W Herts Cardiology Outpatient Follow-Up Guidelines

This guidance provides general advice to practitioners about the appropriateness, or not, of continuing cardiological outpatient follow-up, but each patient's case must be considered individually and carefully before discharge.

General Principles for Medical Clinics (not applicable to specialist Nurse-led or Physiology-led clinics)

1 All patients should be discharged from cardiology follow up (FU)
- EXCEPT when there is a specific reason for continuing FU in a specialist cardiology clinic. (see below)

2 If a specific reason for ongoing FU is not clear:
- **If in doubt, do NOT arrange FU "just in case" - ask advice of a more senior colleague, or consultant.**
- **If a patient is at their *second* FU visit, a consultant must decide if a *third* visit is to be booked.**
  – non-consultant doctors must discuss the patient with a consultant before the patient leaves.
- **If a patient has attended two FU visits with a non-consultant Dr, and a consultant agrees a third visit is required, the next appointment must be to a consultant.**
  – patients requiring long-term FU must see a consultant every third visit at least.

3 In each clinic letter to the GP, there must be a clear statement regarding discharge:
- **If a patient is being discharged from FU** (the norm)**, the letter should state:**
  – "Discharged from follow-up".
  – Management plan and advice to GP regarding follow-up in Primary Care.
- **If a patient is *not* being discharged from FU, the letter should state:**
  – "Not discharged from follow-up", and specify the reason (see below).
  – What is being done/arranged by Cardiology Dept, and what (if anything) is required of GP in "shared care" follow-up in Primary Care.
  – When the next cardiology follow-up is planned.

4 Patients do NOT automatically have to be followed up just to discuss test results – the results can be forwarded to the GP, with advice as to further care as necessary.
  – Follow-up (often to a consultant) *would* be appropriate to discuss decisions regarding surgery or invasive procedures.

5 On discharging a patient from follow-up:
  – Advise the patient if they need to be reviewed by their GP, and when.
  – Explain that the GP can refer the patient back if a cardiological problem arises (and that we will be able to see the patient quicker if we are not seeing follow-up patients unnecessarily!)

6 Patients can be discharged despite a specific reason for ongoing FU:
  – If they choose not to return to FU, or DNA persistently.
  – If they have a terminal illness, or are very frail or demented.
  – If they are violent or abusive to staff.
  but the GP should be involved in arranging any review in Primary Care.

7 Be aware of, and follow, disease specific guidance provided by NICE, ESC/BCS and local guidelines.
(see Cardiology Department intranet site: Reference Archive>Guidelines)

The British Cardiac Society "Guidance for cardiology patient clinic follow-up for junior staff in cardiology" (2002), provides additional information, but some of its advice has been now been superseded by national and local guidelines.
(see Cardiology Department intranet/web site: www.westhertshospitals.nhs.uk/whc : References / Guidelines >Other)

Guidelines for management of specific conditions are grouped and available on the Cardiology Department intranet site.
(see Cardiology Department intranet/web site: www.westhertshospitals.nhs.uk/whc : References / Guidelines)

DVLA advice about fitness to drive is available at www.dvla.gov.uk/at_a_glance/ch2_cardiovascular.htm
(also available from Cardiology Department intranet/web site: www.westhertshospitals.nhs.uk/whc : >Links>Government & NHS sites)

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Specific reasons for continuing follow-up (conditions which EXCLUDE discharge from outpatients)

1 Any patient receiving "named patient" basis cardiological medication (eg Midodrine), or receiving medication prescribed by the Cardiology Dept, in whom the GP does not feel able to accept clinical responsibility.

2 Any patient who remains unstable, who is having adjustments to medication or frequent monitoring.
- – but may be suitable for specialist nurse FU in secondary or primary care.

3 **Prevention**
- **Severe Hypertension** (SBP>200 or DBP>120): undergoing investigations and/or adjustment of Rx.
  - – discharge once investigations complete, advising GP about further adjustments of Rx, unless SBP >200.
  - – any subsequent ambulatory BP monitoring can be reported directly to GP (or performed in Primary Care).
- Stable patients with Diabetes or Hyperlipidaemia do ***not*** require to continue Cardiology FU unless they have other excluding conditions.
- Stable patients with known CHD requiring "secondary prevention" should be discharged to Primary Care CHD FU from Outpatients or Cardiac Rehabilitation classes, unless they have other excluding conditions.

4 **CHD**
- **Deteriorating angina** – considering need for angio/revascularisation.
  - – If patient awaiting angio, do ***not*** book routine FU – this can be arranged if necessary at time of angio.
- **Recurrent angina** – if considering further procedures or requiring complex Rx.
- After PCI, patients are reviewed once (usually with ExECG), and if stable can be discharged.
- Patients with stable angina, or after PCI or CABG, do ***not*** need routine FU unless they have other excluding conditions, they should be routinely discharged to Primary Care CHD FU.

5 **Heart Failure & Cardiomyopathies**
- **Severe or unstable chronic heart failure**, requiring further investigation or complex Rx.
- **CHF due to valve or other structural heart disease, "diastolic dysfunction", reversible myocardial ischaemia/angina, arrhythmia, or when associated with co-morbidities (eg severe renal dysfunction or COPD), or in women who are, or wish to be, pregnant** (NICE guidance).
- **Symptomatic Hypertrophic Cardiomyopathy, or if LV outflow obstruction**: consider intervention.
- **Other Cardiomyopathies, if not on optimal Rx, or if being monitored regularly for any deterioration (eg arrhythmia, echo) –** DCM may be suitable for specialist nurse FU in secondary or primary care.
- Patients with stable HF or Cardiomyopathy can be discharged to Primary Care FU if receiving optimal Rx.
- Patients with stable HF due to LV systolic dysfunction can be referred to Community Specialist Heart Failure Nurse for review, to deliver continuing and optimal structured care according to NICE guidance.
- Patients with terminal CHF should be considered for referral to Palliative Care, and may not need Hospital FU.

6 **Valve disease**
- **Patients with valve replacements (artificial or biological) require annual follow-up, even if stable.**
- **Severe but asymptomatic valve disease requires consultant review, with 6 monthly echo+clinic if not yet proceeding to surgery.**
- **Moderate aortic or mitral valve disease should be followed up with 6-12 monthly echo and yearly clinic review, to assess need to proceed to surgery.**
- **Mild Aortic valve disease or mild rheumatic Mitral Stenosis should be followed up with 2-5 yearly echo, to assess if it is progressing, and clinic review if has become moderate/severe.**
- Mild Mitral, Pulmonary or Tricuspid regurgitation need not be followed up.

7 **Arrhythmias**
- **Patients with paroxysmal or permanent arrhythmias that remain at risk or severely symptomatic, or requiring therapy that cannot be supervised by GP.**
  - – Patients who are stable, with less severe symptoms, on medication if necessary, can be discharged to Primary Care FU, but may need subsequent ambulatory monitoring that can be reported directly to GP (or performed in Primary Care).

8 **Pacemakers / ICDs**
- **All Pacemaker/ICD patients should be reviewed *at least* 6 monthly in pacing/ICD clinics** (MHRA guidance).
  - – Patients should only be "discharged" if they die, or move out of area (need referral to other pacing centre), or if they become too frail/demented to benefit from pacing/ICD FU (as agreed with relatives and GP).
  - – Patients can be discharged if no pacemaker is required after explantation of an ECG loop recorder (Reveal).

9 **Grown up Congenital Heart Disease (GUCH)**
- **Most GUCH patients should be reviewed yearly** (more frequently if unstable).
  (see ESC guidance on GUCH on Cardiology Department intranet/web site: www.westhertshospitals.nhs.uk/whc : References / Guidelines)
  - – Patients with small or closed VSD or PDA + normal RV, or ASD closed age<30, or mild PS, can be discharged.

10 **Other conditions**
- **Specific conditions will often require continuing follow-up, for specific periods or indefinitely, for example:**
  - ► **Pregnancy in heart disease.**
  - ► **Structural heart disease that may progress, eg Marfan's or Pericardial disease –** requiring echo+clinic FU.
  - ► **Rare cardiological conditions, if requiring monitoring, and not appropriate for Primary Care FU.**
  - ► **Patients being followed up for research purposes.**