Recommendations Cardiology Service - Covid 19 pandemic: ULHT

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- **We would ask that wherever possible, primary care colleagues do not refer into our elective out-patient services unless this is deemed to be clinically urgent**.
- **We are ceasing face to face clinic appointments with immediate effect, and all routine echocardiography and rhythm monitoring for routine will also be suspended.**
- **Urgent echocardiograms to facilitate cancer care and urgent surgery will be vetted prior to booking.**
- **Clinics will be conducted via telephone for patients during the next 12 weeks or so.**
- **We have a well-established electronic Advice and Guidance service, with feedback from most users of this service rating it quite highly**.

Summary advice:

- Use **Advice and Guidance** wherever possible rather than referring up to clinic either via Choose and Book or via letter.
- **Rapid Access Chest Pain Clinic (RACPAC)**: Our ACPs will vet referrals and conduct telephone consultations and offer advice on management. Routine investigations for these patients **WILL NOT** be occurring over the next 12 weeks, but possibly longer, after which there may be further delays whilst the backlog is cleared. Please only refer patients in whom you consider the chest pain is CARDIAC in origin. We shall not be accepting referrals for non-specific or atypical symptoms as these are likely to be common in the following few weeks. We are requesting that patients have an ECG sent with the referral as these will be telephone appointments and we are trying to avoid the patient visiting hospital. It is likely that those with unstable angina symptoms will have to be admitted to hospital for further management. Remember – if you feel the symptoms represent TYPICAL angina then it is entirely acceptable to start treatment for this, as this is what we will recommend if they are spoken to over the telephone. Aspirin, Beta-blocker, statin and a s/L GTN spray to start which can be up-titrated as required. In elective angina then angiography and PCI (both will also be temporarily suspended) are usually only indicated when failure of optimal Medical Therapy (2 anti-anginals at maximally tolerated doses) fails to control symptoms.
- **Palpitations:** We will largely go off the patient's history when determining how to manage these patients until elective investigations are once again freely available. Remember more worrying palpitations are in those with structural heart disease, palpitations in association with syncope or in those with a family history of sudden cardiac death. The vast majority of the remainder are relatively low risk and are likely to be prioritised as such. An ECG is the easiest and most available way you have of helping exclude this without the benefit of echo, and also helps pick up any abnormalities such as short PR/Long QT/Brugada etc. If the ECG is normal then it is easier to reassure – we are happy to review scanned ECGs in such patients presenting with palpitations via A and G.

Be aware:

- ✓ **the vast majority of palpitations are benign in nature. Patients who are describing typical awareness of ectopic activity with a normal ECG can largely just be reassured without any further investigations.**
- ✓ **Given these will all be telephone consultations, again, an ECG should be sent with all referrals.**

- **Heart failure:** These clinics will also go to telephone clinics and are likely to generate FP10s rather than hospital prescriptions. We will temporarily try not to up titrate Entresto etc to reduce the burden of patients requiring blood tests and follow-up appointments. These are long term treatments for patients with LV dysfunction, and temporarily interrupting escalation in therapy for 10-12 weeks is unlikely to be significantly detrimental. New heart failure patients should have standard initial therapy (furosemide, ACE inhibitors, Betablockers) commenced and up titrated in the community where possible. We will be trying to keep vulnerable patients with heart failure away from hospital as much as possible over the next few months so judicious use of diuretic therapy will be indicated in a reasonable number. Again – we can offer advice about this via A and G remotely in most cases.

Be aware:

- ✓ **As yet there is no service to provide community IVI Furosemide.** If introduced - It would be very helpful for the community heart failure team to consider options for providing short duration (2-3 days) IV diuretic therapy in the community for deteriorating heart failure patients (under direction from a cardiologist) to try to avoid hospital admission where possible.
- **Hypertension:** there is a robust National and International guidance to guide management in primary care in this area. We will not be accepting routine referrals regarding blood pressure control or routine investigation of hypertension during this period. Accelerated/malignant or complicated hypertension of patients such as those with neurological deficit. Dissection, renal failure etc will continue to be managed on an IP basis as emergencies**. Primary Care has provided a useful resource information sheet for patients to take their own blood pressure at home with a patient home blood monitoring record chart (see attached).**
- **Valve disease:** all surveillance/management of stable valve disease will be deferred for 12 weeks. Highly symptomatic patients or those requiring emergency/urgent intervention such as valve surgery will need to be admitted and dealt with on an in-patient basis
- **Syncope:** Those that are characteristically vasovagal in nature do not require further investigation and can usually be treated with general measures. Avoid standing for prolonged periods, keep hydrated, adding salt to diet if required and pre-emptive avoidance measures when pre-syncopal such as lying down. Red flags for syncope as those with an abnormal EG/Structural heart disease (such as pre-existing heart failure), exertional syncope , family history of sudden cardiac death (usually aged 40 years or below), or syncope associate with chest pain or acute onset breathlessness.
- It is obviously not possible to cover every clinical eventuality or individual presentation, but hopefully this gives some general guidance to help over the next few months? Please discuss specific patients or concerns with us directly, or via A and G. **Refer to the Speciality guides for patient management during the coronavirus pandemic: Clinical guide for the management of cardiology patients during the coronavirus pandemic 20 March 2020: Version 1 for further advice not referenced above if needed.**
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