

**Dificultades para la
aplicación de las Guías en la
práctica clínica.**

Manejo de la Enfermedad Cardiovascular en España.

Aplicación de las Guías

- Situación del tema:
 - ¿Aplicamos las guías en España?
- ¿Por qué?:
 - Algunas de las posibles causas
- Posibles soluciones

¿Aplicamos las guías en España?

SPECIAL COMMUNICATION

Executive Summary of the Third Report of the National Cholesterol Education Panel (NCEP) Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III)

Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults

The Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) summarizes the National Cholesterol Education Program (NCEP) updated clinical guidelines for cholesterol testing and management. The third NCEP document is an evidence-based, and extensively referenced report that provides the scientific rationale for other recommendations contained in the report on treatment of hypercholesterolemia. The report also updates and expands the indications for treatment of hypercholesterolemia. The report also provides information on the clinical practice of lipid management, which must ultimately determine the appropriate treatment for each individual.

The most ATP report updates the existing recommendations for cholesterol management of high blood cholesterol. The NCEP guideline provisions ATP III clinical guidelines are based on evidence from clinical trials conducted by scientists and clinicians.

LDL CHOLESTEROL: THE PRIMARY TARGET OF THERAPY
Research has repeatedly demonstrated

that a major benefit of ATP III outlined a strategy for primary prevention of coronary heart disease (CHD) in persons with high levels of low-density lipoprotein (LDL) cholesterol (≥190 mg/dL) and moderate to high levels of high-density lipoprotein (HDL) cholesterol (50-100 mg/dL) and moderate to high triglyceride (TG) levels (150-200 mg/dL). ATP III also updated the importance of the aggressive and individualized treatment of coronary artery disease (CAD) in persons with moderate to high LDL cholesterol and moderate to high TG levels. ATP III also updated the importance of the aggressive and individualized treatment of coronary artery disease (CAD) in persons with moderate to high LDL cholesterol and moderate to high TG levels.

RISK ASSESSMENT
ATP III also updated the importance of the aggressive and individualized treatment of coronary artery disease (CAD) in persons with moderate to high LDL cholesterol and moderate to high TG levels. ATP III also updated the importance of the aggressive and individualized treatment of coronary artery disease (CAD) in persons with moderate to high LDL cholesterol and moderate to high TG levels.

When ATP III provides information on the management of patients with CHD, the major new addition is a focus on primary prevention in persons with moderate to high LDL cholesterol and moderate to high TG levels. The report also provides information on the management of patients with CHD, the major new addition is a focus on primary prevention in persons with moderate to high LDL cholesterol and moderate to high TG levels.

LDL CHOLESTEROL: THE PRIMARY TARGET OF THERAPY
Research has repeatedly demonstrated

SPECIAL COMMUNICATION CLINICIAN'S CORNER

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure: The JNC 7 Report

Arun V. Chakraborty, MD
George L. Black, MD
Henry H. Black, MD
William C. Cushman, MD
Lynn C. Gross, MD, MPH
Joseph J. Stam, Jr, MD
Harold W. Jones, MD
Barry J. Mannan, MD, MHA
Nathan Sprott, MD
Jacklyn T. Wright, Jr, MD, PhD
Edward J. Borucki, PhD, MPH
and the National High Blood Pressure Education Program Coordinating Committee

BACKGROUND
The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) is the seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC). The report provides clinical guidelines and advice designed to increase awareness, prevention, treatment, and control of hypertension (high blood pressure [BP]). Since the publication of "The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (JNC VI) released in 2002,¹ many large-scale clinical trials have been published.

The decision to appoint a coordinator for "The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (JNC 7) was made by the JNC 7 Steering Committee.

"The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" provides a guideline for hypertension prevention and management. The following are the key messages: (1) In persons older than 50 years, systolic blood pressure (BP) of more than 140 mm Hg is a much more important cardiovascular disease (CVD) risk factor than diastolic BP (DBP). (2) The risk of CVD begins at 115/75 mm Hg, doubles with each increment of 20/10 mm Hg, and individuals who are normotensive at 55 years of age have a 90% lifetime risk of developing hypertension. (3) Individuals with a systolic BP of 130 to 140 mm Hg or a diastolic BP of 80 to 89 mm Hg should be considered as hypertensive and require health-promoting lifestyle modifications to prevent CVD. (4) Thiazide-type diuretics should be used in drug treatment most patients with uncomplicated hypertension, either alone or combined with drugs from other classes. Certain high-risk conditions are exceptions for the initial use of other antihypertensive drug classes (ie, insulin-cooperating enzyme inhibitors, angiotensin-receptor blockers, beta-blockers, calcium channel blockers). (5) Most patients with hypertension will require 2 or more antihypertensive medications to achieve goal BP (<140 mm Hg, or <130/80 mm Hg for patients with diabetes or chronic kidney disease). (6) BP is more than 20/10 mm Hg above goal BP, consider should be given by initiating therapy with 2 agents, 1 of which usually should be a thiazide-type diuretic, and (7) The most effective therapy prevents the most careful clinician will control hypertension only if patients are treated. Motivation improves when patients have positive experiences and trust in the clinician. Empathy builds trust and is a potent motivator. Finally, in presenting these guidelines, the committee recognizes that the responsible physician's judgment remains paramount.

CONCLUSIONS
The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) is the seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC). The report provides clinical guidelines and advice designed to increase awareness, prevention, treatment, and control of hypertension (high blood pressure [BP]). Since the publication of "The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (JNC VI) released in 2002,¹ many large-scale clinical trials have been published.

The decision to appoint a coordinator for "The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (JNC 7) was made by the JNC 7 Steering Committee.

CLINICIAN'S CORNER

European Heart Journal (2003) 24, 469-470



Executive summary European guidelines on cardiovascular disease prevention in clinical practice Third Joint Task Force of European and other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of eight societies and by invited experts)

Guy De Backer (Chairperson)*, Estere Ambrósio†, Knut Borch-Johnsen, Carlos Brotons*, Renata Cifkova*, Jean Dallongeville*, Shah Ebrahim*, Ole Faergemaa*, Jan Graham*, Giuseppe Mancini*, Volker Manger††, Kristina Orsh-Gomer*, Joop Perk*, Kalevi Pyörälä*, José L. Rodicio*, Susana Sans*, Václav Seber*, Udo Sechtem*, Sigmund Silber*, Troels Thomsen*, David Wood***

Other experts who contributed to parts of the guidelines: Christian Albes, Marl Beger, Guille Borral, Roman Conroy, Hans Christian Dorner, Christoph Hermann-Lingen, Steffen Haughey, Anthony Fitzgerald, Brian Chubb, Neil Schwenken, Arndt Vahedi, Rodford Williams, John Verwey

ESC Committee for Practice Guidelines (CPG): Silvia G. Priori (Chairperson), Maria Angeles Alonso Garcia, Jean-Jacques Blanc, Andrius Budrys, Martin Conley, Veronica Dean, Jaap Douma, Enrique Fernandez-Berni, John Leshem, Ravi Livi, Gianfrancesco Nicolucci, Kersti Reindlinger, John Reunanen, Arif Özyürek, Olof Sennarath, Hans-Joachim Trappe

Disclaimer: Statements in this document have been reviewed by experts, recommended by their societies, who were independent of the Task Force. Andrius Budrys (CPG Review Coordinator), Carl David Appleby*, Philip Bevilacqua*, José Benavente*, Aislinn Bradley*, Anthony Burnett*, Robert Calver*, Philip Harris*, Simeon Pevsner*, Pekka Pulkki*, Mike Rayner*, Anuika Ravarino*, Maria Saavola*, James Shepherd*, Johannes Steiniger*, Mathias Simon*, Michel Tender*, Alberto Tenaglia*

Preamble
Cardiovascular disease is the leading cause of death and disability in many countries. The burden of cardiovascular disease is increasing worldwide. The European Society of Cardiology (ESC) and other societies have issued recommendations for preventing and managing cardiovascular disease. This document is a joint effort of the ESC and other societies to provide a comprehensive, evidence-based, and practical guideline for the prevention and management of cardiovascular disease. The guideline is intended to assist clinicians in their decision-making process. They should be helpful in everyday clinical decision-making. A great number of guidelines have been issued in recent years by different organizations: European Society of Cardiology (ESC), American Heart Association (AHA), American College of Cardiology (ACC), and other related societies. By means of links to web sites of National Societies general guideline documents are available. This guideline can also be found on the ESC and other societies websites, which can be downloaded in other languages. This is one of the reasons why the ESC and others have issued recommendations for formulating and publishing guidelines.

© 2003 European Society of Cardiology. Published by Elsevier Ltd. All rights reserved. 0954-6820/03/\$ - see front matter. DOI: 10.1054/euhj.2003.24.4.469

See also pp 2346 and 2349-2351.
© 2003 American Medical Association. All rights reserved.

See also pp 2346 and 2349-2351.
© 2003 American Medical Association. All rights reserved.

El estudio DISEHTAC II: diagnóstico y seguimiento de la HTA en Cataluña. Comparación con datos de 1996.

- **OBJECTIVO:** Evaluar los cambios en el diagnóstico y seguimiento de la HTA, y en la evaluación del riesgo cardiovascular, en una población atendida por centros de AP en Cataluña.
- **PARTICIPANTES:** Doce EAP elegidos entre los 31 que participaron en el estudio DISEHTAC I (1996), con un total de 990 registros de pacientes.
- **FECHA:** 2001

El estudio DISEHTAC II: diagnóstico y seguimiento de la HTA en Cataluña. Comparación con datos de 1996.

RESULTADOS:

De los 171 nuevos casos diagnosticados de HTA

- » Solo 16.7% fueron diagnosticados en base al menos 3 pares de medidas (triple toma) o como resultado de un episodio agudo de HTA.
- » Se realizó despistaje de FRCV, para poder realizar estratificación, solo en el 50.4% de los pacientes (63.1% en 1996).

ESTUDIO ELIPSE: PREVENCIÓN SECUNDARIA EN PACIENTES CON CARDIOPATÍA ISQUÉMICA (ÁMBITO: ATENCIÓN PRIMARIA, CIUDAD REAL)

% de pacientes en cifras objetivo



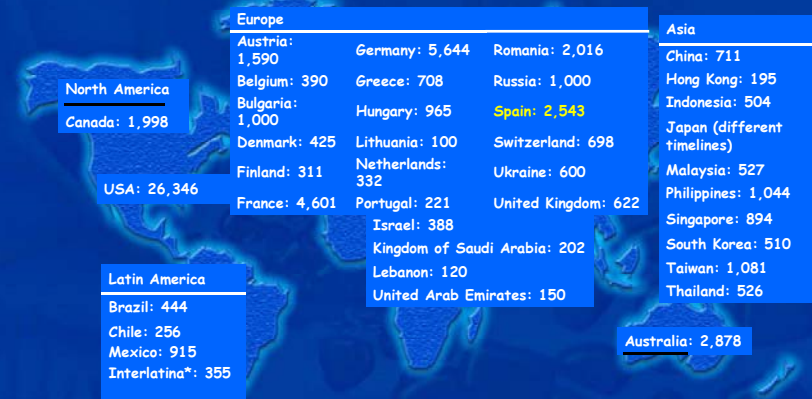
Registro REACH 63,814 patients

Estudio Nacional

- Especialidades:
 - Cardiología: 33%
 - Cirugía vascular 1,3%
 - Cirujanos generales: 10%
 - Medicina Interna 31%
 - Neurología 17%
 - Familia 4%
 - Endocrinólogos: 3%

- 257 sitios
- 237 investigadores
- 2515 pacientes

REACH Registry: recruitment/country (Total=63,814 patients)



* Interlatina: Panama, Costa Rica, Cuba, Dominican Rep, Ecuador, Guatemala, Peru

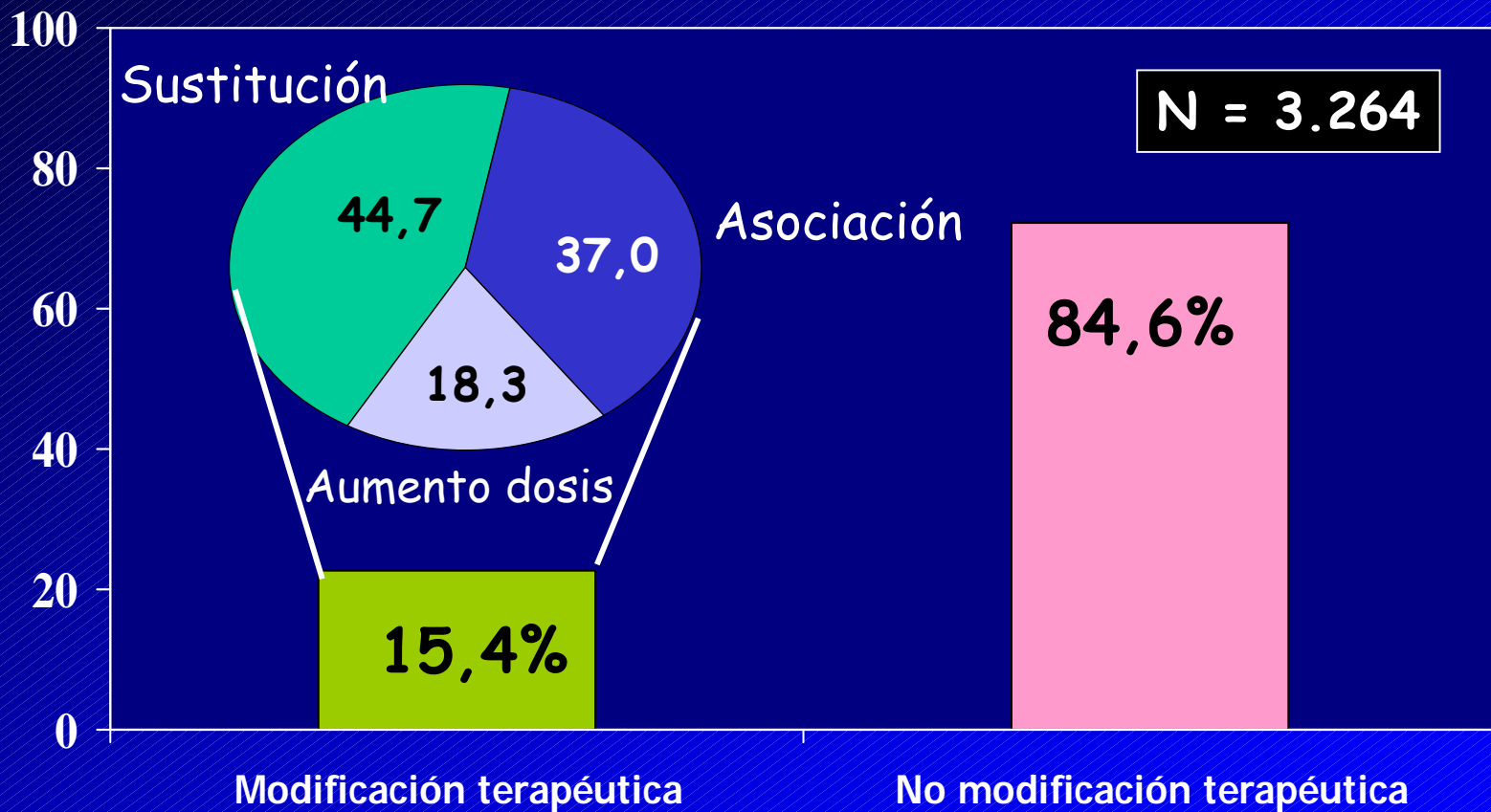
Basal: RF Control and use of medication.

	Total	Multiple risk factors	CD	CVD	PAD	p
N	2515	297	1363	812	415	
BP < 140/90 mmHg (%)	59.36	76.53	50.22	42.9	32.93	<0.005
TC < 200 mg/dl (%)	56.71	44.32	58.69	51.79	49.79	<0.005
Anomalous basal glucose* (%)	35.04	30.92	31.67	30.0	38.89	<0.005
Current smokers	13.89	22.03	9.56	11.74	22.49	<0.005
Use of at least one antiplatelet agent(%)	81.52	44.07	86.52	83.17	81.62	<0.005
Use of statin (%)	65.81	65.12	79.90	53.0	54.57	<0.005

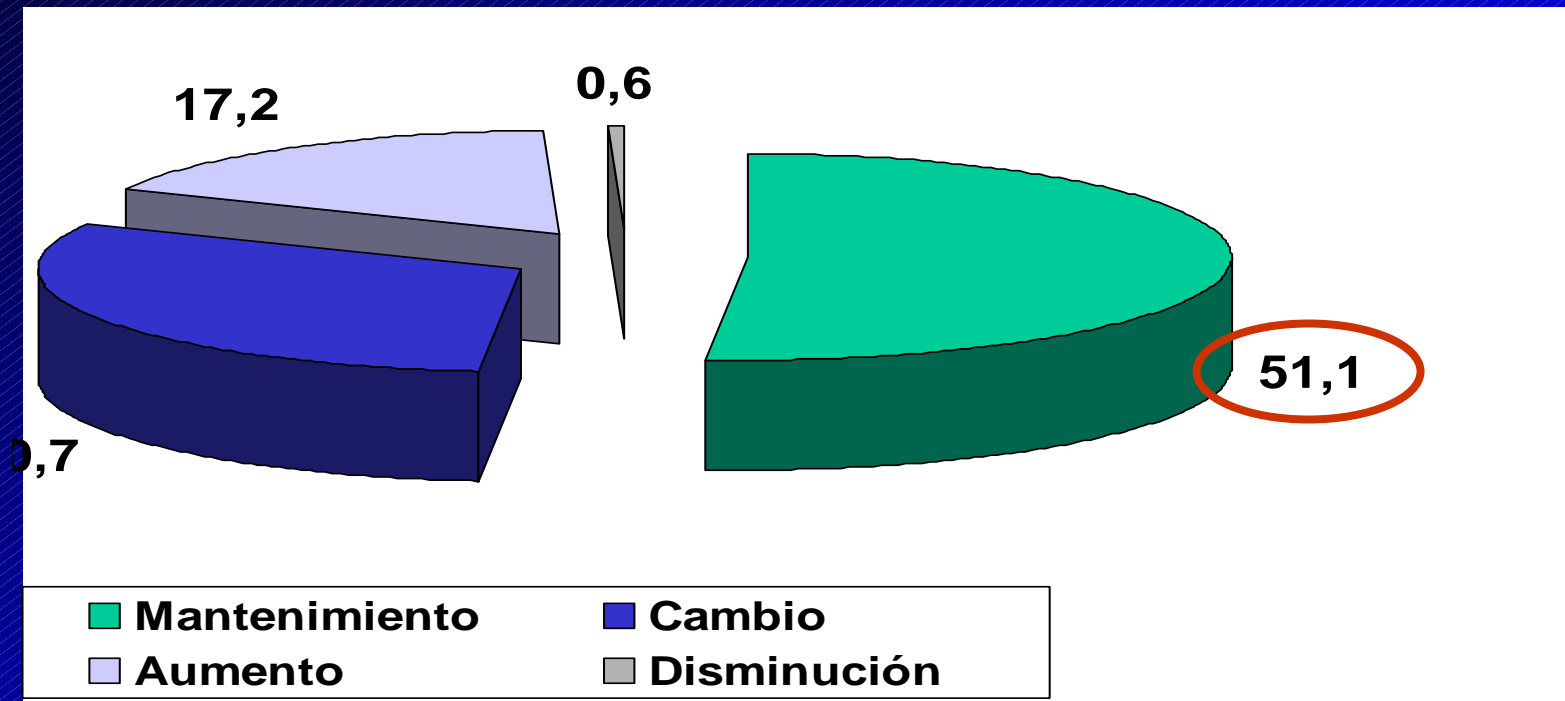
Prophylactic treatment after myocardial infarction

	CARDIOLOGY n=2054 (1998)	GP n = 369 (1999)	STANDARD
B-Blockers	45.1%	50.2%	94.5%
ACEIs	46.4%	35.2%	71.8%
STATIN	29.4%	52%	50.5%

Conducta del médico en pacientes no controlados con monoterapia inicial (58,4%). Estudio Controlpres 2003



Actitud ante el paciente no controlado. Estudio CLUE. 31,5% en monoterapia



La inercia terapéutica no es un problema de primaria.

¿por qué no las
aplicamos?

¿Qué se requiere para aplicar una Guía?

- Conocerla.
- Aceptarla.
- Tener tiempo para aplicarla.

¿Por qué no seguimos las guías?

- Múltiples guías.
 - Dificultad de elección.
 - Criterios de elección diversos (políticos, económicos...)
 - Directrices no coincidentes.
- Guías complejas
- Falta de convencimiento.
- Desconocimiento de las recomendaciones.
- Presión asistencial
 - Falta de tiempo.
 - " Síndrome del quemado"

¿Por qué no seguimos las guías?

- Infraestimación del riesgo del paciente
- Sobreestimación de la eficiencia de nuestra intervención (% de controlados).
- Resistencia ante el incremento del nº de fármacos (dudas de utilidad, coste....)
- Dificultad para conseguir los objetivos terapéuticos

Guías de Práctica Clínicas españolas sobre manejo ECV Recogidas por la SEC (I)

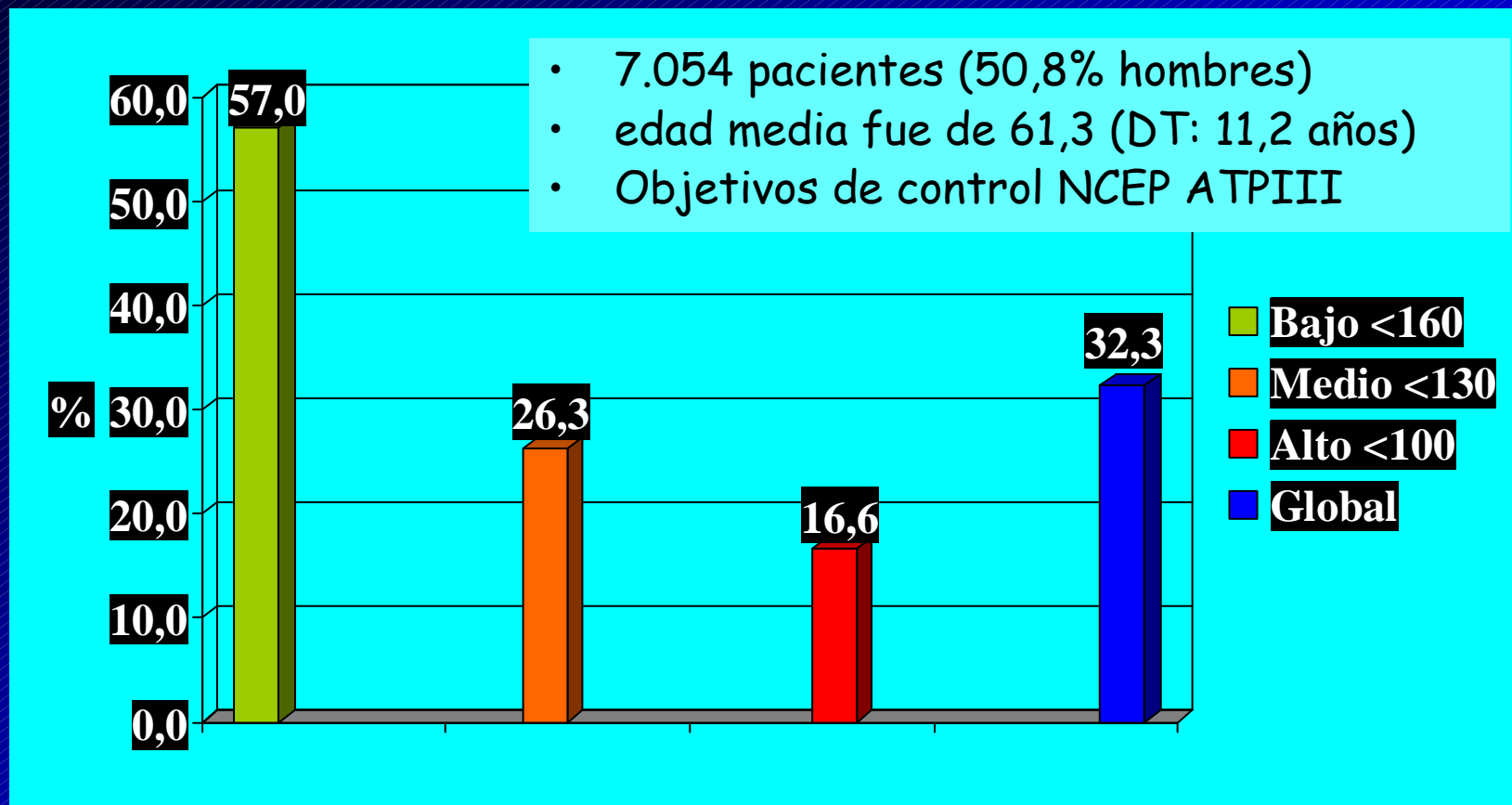
→ Actualización de las Guías de Práctica Clínica de la Sociedad Española de Cardiología en hipertensión arterial

- Arritmias cardíacas
- Angina estable
- Angina inestable / Infarto sin elevación ST
- HTA
- Infarto agudo de miocardio
- Insuficiencia Cardíaca y el Shock Cardiogénico
- Prevención cardiovascular y Rehabilitación cardíaca
- Recomendaciones para el uso del tratamiento antitrombótico en cardiología
- **Cardiopatía Isquémica**
- Angor inestable (**fisterra**, 2004)
- Infarto agudo de miocardio (**fisterra**, 2002)
- Protocolos basados en la evidencia para el tratamiento de la angina estable en atención primaria 2001 (PDF) (Grupo para el Desarrollo de Protocolos sobre la Angina Estable del Norte de Inglaterra)
- **Dislipemias**
- Manejo de las Dislipemias (**fisterra**, 2004)
- Hipercolesterolemia: protocolo de actuación. FMC 1999; 6 (supl. 7). [No disponible en formato electrónico]
- Hipercolesterolemia (Institut Catalá de la Salut)
- **Fibrilación Auricular**

Guías de Guías de Práctica Clínicas españolas sobre manejo ECV Recogidas por la SEC (II)

- **Fibrilación Auricular**
- Fibrilación Auricular (fisterra, 2004)
- **HTA**
- Crisis hipertensivas (fisterra, 2005)
- HTA (fisterra, 2004)
- Hipertensión arterial en Atención Primaria. FMC 1999; 6 (supl. 3). [No disponible en formato electrónico]
- Guía sobre el diagnóstico y el tratamiento de la hipertensión arterial en España 2005 (Sociedad Española de Hipertensión - Liga española para la lucha de la HTA)
- Guía sobre el diagnóstico y el tratamiento de la HTA OMS 2003
- Guía sobre diagnóstico y tratamineto de la HTA. Sociedad Británica de Hipertensión
- Séptimo Informe del Joint Nacional Committee sobre Prevención, Detección, Evaluación y Tratamiento de la Hipertensión Arterial (JNC 7) (2003)
- Guía sobre HTA (Sociedad Vasca de Medicina Familiar y Comunitaria)
- Hipertensió arterial (Institut Català de la Salut)
- Guías del 2003 de la Sociedad Europea de Hipertensión y la Sociedad Europea de Cardiología para el manejo de la HTA (PDF)
- **Insuficiencia Cardíaca**
- Insuficiencia Cardíaca (fisterra, 2005)
- Edema agudo de pulmón (fisterra, 2003)
- Insuficiencia Cardíaca: Cuidado continuo. Guías, circuitos y educación del paciente (Área del Corazón. Hospital Juan Canalejo, A Coruña)
- **Síncope**
- Síncope (fisterra, 2005)
- **Tabaquismo**
- Guía para ayudar a la gente a dejar de fumar (PAPPS de la semFyC)
- Guía sobre manejo del Tabaquismo (fisterra, 2002)
-

Estudio LIPICAP. Grado de control para el colesterol LDL por categorías de riesgo



Investigadores del Estudio LIPICAP: GC RODRÍGUEZ ROCA, S LOU ARNAL, V BARRIOS ALONSO, JL LLISTERRI CARO, JR BANEGAS BANEGAS, A RÁBER BÉJAR, A MATALI GILARRANZ, R DE CASTELLAR SANSÓ; FJ ALONSO MORENO

Valoración del investigador de los objetivos de control cLDL

		Cifras de cLDL controladas				p
		Sí		No		
		n	%	n	%	
¿Considera que su paciente tiene habitualmente las cifras de lípidos controladas?	Sí	1.400	46,7	1.599	53,3	<0,001
	No	544	8,3	.433	81,7	

ESTUDIO CONTROLMAP

Porcentaje de pacientes controlados según metodología utilizada para la medida de la PA (n: 197)

PAHC (PA historia Cl ^a)	PAI (una medida)	M3 (media de 3)	M2 (media de la 2 ^a y 3 ^a)
17,20%	16,20%	39,80%	42,90%

PAHA ó PAI vs M3 ó M2.....p< 0,001

El tiempo medio requerido para realizar las tres medidas de la PA en condiciones estándar fue de **11,34 minutos**. La medida de la PA según PAC consume **3 minutos**.

Posibles soluciones

- Simplificación de las guías
- Unificación de guías dirigidas a un mismo proceso.
- Formación Continuada
- Aumentar el tiempo de consulta
- Implicación de la enfermería
- Incentivación (Productividad) por consecución de objetivos de control.
- Educación sanitaria
- Etc...

Conclusiones

- Baja implementación de las guías en España, en todos los niveles asistenciales.
- Múltiples motivos cuya solución afectan a:
 - Las sociedades científicas
 - La administración sanitaria
 - Los médicos