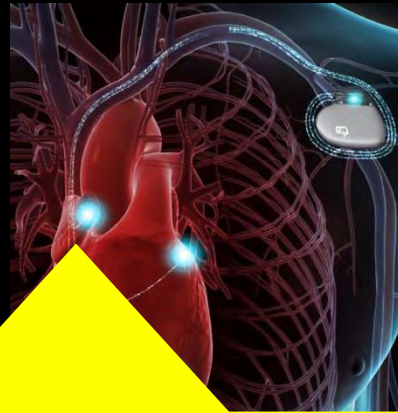
- 4.5 FTE Consultant Staff – Imaging, intervention and Heart Failure
- 10 outpatient clinics per week (not including 3 PICS clinics)
- Outreach clinics to Gatton, Boonah, Esk, UIH Goodna
- Specialist multidisciplinary heart failure clinic
- >3500 referrals per year

WMHHS Cardiology future state

- Infrastructure
 - 2027 new build
 - 14 bed CCU and additional ward and recovery beds
 - 2 cardiac cath labs
 - Dedicated imaging centre
- Relationships
 - Cohesion from hospital ↔ GP ↔ home
- Research and engagement

Approaches to therapy – Aligning goals





GPs, Community
nurses, nurse
practitioners,
exercise
physiologists,
pharmacists,
psychologists, social
workers, palliative
care

Optimal management

