Pacientul cu HTA & echipa de ingrijire in pandemie

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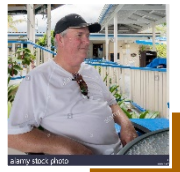
Agenda

1. Cazurile clinice
2. Clasificare HTN de pandemie
3. Diagnostic HTN de pandemie
4. Optiuni terapeutice de pandemie
5. Evaluarea hipertensivului
   - Particularitati la vaccinare

Trei hipertensivi, aceeasi garda

F, 62 ani

- PR, Leflunomide
- Cefalee, tulburari de vedere, vertij
- TA 240/140 mmhg



M, 55 ani

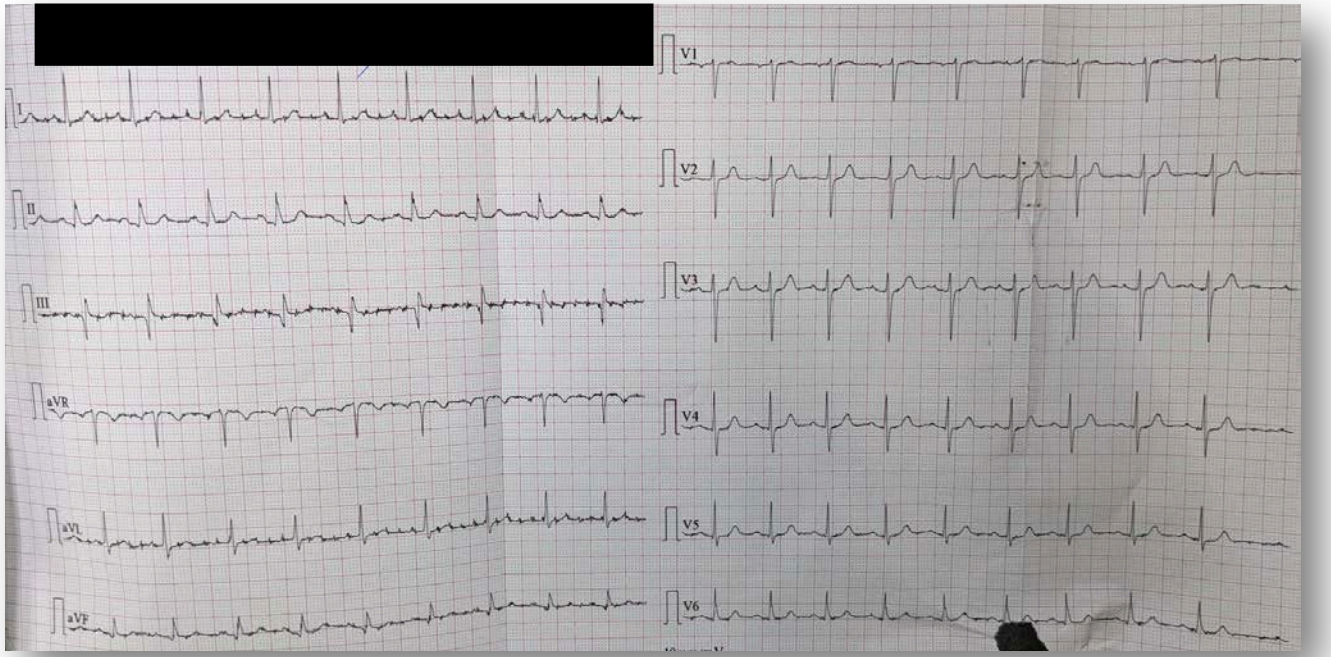
- HTN, 5 ani
- Neglijat terapeutic de 3 saptamani
- Dispnee la efort mic de 3 zile
- TA 210/120 mmHg

F, 97 ani

- Cardiostimulare permanenta BAV III
- Dispnee efort progresiv mai mic
- TA 195/100 mmHg

F, 61 ani, TA 240/140 mmHg

Psoriazis, PR, Leflunomide 200 mg/zi, 2 ani
Cefalee, tulburari de vedere, vertij



Eco cord – VS nedilatat, nehipertrofiat; fara valvulopatii sau alte elemente patologice notabile

CT cerebral – fara leziuni

Enalapril iv

Furosemid iv

Urapidil iv bolus

→ TA 120/80 mmHg → Confuzie, varsaturi

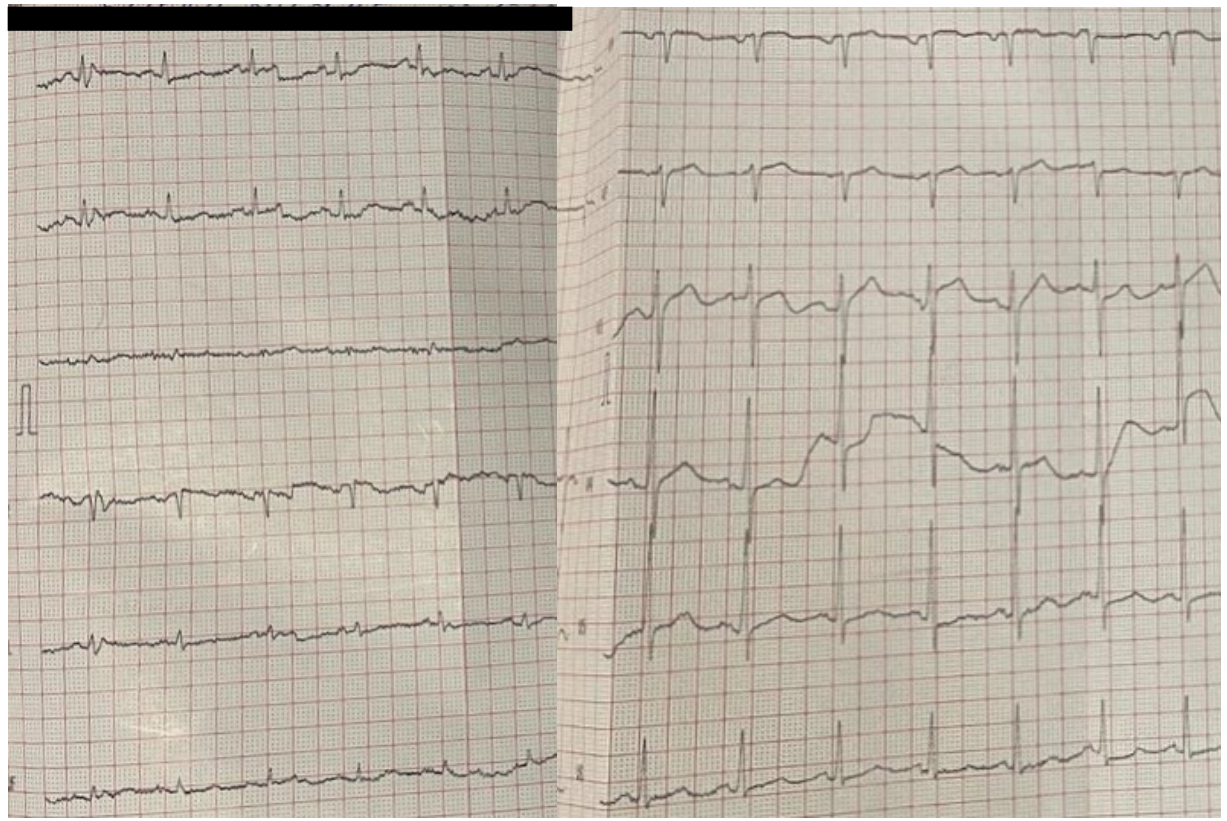
Internare
Accident ischemic tranzitor

M, 55 ani, TA 210/120 mmHg

HTN 5 ani, fara regim hiposodat
Obez, fumator
De 3 saptamani neglijat terapeutic

Eco cord – VS nedilatat, hipertrofie concentrica usoara; fara valvulopatii sau alte elemente patologice notabile

SpO2 92-94%; fara raluri pulmonare
Rx pulmonar – fara leziuni



Enalapril iv

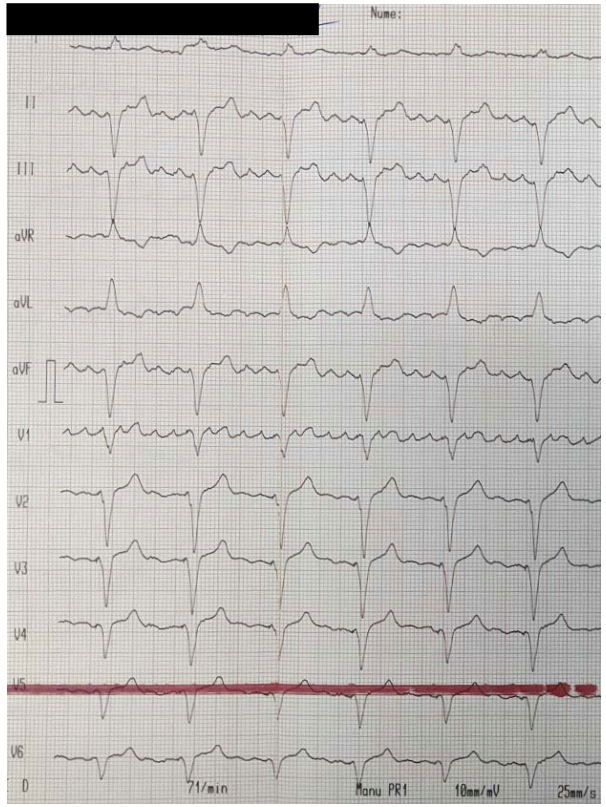
Furosemid iv

→ TA 175/95 mmHg → Ameliorare dispnee

La domiciliu – reluarea Tx

F, 97 ani, TA 195/100 mmHg

CS permanenta BAV III
HTN > 10 ani, Telmisartan 80 mg/zi
De 1 luna dispnee progresiva efort tot mai mic -> dispnee de decubit



Eco cord – VS nedilatat, hipertrofie concentrica usoara, FEVS 40%; stenoza aortica moderata; atrii sever dilatate

SpO2 88%;
Raluri subcrepitante bazal bilateral
Rx pulmonar – edem pulmonar

Digoxin iv

Furosemid iv

→ TA 170/85 mmHg → Stationar

Internare
Insuficienta ventriculara stanga tahiaritmica

Clasificarea HTN “de pandemie”

La domiciliu

Cand situatia clinica permite evaluarea la distanta, rol **Telemedicina**

La cabinet

Cand pacientul se poate deplasa – “**ambulator**”

La garda

Urgentele hipertensive **cu risc vital**

www.tensiuneamea.ro

Dg HTN “de pandemie”

Regulile de masurare & tensiometre validate

Ziua		Prima masuratoare		A doua masuratoare	
		Tensiunea sistolica(mmHg)	Tensiunea diastolica(mmHg)	Tensiunea sistolica(mmHg)	Tensiunea diastolica(mmHg)
1	Dimineata				
	Seara				
2	Dimineata				
	Seara				
3	Dimineata				
	Seara				
4	Dimineata				
	Seara				
5	Dimineata				
	Seara				
6	Dimineata				
	Seara				
7	Dimineata				
	Seara				

Salveaza datele introduse

Conform recomandarilor europene si internationale de practica medicala

Categorie	Sistolica		Diastolica
Cabinet (Office)	**≥140**	si	**≥90**
Ambulatoriu			
Diurn/awake	≥135	si/sau	≥85
Nocturn/asleep	≥120	si/sau	≥70
24h	≥130	si/sau	≥80
La domiciliu (Home)	**≥135**	**si/sau**	**≥85**

Realitatea urgentelor hipertensive

Hypertensive urgency **Urgenta hipertensiva fara risc vital**
TAs > 180 mmHg sau TAd > 120 mmHg
Fara afectare acuta de organ tinta
Rareori usor simptomatica (cefalee, vertij)

Hypertensive emergency **Urgenta hipertensiva cu risc vital**
TAs > 180 mmHg sau TAd > 120 mmHg
Cu afectare acuta de organ tinta
Asociaza simptomatologia afectarii organului tinta

- Encefalopatia hipertensiva
- Hemoragia cerebrala
- AVC ischemic
- Sindrom coronarian acut
- Edem pulmonar acut cardiogen
- Disectia acuta de aorta
- Insuficienta renala acuta
- Pre-eclampsia / Eclampsia
- Status hiperadrenergic

Realitatea urgentelor hipertensive

- Previn evenimentele CV majore
- Ramificatiile legale…

Fara risc vital

- Salvez viata
- Ameliorez prognosticul

Cu risc vital

In ore…zile

Tratament oral

Urgency – **fara** risc vital

SCOP
control termen lung

In minute…ore

Tratament iv

Emergency – **cu** risc vital

SCOP
salvarea vietii

Hipertensiunea, mai practic

HTA nou diagnosticata	HTA necontrolata	HTA rezistenta
2 antiHTA doze mici-moderate IEC/BCC	Cresterea dozelor Adaugarea unei noi clase (diuretic) Utilizare combinatii	Pseudo-rezistenta Spironolactona

Quintesenta farmacoterapiei in Ghidul HTA ESC/ESH 2018

Algoritmul este potrivit pentru majoritatea pacientilor cu AOTMH, boala cerebrovasculara, diabet, boala arterial periferica

1 Pilulă — **Inițializarea tratamentului** Dubla terapie → **IECA sau BRA + BCC sau diuretic**

Se consideră monoterapia la pacienți cu hipertensiune arteriala grad 1 risc scăzut (TAS 150 mmHg), sau pacienți vârstnici (80 ani) sau tarați.

1 Pilulă — **Pasul 2** Tripla terapie → **IECA sau BRA+BCC+diuretic**

2 Pilule — **Pasul 3** Tripla terapie + spironolactonă sau alta clasă antihipertensivă → **Hipertensiune rezistentă** Se adaugă spironolactonă (25-50 mg o.d) sau alt diuretic, alfa-blocant sau beta-blocant

Se consideră îndrumarea spre un centru de referință pentru investigații suplimentare.

Beta-blocanții

Se consideră beta-blocanții la oricare pas în terapia hipertensiunii arteriale dacă există indicație specifică pentru utilizarea lor ex. Insuficiență cardiacă, angină, post-IM, fibrilație atrială sau femei însărcinate sau care planifică o sarcină.

ESC European Society of Cardiology

European Society of Hypertension

SOCIETATEA ROMÂNĂ DE CARDIOLOGIE

Grupul de Lucru de Hipertensiune Arteriala 140/90mmHg

Rom J of Cardiology Vol. 29, No. 1, 2019

Adaptare de pandemie

Blocantele canalelor de calciu

Optiunea “safe”, neutra metabolic & electroliti

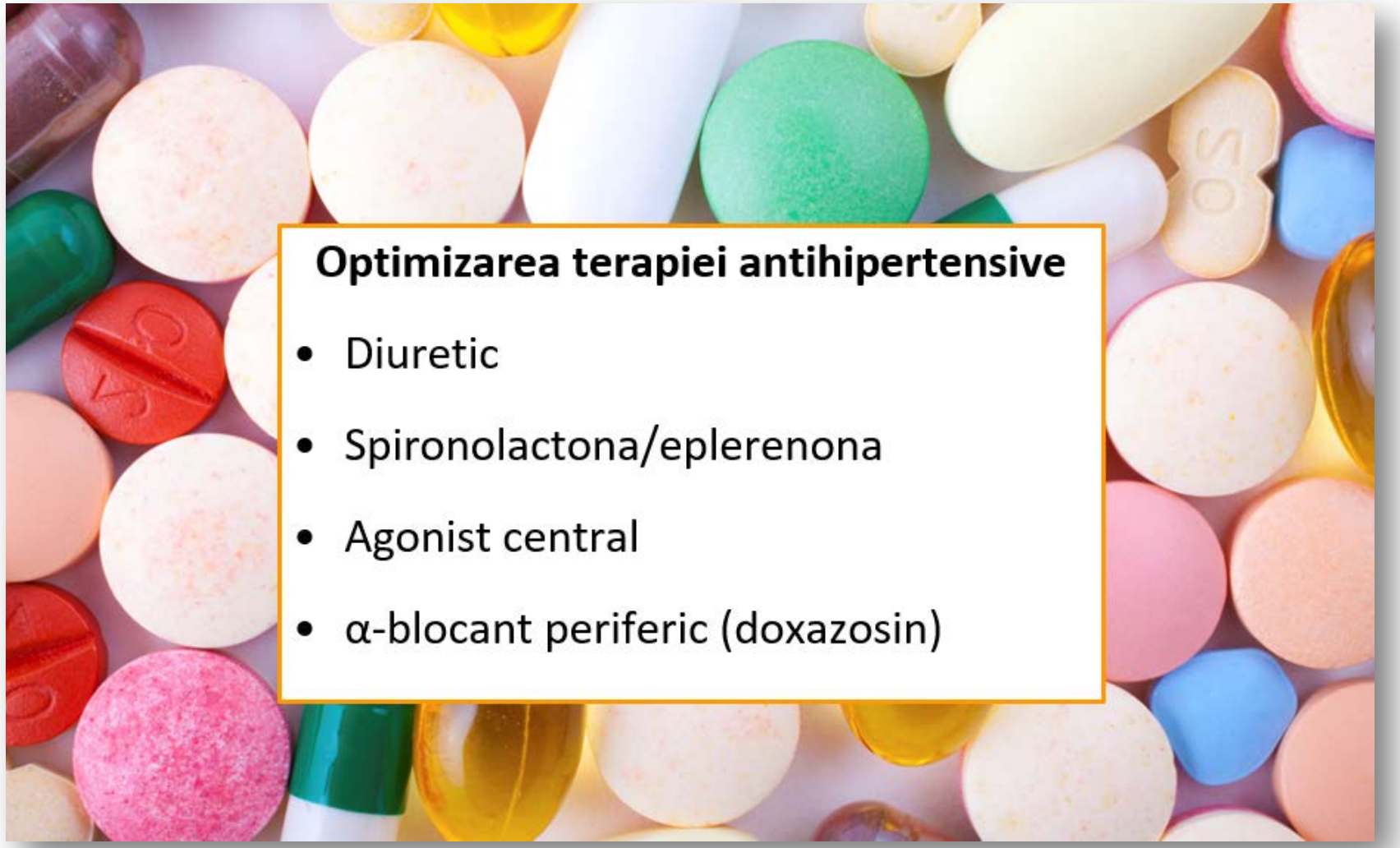
IEC/BRA
spironolactona

Creatinina, Na, K – inainte & la 1-2 saptamani

Betablocant

ECG – inainte & 1-2 saptamani
Urmarire AV

HTN necontrolata



HTN rezistenta

Confirma rezistenta

- Masurare corecta la cabinet
- ABPM/24h & **HBPM/7 zile**

- HTA izolata de cabinet
- HTA rezistenta mascata

Exclude pseudorezistenta

- Complianta scazuta
- Tratament suboptimal

- aderenta & persistenta
- doze maxime tolerate

Stilul de viata

- **Sedentarism/Obezitate**
- **Aport crescut de sare (Na)**
- **Alcool, “binge drinking”**

Medicatia

- **AINS** & AIS
- Contraceptive orale
- Simpatomimetice
- Droguri

- Anorexogene
- Licorice (lemn dulce)
- Ciclosporine, EPO, inhibitori angiogeneza
- “Suplimente”

Cauze identificabile HTA secundara

HTA rezistenta

Interventie asupra TA

Retentie de Na / hipervolemie

RFGe (ml/min/1.73m²)

60

50

40

30

Hidroclorotiazida / Clortalidona / Indapamid

Clortalidona / Indapamid

Indapamid

Furosemid / Torasemid / Budesonid

Spironolactona
RFGe > 45ml/min/1.73m²

HTA rezistenta

Interventie asupra TA

SRAA

SNS

IEC/BRA + β-blocant + BCC

↓↓↓ TA ☺
↑↑↑ Reactiile adverse ☹

Bisoprolol / Carvedilol/ Nebivolol

+ / inlocuieste β-blocant

Doxazosin

+ α1-blocant

Clonidina / Rilmenidina / Moxonidina

+ α2-agonist
+ agonist rcpt imidazolinici

Metildopa

+ inh DOPA decarboxilaza

Hidralazina

+ vasodilatator periferic

Medicina de familie

Specialist in HTN & alte specialitati

Medicina Interna

Pacient HTN

Familie & suport social

Cardiologie

Farmacie

Guidance

COVID-19: the green book, chapter 14a

Coronavirus (COVID-19) vaccination information for public health professionals.

From: Public Health England
Published: 27 November 2020
Last updated: 12 February 2021, see all updates

Documents

COVID-19: the green book, chapter 14a

Ref: PHE gateway number 2020300
PDF, 434KB, 24 pages

This file may not be suitable for users of assistive technology.

▶ Request an accessible format.

Details

This chapter includes information on:

- the coronavirus (COVID-19) vaccines
- the dosage and schedule for the UK
- recommendations for the use of the vaccine

Individuals on stable anticoagulation therapy, including individuals on warfarin who are up-to-date with their scheduled INR testing and whose latest INR is below the upper level of the therapeutic range, can receive intramuscular vaccination. A fine needle (23 or 25 gauge) should be used for the vaccination, followed by firm pressure applied to the site without rubbing for at least 2 minutes (ACIP 2019).

The patient or family should be given information on the risk for hematoma from the injection. Patients receiving anticoagulation therapy presumably have the same bleeding risk as patients with clotting factor disorders and should follow the same guidelines for intramuscular administration. If possible, vaccination could be scheduled prior to the use of these medications, so that the patients' risk of bleeding is not increased by their therapeutic action.

Avem impresia că
că viețile noastre
sunt puse
“în așteptare”
în timpul
pandemiei -
este însă periculos
să credem că
putem putem
spune stop inimii!

Inima nu
așteaptă!

INIMA NU AȘTEAPTĂ!

Sănătatea inimii tale este esențială, chiar și în timpul pandemiei. Nu neglija niciodată simptomele dacă știi că ai o problemă cardiacă. Dacă crezi că ai simptomele unui infarct, cere ajutor medical de urgență, sună imediat la 112!

ESC European Society of Cardiology

SOCIETATEA ROMÂNĂ DE CARDIOLOGIE

DESIGN OF BRACE CORONA TRIAL

Continuing versus Suspending angiotensin-converting enzyme inhibitors and angiotensin receptor blockers and its impact on adverse outcomes in hospitalized patients with coronavirus infection (SARS-CoV2)

STUDY POPULATION

National registry on suspected and confirmed cases of COVID-19

Confirmed diagnosis of COVID-19

and

Chronic use of renin-angiotensin system blockers (ACEI/ARB)

500 participants at 34 sites in Brazil

1:1 RANDOMIZATION

Continue to use ACEI/ARB treatment

Temporarily descontinue ACEI/ARB treatment for 30 days

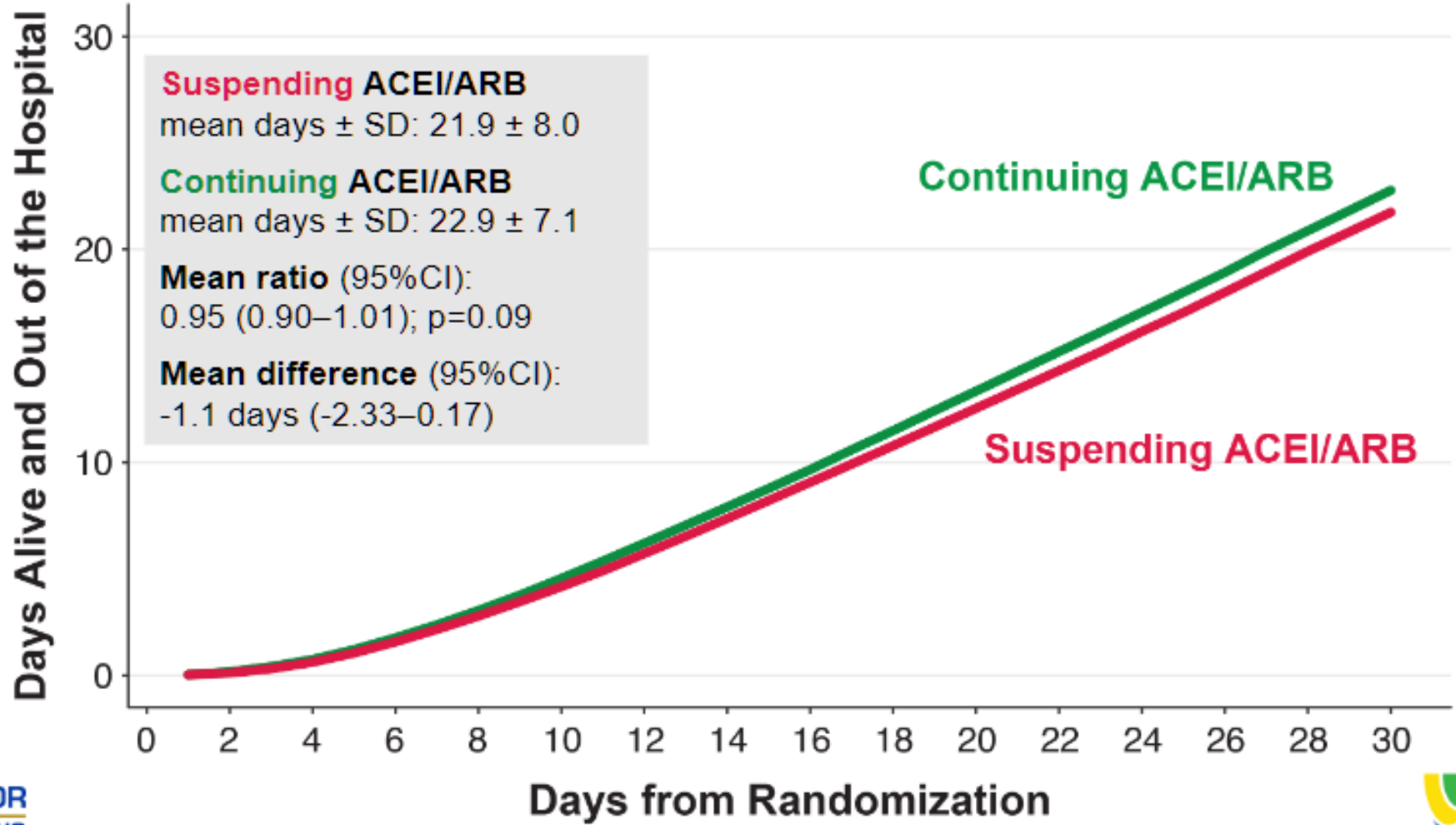
PRIMARY OUTCOME

Median days alive and out of the hospital at 30-days

SECONDARY OUTCOMES

- Progression of COVID-19 disease
- All cause mortality
- Cardiovascular death
- Acute myocardial infarction
- New or worsening heart failure
- Stroke, transient ischemic attack
- Myocarditis, pericarditis
- Arrhythmias that need treatment
- Thromboembolic phenomena
- Respiratory failure, renal failure
- Hemodynamic decompensation
- Sepsis, hypertensive crisis
- Level of troponin, NT-ProBNP, BNP, and D-dimer

Primary Outcome: Days Alive and Out of Hospital at 30 Days



Renin–Angiotensin–Aldosterone System Blockers and the Risk of Covid-19

Giuseppe Mancia, M.D., Federico Rea, Ph.D., Monica Ludergnani, M.Sc., Giovanni Apolone, M.D., and Giovanni Corrao, Ph.D.

Table 4. Adjusted Odds Ratios for Covid-19 Associated with Use of RAAS Blockers and Other Antihypertensive Drugs.

Variable	Odds Ratio for Covid-19 (95% CI)*				
	ACE Inhibitors	ARBs	Calcium-Channel Blockers	Diuretics	Beta-Blockers
Severity of clinical manifestations					
Mild to mode					0.98 (0.89–1.07)
Critical or fata					1.07 (0.84–1.37)
Sex‡					
Female					1.04 (0.91–1.20)
Male	0.98 (0.87–1.11)	0.98 (0.86–1.11)	1.00 (0.90–1.11)	1.02 (0.91–1.15)	0.97 (0.87–1.08)
Age at diagnosis§					
<60 Yr	0.94 (0.71–1.25)	0.89 (0.67–1.18)	1.13 (0.88–1.46)	0.99 (0.75–1.31)	1.00 (0.78–1.29)
≥60 Yr	0.97 (0.87–1.08)	0.95 (0.85–1.06)	1.01 (0.93–1.11)	1.07 (0.97–1.19)	0.99 (0.90–1.08)

The present study does not provide evidence that the use of ACE inhibitors or ARBs is independently associated with the risk of Covid-19.