CASE STUDY A

Outpatient case study:

John Brown is a 75 year old retired accountant who has been referred to Rapid Access Heart Failure Clinic with increasing breathlessness and fatigue over the last few months.

He had an MI in 2001 following by a CABG after which he was well for many years. He has type 2 diabetes, hypertension and suffers with osteoarthritis to his knees.

He lives with his wife in a three storey town house and has been having problems getting up the stairs, having to stop several times. He sleeps with 3 pillows but does not wake at night with breathlessness. He does not get any chest pain but feels very tired all the time. His appetite is reasonable. He quit smoking at the time of his MI and drinks half a bottle of wine per day.

GP referral states:

CXR with cardiomegaly and upper lobe blood diversion.

ECG sinus rhythm 76 with LBBB. B/P 110/65

Bloods: NT ProBNP 350 Na 138 K 4.2 Urea 10.6 Crea 148 Normal LFTs and TFTs Hb 14.3

Echocardiogram shows slightly dilated LV with LVEDD 5.8 reduced function EF 30%.

Current medication: Atenolol 50mgs od, Amlodipine 10mgs od, Bendroflumethazide 2.5mgs od, Metformin 1.5g evening, Simvastatin 20mgs nocte, aspirin 75 mgs od Ibuprofen 300mgs bd

What further investigations may be required?

What changes need to be made to his medication?

What further treatment may be offered?

How will you explain to the patient his condition, especially as he can't understand how he is unwell as he was cured by his CABG!

CASE STUDY B

In patient case study:

William Brown is a 52 year old labourer who has been admitted with worsening shortness of breath and ankle swelling.

CXR shows cardiomegaly and blunting of the costophrenic angles, and ECG shows fast ventricular response AF rate 130.

He denies any chest pain but says he has not been able to work for the last 4 weeks due to SOB which his GP has treated with antibiotics and a Salbutamol inhaler, although his SOB has continued to worsen. He has been sleeping propped up in bed and has been waking with 'panic attacks'. Over the last week his ankles had started swelling.

He has no past medical history of note. His father and older brother died of a heart attack in their early 60s. He smokes 10 cigarettes a day, and admits to drinking 3 or 4 cans of lager every evening, and sometimes drinks up to 10 cans per day at the weekend.

He lives alone since his divorce 5 years ago, but still sees his adult children regularly.

Echocardiogram (in fast AF) shows a dilated left ventricle with an LVEDD 7.2 and poor LV function with EF 10-15%.

He has been commenced on Lisinopril 2.5mgs od, Digoxin 250mcgs od, Frusemide 40mgs od.

You are asked to see him on the ward the day after admission: Normal U&Es, Hb 17.2, LFTs elevated Alk phos, ALT & gamma GT. B/P 140/80 ECG AF 90

1. What education does he require about his condition, and how will you go about doing this?
2. What changes would you recommend are made to his drug therapy?
3. What further investigations are likely to be needed?
4. What support should be offered to him?

CASE STUDY C

Outpatient case study

Mabel Jones is an 88 year old lady with a long history of hypertension, who last year was diagnosed with heart failure with preserved systolic function (diastolic dysfunction) after being hospitalised with severe peripheral oedema. She lives alone in sheltered accommodation, and has a daily carer.

She is complaining of feeling very weak and listless. There is no change in her degree of breathlessness she has an exercise tolerance of about 20yards, but is more limited by pains in her joints. She is sleeping with 2 pillows and does not wake with breathlessness.

HR 65 (regular), B/P 135/80, weight 52kgs (stable). On examination her chest is clear but she does have pitting oedema from ankle to mid calf.

Current medication: Ramipril 5mgs bd, Carvedilol 6.25mgs bd, Frusemide 40mgs bd, Spironolactone 25mgs od, Aspirin 75mgs od, Paracetamol 1g qds.

Bloods: Na125 K 4.9 Urea 10.4 Crea 148

What could be the cause of her symptoms?

What are the options for treatment?