PODCAST SERIES: Managing the Post-MI Patient: Perspectives in Primary Care

Podcast 1: Cardiac Risk and Chronic Disease Management in Primary Care

Host: Milan Gupta, MD, FRCPC, FCCS, FACC, FAHA

Guest speaker: Vivien Brown, MDCM, CCFP, FCFP, NCMP

Edited slightly for readability.

Milan Gupta
Welcome to this podcast series, hosted on MDListen, entitled Managing the ***Post-MI Patient: Perspectives in Primary Care.*** My name is Dr. Milan Gupta. This podcast series was developed by the Canadian Collaborative Research Network and is accredited. Each podcast is worth 0.25 Mainpro+ credits. And if you complete all four podcasts in the series, you will be able to claim one full credit. Today's is the first in the series of four podcasts and today we are focusing on cardiac risk and chronic disease management in primary care. The learning objectives and our faculty and program disclosures along with other relevant information are all available at the MDListen tab at MDLearn.com, where participants can also download a handout with key messages. It's my pleasure to be discussing this topic today with my colleague, Dr. Vivien Brown. Dr. Brown is a family physician in Toronto and a noted educator. Vivien, welcome.

Vivien Brown
Thank you so much, my pleasure to be here.

Milan Gupta
Disclosures for myself and Dr. Brown are listed in the program handout available for download. This program received financial support from Amgen Canada, and the planning committee took all steps necessary to mitigate potential bias. These steps are also listed in the handout. So, Vivien, to prime our pumps, if you will, I'm going to give you a brief case outline, which I believe is a fairly typical type of post-MI patient that you might see in family practice. This is a 62-year-old woman. She's a financial analyst at a bank. She has long standing diabetes, hypertension, she's an ex-smoker, she has a history of stable coronary disease. And she was recently discharged from hospital following a non-ST-elevation MI, she had two vessel stenting, had mild LV dysfunction with no major complications. And she was discharged on the usual post-MI cocktail of medications. With respect to her lipids, she was discharged on a high intensity statin, that being atorvastatin 80 mg once a day. So, right off the top of your head, is this typical type of patient a family physician sees in practice? And if so, what are some of the key points that come to your mind as you see this patient on your day sheet and are preparing to go and see them? What are you thinking about? What are you hoping to instill in the patient?

Vivien Brown
Well, I think this is a very typical patient, multiple comorbidities, ex-smoker. This is the kind of thing that we do see. And I think it's really important that we have some notion of exactly what went on in the hospital, some discharge summary so that we can follow this patient and help the patient understand that they now have a chronic disease. They didn't just have a bypass mechanically of a local problem. And I think that concept of understanding that this is an ongoing issue is sometimes very hard for a patient to accept. They're in the hospital and the cardiologist says, you're fine, and you're okay, and we did a stent and you're done. Well, you're not done. And I think part of what family practice needs to do is to really explain what drugs someone is on and why. Why are they on dual antiplatelet therapy and for how long? What is important about this cocktail, as you said, that they got leaving the hospital? Because I think if people understand what they're taking, they're more likely to adhere to the regimen that's been advised.

Milan Gupta
We obviously understand as physicians that medications are necessary in life saving in patients following an MI. But what about the role of behavioral and lifestyle modifications, participation in cardiac rehab? Is that a discussion point for you with these patients?

Vivien Brown
Absolutely. There is a waitlist for cardiac rehab, but I think it's really important so that patients understand they're making changes for the rest of their life. They're not trying to lose weight for an event or be really good for the next blood test. They're really making changes that they can live with. And I don't underestimate the importance of the lifestyle changes. You know, the drugs are excellent, and that's important. But lifestyle changes, for example, someone learning to quit smoking, is going to have a huge impact on their long-term longevity.

Milan Gupta
Excellent. Now, we know that lipid management and specifically LDL cholesterol-lowering really is foundational in the prevention of coronary disease and is particularly important in the post-MI patient because the risk of recurrent events is highest in the first few months and certainly in the first year after an MI. What often gets lost in the mix, though, is the patient is discharged, in this case on a high intensity statin, without any explicit instructions as to timing of follow-up for reassessing the LDL cholesterol, or even who is responsible for that. Should it be the family doc? Should it be the cardiologist? Should it be the cardiac rehab clinic? So again, in your practice, who takes ownership of lipid management for these high-risk patients, and what is what is the timing around when you want to reassess the patient's lipid profile?

Vivien Brown
Milan, quite truthfully, you're talking to a family doctor who's biased in favor of family medicine. You know, I think in the long run it's family medicine that's going to take care of this patient for ongoing issues. And whether I see the patient back at that two-week interval from discharge, which is what is encouraged in family medicine, hospital discharge, see within two weeks, or whether I see that patient closer to four weeks. By four weeks I want to do some blood tests and I want to see where someone is going. I know this podcast is all audio. But I actually brought one of the models that I use. I was going to show this on

screen to explain to patients why lipid lowering is so important. And why, of course, blood pressure lowering is so important, because those two things together I think are in the hands of the family doctor. We see the patients. Often, they come in with family members, they may be coming in for flu shots, they're coming in for different things at different times. And so that ongoing relationship is really important. And we don't want to discourage the value of diet and exercise and making good lifestyle choices. But we need to be very clear about what is modifiable for this patient and what isn't.

Milan Gupta
I think that last point is particularly important because often patients believe that lifestyle changes can have major effects on LDL cholesterol. And while we know they can have major effects on triglycerides, on glucose, dietary changes have very modest effect on LDL. And I think, like you said, if patients become educated about that it may make them more willing to be adherent with their long-term statin therapy. When would you typically recheck the lipid profile in a patient discharged following an MI?

Vivien Brown
I personally want to do this quickly. I want to do this by four to six weeks because I want them to see the numbers. Patients love knowing their numbers, there's no question about that. And if they see how successful they are, and how low their LDL is, if they've got their LDL to the threshold that we're aiming for, it's extremely reassuring, and they're more likely to continue, and they're more likely to have a good concept. Alternatively, if by four weeks, which is a short timeframe after a heart attack, patients are generally listening in that first four weeks, they want to do everything right so they don't end up back in emergency. And if at four weeks, they clearly are far from the threshold that we're looking for, it really is time to have a discussion and move forward about other choices.

Milan Gupta
You know, family docs are usually the first point of care following hospital discharge, right? A patient like this may very well come and see their cardiologist but that often may not happen for several months after an MI. And hopefully, the messaging will be reinforced at the cardiology visit as well. So, it sort of brings home that whole concept of collaborative or shared care. But I agree with you, family docs are vital in helping our patients get to their targets, whether their lipids or blood pressure or even lifestyle. We talked about the timing of labs when you typically make an adjustment in lipid therapy, whether it's increasing a statin dose or adding a second agent. Again, when do you bring that patient back? Or do you? Do you then recheck the lipids and book another follow-up? Or do you assume that the lipids will end up where you want them? How do you handle that?

Vivien Brown
I think for the patient, they need to understand that this is important. They need to understand that this is urgent. I can't go away and say, go home for three to six months and watch your weight and watch your diet, and we'll see how it goes. That's fine in a very low-risk person, maybe for primary prevention, when we're just talking about lifestyle. But in someone that's just had an event, I want to know that they are at their threshold as quickly as possible. So, if I'm adding in a second agent, I'll again repeat their blood in four to six weeks. And the reason I say four to six weeks is because everybody has something in their life. Four weeks is not always doable for everyone. And that's fine, we can wait as long as six, but I'm not sending them away for three months. When I give them that lab requisition, either in their hand, or I've

emailed it to them, I explain why I'm doing liver function, why I'm going to accept minor changes in liver function. I want them to understand that this is ongoing care, this is not a one-shot deal. People now can access their own results, and if their ALT is 40 instead of 36, they'll phone you and say something's wrong. I think we need to really manage expectations when we give that requisition so that they know what to expect, and why we're watching this so closely. Now the whole goal is to prevent another event.

Milan Gupta
Very good. So just in closing, then, the post-MI patient is at very high risk in those first few months or a year. But eventually they transition, hopefully, into a patient with stable coronary disease and a more manageable risk profile. And that brings up the whole area of chronic disease management in primary care. What would you say are your key messages around chronic coronary disease management?

Vivien Brown
I think that patients need to understand that they are automatically high risk forevermore. That doesn't mean walking out the door, they're going to have an event, but they are high risk because they've already had their first event. And what we want to do is help them be a partner in their health care management, in order to continue to be adherent to the choices that they're making - the medications, the lifestyle changes. You know, I think patients get fatigued. We talk about vaccine fatigue now with COVID. I think patients get fatigued about hearing they have chronic heart disease. And my role as their doctor is to say, yes, you've got chronic heart disease, but our goal is to keep it stable, to keep you low risk, to keep you independent, to keep you in the community. That's what this is all about. And I think what we really want to do is be aggressive right from the get-go so that people take this seriously, understand that whether they've had a bypass or a stent or whatever, it's not just that vessel in that location. This is a chronic disease in all their vessels, and we can manage it well. But only if they're a good partner. I can't fix what they don't want to fix.

Milan Gupta
If I were to summarize what you're trying to tell me, it sounds like, clearly there's got to be a collaborative approach between the family physician and the patient. Communication is key so that the patient understands they now have a chronic disease placing them at high risk, and that while lifestyle modifications are always helpful, they're going to need additional help in the form of medications, in this case, to get their LDL to below treatment thresholds. And that close is not good enough. We need aggressive care to maximally improve their long-term outcomes. And that if our patients and our family physicians and the rest of our healthcare team work well together with these goals in mind, we should be able to do very good for our patients.

Vivien Brown
You know, Milan, I've used the term that it's time for aggressive prevention. And what we want to do is prevent another episode. This patient's already been identified. We know they have chronic disease. Let's prevent another episode.

Milan Gupta
Couldn't agree more. Vivien, it's been a great pleasure speaking with you today. I'd like to thank you.

Vivien Brown
My pleasure.

Milan Gupta
And for our listeners, just a reminder that following the podcast, you can complete the reflective exercise and program evaluation, and you'll then receive a certificate by email of your participation. I'll remind all of you that this was the first in a series of four podcasts centered on the topic of managing the post-MI patient in primary care. Podcast number two, entitled ***Clinician Self-reflection and Cardiac Risk Reduction*** is coming soon. And we look forward to joining you then.

References

Gouda P, Welsh RC, Padarath M, Grégoire JC, Hegele RA, Gupta M. Landscape of lipid management following an acute coronary syndrome event: survey of Canadian specialists. *CJC Open*. 2020;2(6):625-631. doi:10.1016/j.cjco.2020.08.009

Wong GC, Welsford M, Ainsworth C, et al. 2019 Canadian Cardiovascular Society/Canadian Association of Interventional Cardiology guidelines on the acute management of ST-elevation myocardial infarction: focused update on regionalization and reperfusion. *Can J Cardiol*. 2019;35(2):107-132. doi:10.1016/j.cjca.2018.11.031