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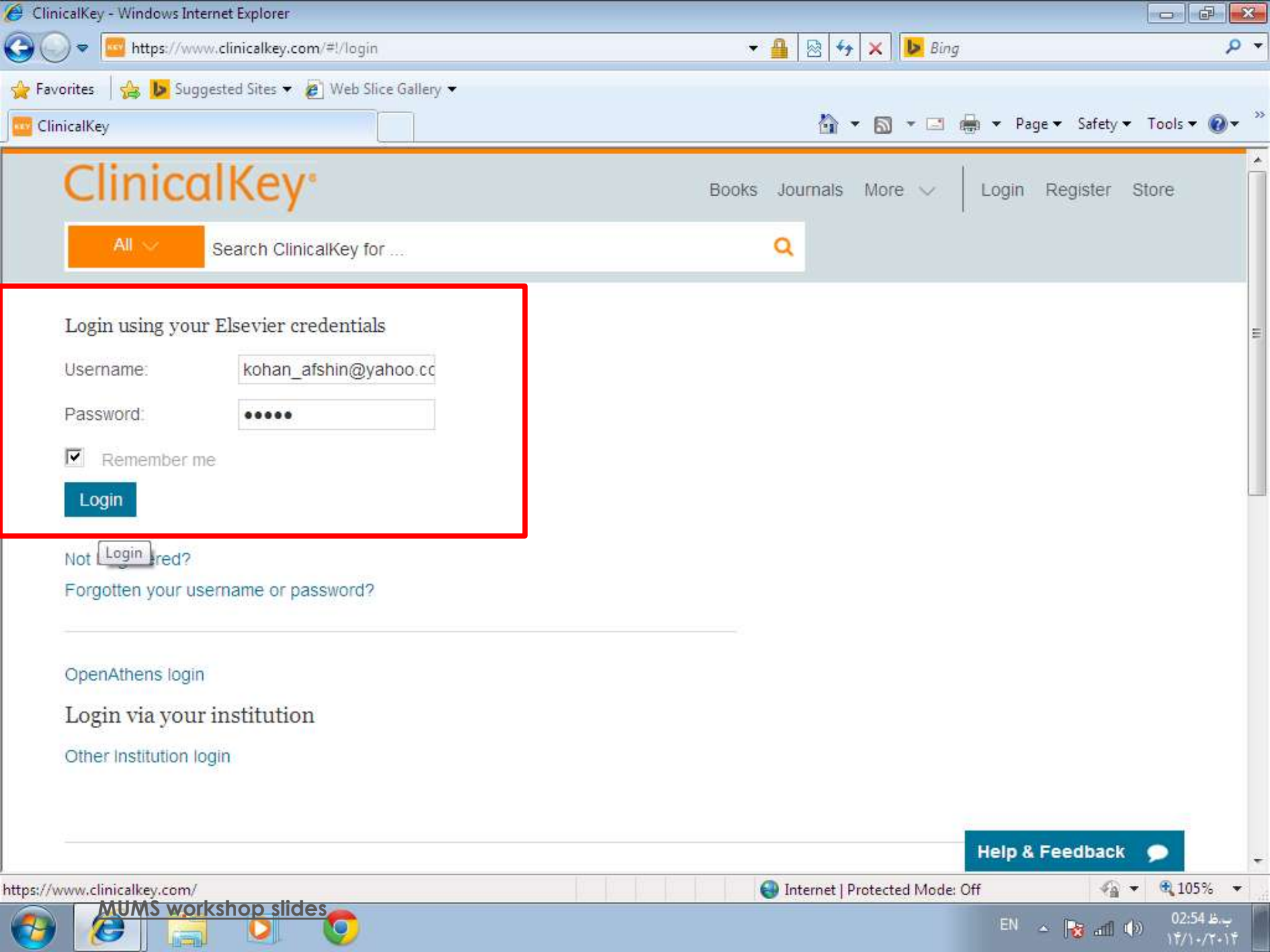
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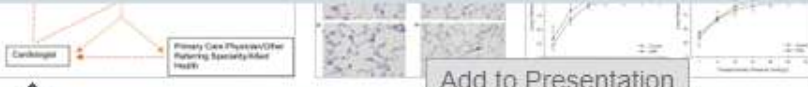


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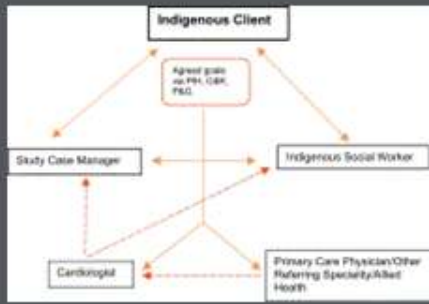


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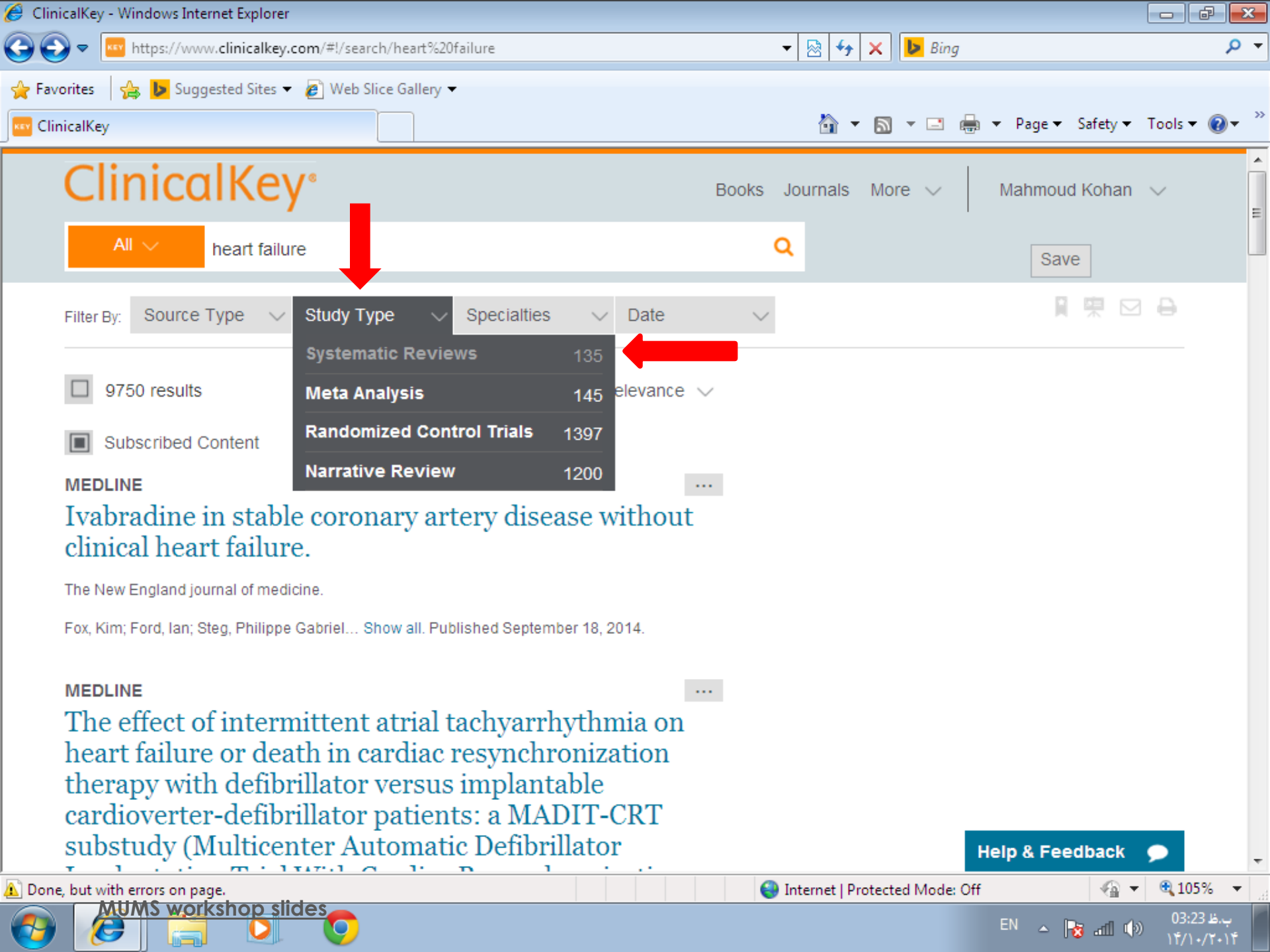
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Taylor RS, Sagar VA, Davies EJ, Briscoe S, Coats AJ, Dalal H, Lough F, Rees K, Singh S. - Cochrane Database Syst Rev - ; 4 (); CD003331

Abstract

Previous systematic reviews and meta-analyses consistently show the positive effect of exercise-based rehabilitation for heart failure (HF) on exercise capacity; however, the direction and magnitude of effects on health-related quality of life, mortality and hospital admissions in HF remain less certain. This is an update of a Cochrane systematic review previously published in 2010.

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The Reality of Heart Failure in Latin America

Edimar Alcides Bocchi MD, PhD, Alexandra Arias, Hugo Verdejo MD, Mirta Diez, Efraín Gómez MD and Pablo Castro

The Reality of Heart Failure in Latin America, 2013-09-10Z, Volume 62, Issue 11, Pages 949-958, Copyright © 2013 American College of Cardiology Foundation

Heart failure (HF) data in Latin America (LA) were reviewed to guide health service planning in the prevention and treatment of HF. The HF epidemiology and the adequacy of relevant health service provision related to HF in LA are not well delineated. A systematic search of the electronic databases and the World Health Organization website was undertaken for HF in LA. LA countries have reduced gross income and lower total expenditure on health per capita. LA is a heterogeneous region with HF risk



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Vol. 62, No. 11, 2013
ISSN 0735-1097/\$36.00
http://dx.doi.org/10.1016/j.jacc.2013.08.014

STATE-OF-THE-ART PAPER

The Reality of Heart Failure in Latin America

Edimar Akides Bocchi, MD, PhD,* Alexandra Ariza, MD,† Hugo Varela, MD,‡ Mirra Diaz, MD,§ Efraín Gómez, MD,‡ Pablo Castro, MD,‡ for the Interamerican Society of Cardiology
São Paulo, Brazil; Mexico City, Mexico; Santiago, Chile; Buenos Aires, Argentina; and Bogotá, Colombia

Heart failure (HF) data in Latin America (LA) was reviewed to guide health service planning in the prevention and treatment of HF. The HF epidemiology and the adequacy of current health service provision related to HF in LA are not well defined. A systematic search of the electronic databases and the World Health Organization website was undertaken for HF in LA. LA countries have reduced gross income and lower total expenditure on health per capita. LA is a heterogeneous region with HF risk factors of developed and nondeveloped countries, including lower risk of raised blood glucose levels, obesity, tobacco, and aging, whereas systemic hypertension (SH), rheumatic fever, and Chagas' disease (CD) are higher in LA. In etiologies of HF in LA are idiopathic dilated cardiomyopathy (from 1.3% to 3.7%), CD (from 1.3% to 21.5%), ischemic (from 68% to 17%), SH (from 54% to 70%), valvular (from 3% to 2.2%), and alcohol related (from 1.1% to 5%). The prognosis of CD HF is worse than for other etiologies. Chronic HF is a cause of death in 6.3% of cases. Decompensated HF is the main cause of cardiovascular hospitalization. The prevalence of systolic HF varies from 64% to 6.9%. LA is under the awful paradox of having the HF risk factors and HF epidemiology of developed countries with the added factors of SH, CD, and rheumatic fever. Overall, in the scenario of lower total expenditure on health per capita and lower gross national income per capita, new strategies are essential for prevention and treatment of HF in LA. (J Am Coll Cardiol 2013;62:1029-40) © 2013 by the American College of Cardiology Foundation

The knowledge of risk factors of heart failure (HF) in Latin America (LA) is essential because apart from the prevalence of risk factors comparable to developed countries in certain areas, the epidemiology of HF can also be influenced by risk factors that are more frequent in LA. In fact, a review about HF in LA is of immediate interest. Also, the review of new LA HF data, including HF risk factors obtained from the World Health Organization (WHO), recent registry data from LA countries and institutions, epidemiological studies, analyses of LA HF populations selected for most HF trials, LA expenditure in health and gross income, and new advances in the cumulative knowledge of neglected diseases in LA, could have a strong impact on planning future health policies for HF in LA. Therefore, the objective of this review is to offer an HF LA update as a valuable resource for researchers, clinicians, healthcare policymakers, media professionals, and many others who seek the best available data on HF.

Systematic Review Methodology

The online MEDLINE PubMed database (National Center for Biotechnology Information, U.S. National Library of Medicine, Bethesda, Maryland) and other electronic bibliographic databases (e.g., ClinicalTrials.gov, Cochrane Library, Elsevier/ScienceDirect, Scielo, LILACS) were searched for data literature from LA in September and October 2012. The search strategy used the MeSH terms "heart failure," "chronic heart failure," "decompensated heart failure," "acute heart failure," "Chagas' disease," "chagasic heart failure," "diastolic heart failure," and "systolic heart failure." All titles and abstracts of the articles were evaluated. After exclusion based on the title and abstract, full articles were evaluated and articles meeting the inclusion criteria were identified. Relevant articles with information about epidemiology were examined and those reviewed. Data from the WHO were also obtained.

Risk Factors for HF in LA

Socioeconomic deprivation is a powerful independent predictor of HF development and adverse outcomes (1). The midland gross income per capita of LA countries (US\$3,535) in comparison with Canada (US\$13,170) and the United

From the *Heart Institute (InCor) of São Paulo University Medical School, São Paulo, Brazil; Instituto Nacional de Cardiología Ignacio Chávez-México, Mexico City, Mexico; †Instituto de Medicina, Pontificia Universidad Católica de Chile, Santiago, Chile; ‡Instituto Cardiovascular de Buenos Aires, Buenos Aires, Argentina; and §Instituto Cardiovascular de Colombia, Cali, Colombia. Dr Bocchi has received research funding from Argentinian and Serbian institutions (from Fundación de Estudios e Investigaciones Cardíacas, and registration fees from Fundación de Estudios e Investigaciones Cardíacas, and served as a steering committee for Servicio De Cardiología de Universidad de Buenos Aires, Santiago, Chile, and as a steering committee for Servicio De Cardiología de Universidad de Chile, Santiago, Chile. Dr Bocchi has received research funding from Argentinian and Serbian institutions (from Fundación de Estudios e Investigaciones Cardíacas, and registration fees from Fundación de Estudios e Investigaciones Cardíacas, and served as a steering committee for Servicio De Cardiología de Universidad de Buenos Aires, Santiago, Chile, and as a steering committee for Servicio De Cardiología de Universidad de Chile, Santiago, Chile. All other authors have reported that they have no relationships or conflicts of interest related to the content of this paper or research.

Manuscript received April 24, 2013; revised manuscript received June 7, 2013; accepted June 10, 2013.

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Published August 29, 2014. Conditions: Heart Failure; Coronary Artery Disease; Ischemic Cardiomyopathy; Non-ischemic Cardiomyopathy. Interventions: Other: Advanced cardiac imaging; Other: Standard Cardiac Imaging.

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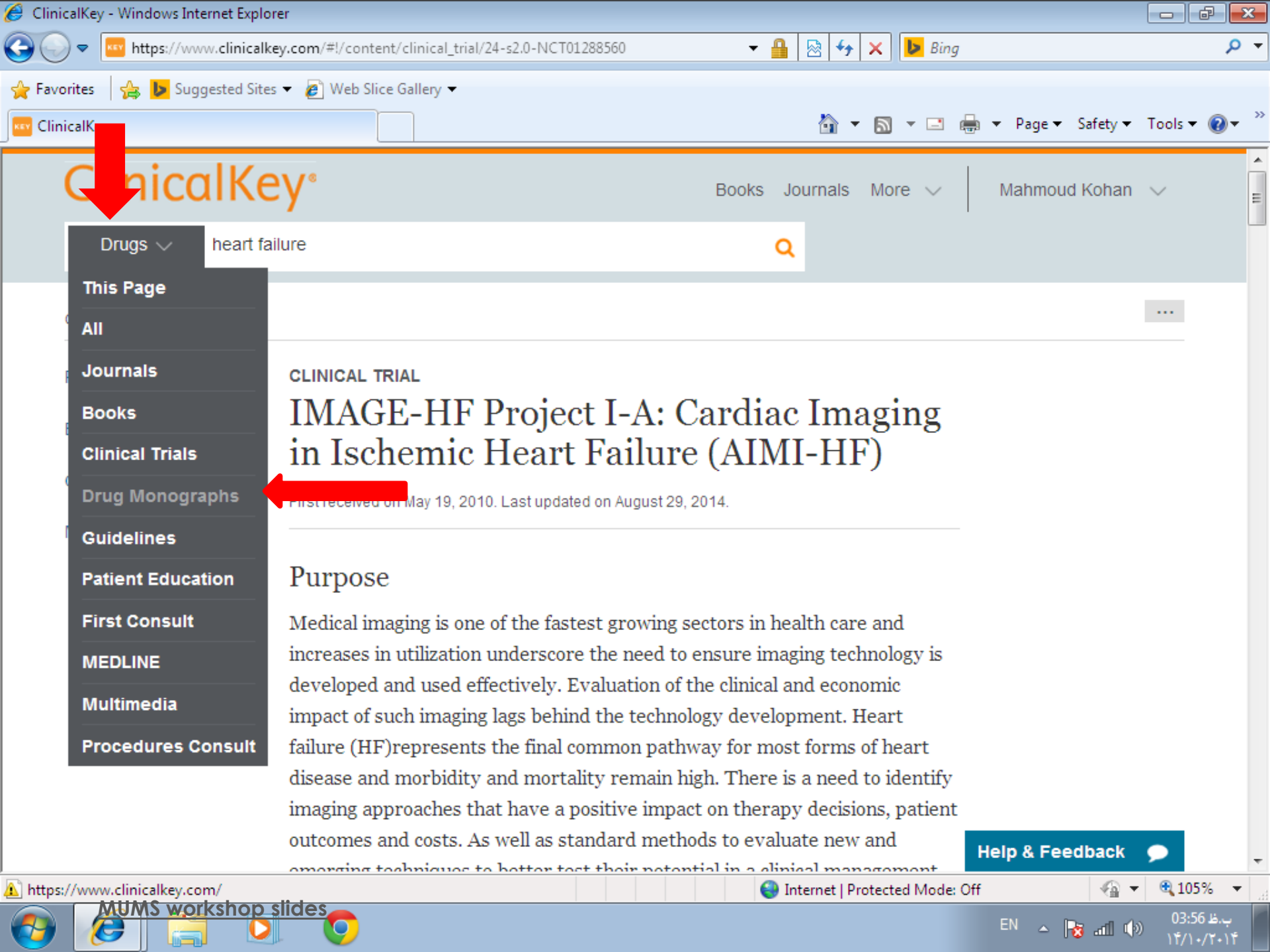
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First received on May 19, 2010. Last updated on August 29, 2014.

Purpose

Medical imaging is one of the fastest growing sectors in health care and increases in utilization underscore the need to ensure imaging technology is developed and used effectively. Evaluation of the clinical and economic impact of such imaging lags behind the technology development. Heart failure (HF) represents the final common pathway for most forms of heart disease and morbidity and mortality remain high. There is a need to identify imaging approaches that have a positive impact on therapy decisions, patient outcomes and costs. As well as standard methods to evaluate new and emerging techniques to better test their potential in a clinical management

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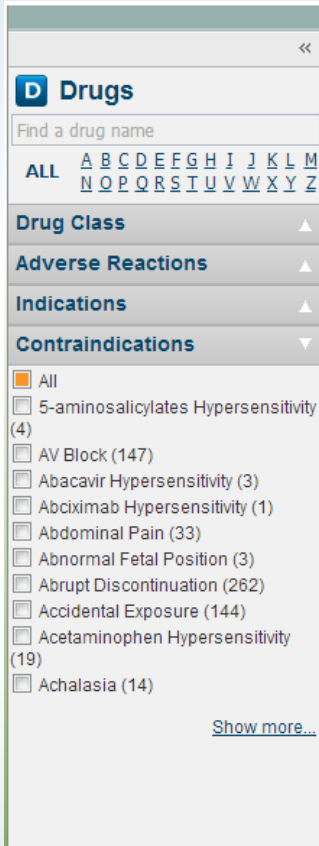
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We explore the menu bar : DRUGS



The screenshot displays the ClinicalKey Elsevier website interface. At the top, a dark blue navigation bar contains the following menu items: Journals, Books, Practice Guidelines, Patient Education, **Drugs** (highlighted with a red box), Multimedia, and CME. To the right of this bar is a 'My ClinicalKey' dropdown menu. Below the navigation bar, the 'CLINICAL KEY' logo is prominently displayed in green and orange, followed by the 'ELSEVIER' logo in blue. A secondary navigation bar below the logo repeats the menu items: Journals, Books, Practice Guidelines, Patient Education, **Drugs**, Multimedia, and CME. On the right side of this bar, it shows 'My ClinicalKey', a user profile for 'Shirazeh Esk...', and a 'Logout' link. A search bar is located below the navigation bar, with a 'Search' button to its right. The main content area is titled 'Drugs' and features a search input field with the placeholder text 'Find a drug name'. Below the search field are several filterable sections: 'All' (with a dropdown menu for letters A-Z), 'Drug Class', 'Adverse Reactions', 'Indications', and 'Contraindications'. The 'Contraindications' section is expanded, showing a list of categories such as '5-aminosalicylates Hypersensitivity (4)', 'AV Block (149)', 'Abacavir Hypersensitivity (3)', 'Abacavir; Lamivudine, 3TC', 'Abacavir; Lamivudine, 3TC; Zidovudine, ZDV', 'Abarelix', 'Abatacept', 'Abciximab', 'Abetimus', 'Abiraterone', 'AbobotulinumtoxinA', and 'Absorbable Gelatin Sponge'. A 'Show more...' link is visible at the bottom of this list. On the right side of the main content area, there is a list of drug categories starting with 'A Thru Z', including 'A Thru Z Advantage', 'A Thru Z Select', 'A-Free Prenatal®', 'ADEKs', 'ADEKs® Drops', 'Abacavir', 'Abacavir; Lamivudine, 3TC', 'Abacavir; Lamivudine, 3TC; Zidovudine, ZDV', 'Abarelix', 'Abatacept', 'Abciximab', 'Abetimus', 'Abiraterone', 'AbobotulinumtoxinA', and 'Absorbable Gelatin Sponge'. At the bottom of the page, there is a footer with 'MUMS workshop slides' on the left and 'Copyright © 2014 Elsevier Inc. All rights reserved.' on the right.

Filters: DRUGS



D Drugs

Find a drug name

ALL A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

Drug Class ▲

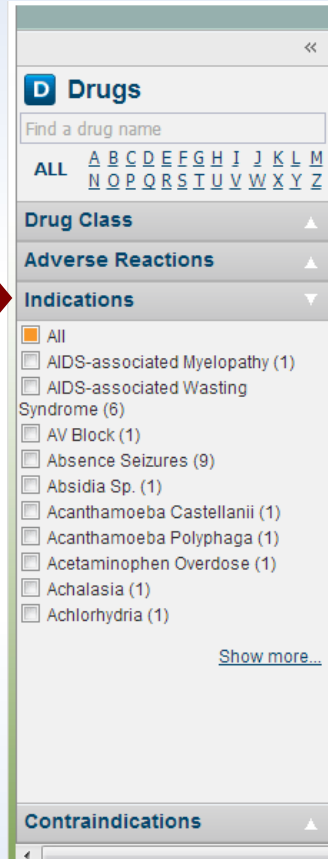
Adverse Reactions ▲

Indications ▲

Contraindications ▼

- All
- 5-aminosalicylates Hypersensitivity (4)
- AV Block (147)
- Abacavir Hypersensitivity (3)
- Abciximab Hypersensitivity (1)
- Abdominal Pain (33)
- Abnormal Fetal Position (3)
- Abrupt Discontinuation (262)
- Accidental Exposure (144)
- Acetaminophen Hypersensitivity (19)
- Achalasia (14)

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D Drugs

Find a drug name

ALL A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

Drug Class ▲

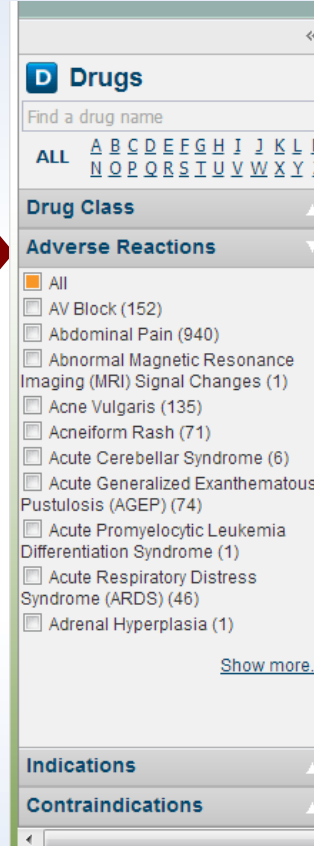
Adverse Reactions ▲

Indications ▼

- All
- AIDS-associated Myelopathy (1)
- AIDS-associated Wasting Syndrome (6)
- AV Block (1)
- Absence Seizures (9)
- Absidia Sp. (1)
- Acanthamoeba Castellanii (1)
- Acanthamoeba Polyphaga (1)
- Acetaminophen Overdose (1)
- Achalasia (1)
- Achlorhydria (1)

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Contraindications ▲



D Drugs

Find a drug name

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Drug Class ▲

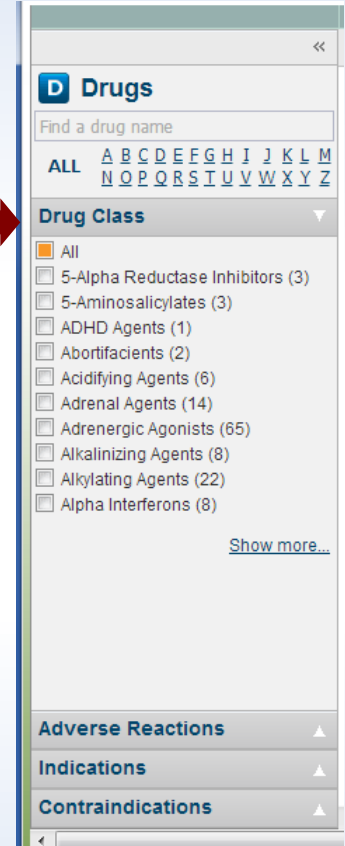
Adverse Reactions ▼

- All
- AV Block (152)
- Abdominal Pain (940)
- Abnormal Magnetic Resonance Imaging (MRI) Signal Changes (1)
- Acne Vulgaris (135)
- Acneiform Rash (71)
- Acute Cerebellar Syndrome (6)
- Acute Generalized Exanthematous Pustulosis (AGEP) (74)
- Acute Promyelocytic Leukemia Differentiation Syndrome (1)
- Acute Respiratory Distress Syndrome (ARDS) (46)
- Adrenal Hyperplasia (1)

[Show more...](#)

Indications ▲

Contraindications ▲



D Drugs

Find a drug name

ALL A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

Drug Class ▼

- All
- 5-Alpha Reductase Inhibitors (3)
- 5-Aminosalicylates (3)
- ADHD Agents (1)
- Abortifacients (2)
- Acidifying Agents (6)
- Adrenal Agents (14)
- Adrenergic Agonists (65)
- Alkalinizing Agents (8)
- Alkylating Agents (22)
- Alpha Interferons (8)

[Show more...](#)

Adverse Reactions ▲

Indications ▲

Contraindications ▲

D Drugs

Find a drug name

ALL A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

Drug Class

Adverse Reactions

All

Acute Promyelocytic Leukemia

D Arsenic Trioxide

Indications

Contraindications

References

Top of Monograph

Classifications

Indications

Administration

Contraindications

Interactions

Adverse Reactions

Monitoring Parameters

References

D Arsenic Trioxide

Trisenox

Drug Information Provided by Gold Standard

Classifications

- Antineoplastic Agents

Description: Arsenic trioxide (As_2O_3) is an inorganic metal. Arsenic has been used for centuries as a component of medicinal preparations. Commonly, arsenic was used to treat syphilis before the introduction of penicillin; arsenical melarsoprol is used in the treatment of the meningoencephalitic stage of African trypanosomiasis. The medical effects of systemic arsenic (as Fowler's solution) in the treatment of myelogenous leukemia have been described in medical texts of the 19th and early 20th centuries. Arsenic trioxide has been shown to be an effective differentiating agent and inducer of apoptosis, or programmed cell death. Similar to all-*trans*-retinoic acid (tretinoin, ATRA), arsenic trioxide has been shown to have specific activity in acute promyelocytic leukemia (APL), although the exact mechanisms differ. Arsenic trioxide can produce complete remissions in patients who have relapsed with APL following treatment with ATRA and chemotherapy. Arsenic trioxide has received FDA orphan drug designations for the treatment of APL, chronic and acute myeloid leukemias, multiple myeloma, and myelodysplastic syndromes. Clinical studies are evaluating the role of arsenic trioxide in the treatment of hormone-refractory prostate cancer, renal cell carcinoma, cervical cancer, non-Hodgkin's lymphoma, Hodgkin's disease, acute lymphocytic and myelogenous leukemias, and lymphoproliferative disorders. The combination of tretinoin, chemotherapy, and arsenic trioxide for the treatment of APL is being evaluated in a phase III study. The FDA approved arsenic trioxide for relapsed or refractory APL in September 2000.

Mechanism of Action: The mechanism of action of arsenic trioxide is not completely understood, but may be dependent to some degree on the dose administered and tumor type. Observations of arsenic trioxide *in vitro* have not completely correlated with *in vivo* results. Acute promyelocytic leukemia is caused by a genetic lesion that disrupts the alpha retinoic acid receptor (RAR-alpha). The fusion protein that is formed, PML-RAR-alpha, inhibits apoptotic pathways and blocks myeloid differentiation. Arsenic trioxide degrades the PML-RAR-alpha fusion protein; however, arsenic trioxide causes a different pattern of proteolysis than all-*trans*-retinoic acid (ATRA). By degrading the PML-RAR-alpha protein, arsenic trioxide therapy allows myeloid differentiation to continue and apoptosis to occur. Unlike ATRA, arsenic trioxide does not down regulate wild-type RAR-alpha. Effects of arsenic trioxide are concentration dependent: induction of terminal differentiation occurs at relatively low concentrations (0.1—0.5 nM) and apoptosis occurs at higher concentrations (0.5—2 μM). Other suggested actions include downregulation of Bcl-2, modification of the glutathione redox system, caspase activation, modulation of mitochondrial permeability transition pore, and inhibition of angiogenesis via decreases in vascular endothelial growth

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Heart Failure in Adults

Institute for Clinical Systems Improvement. Published November 26, 2013.

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National Institute for Health and Care Excellence NICE. Published October 6, 2014.

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Executive Summary – July 2013

Heart Failure in Adults Guideline

Scope and Target Population:

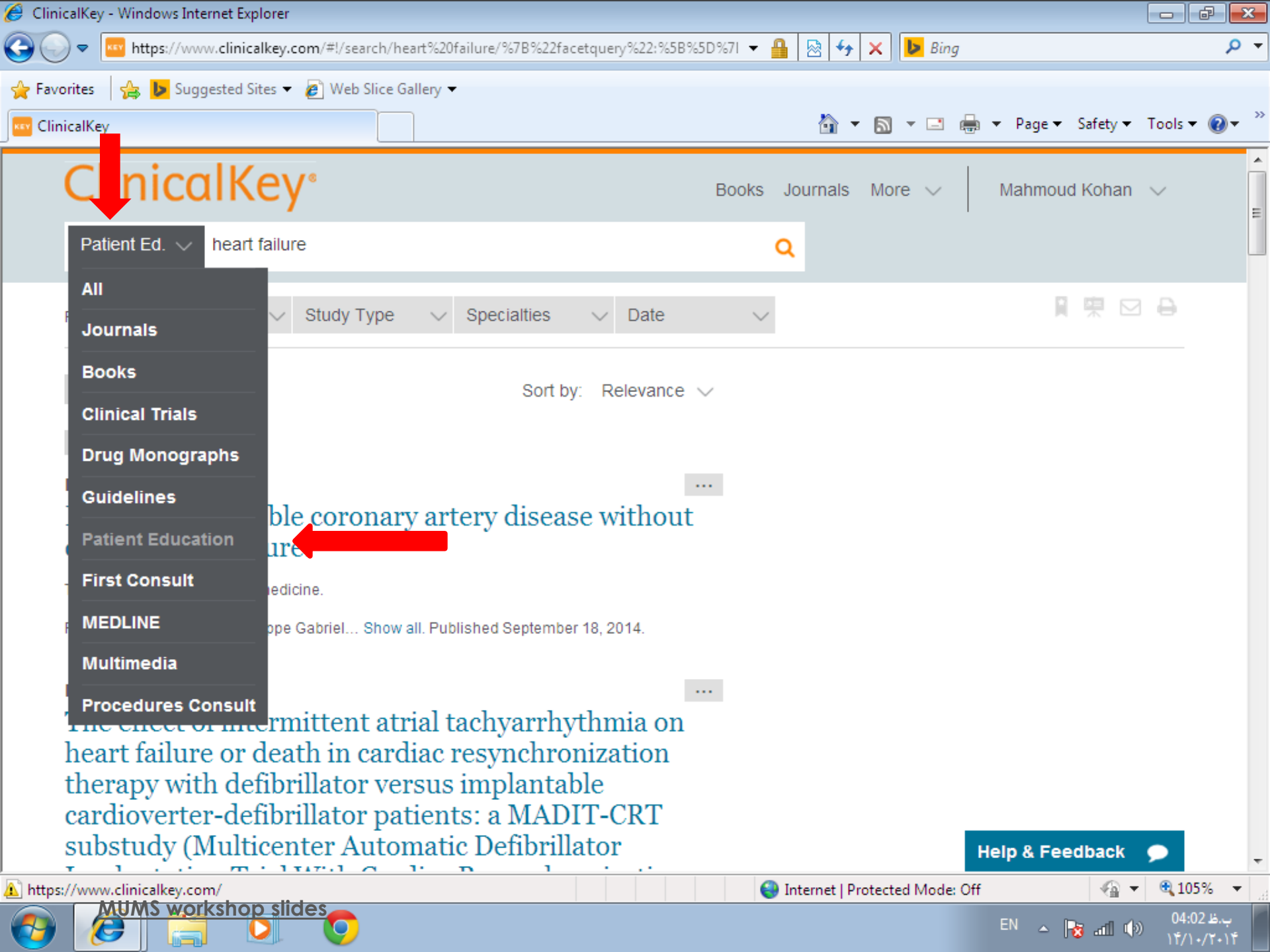
The scope and target population of this document focuses on the adult patient age 18 years and older with suspected heart failure. This includes the diagnosis and outpatient management of the patient. Consideration will also be made to reducing all-cause readmission rates to the hospital for patients who had been previously hospitalized with an exacerbation of heart failure.

Aims:

1. Decrease the readmission rate for patients 18 years and older with heart failure diagnosis, within 30 days of discharge following hospitalization for heart failure.
2. Increase the rate of heart failure patients 18 years and older who receive optimum evidence-based pharmacologic treatment with heart failure.
3. Improve the use of diagnostic testing in order to identify and then appropriately treat adult patients with heart failure.
4. Increase the rate of heart failure patients age 18 years or older who have comprehensive patient education and follow-up care.

Clinical Highlights:

- Evaluate patients presenting with heart failure for exacerbating and underlying causes, including coronary artery disease, hypertension, valvular disease and other



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Patient Ed. heart failure

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Study Type

Specialties

Date

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able coronary artery disease without

medicine.

ope Gabriel... Show all. Published September 18, 2014.

The effect of intermittent atrial tachyarrhythmia on heart failure or death in cardiac resynchronization therapy with defibrillator versus implantable cardioverter-defibrillator patients: a MADIT-CRT substudy (Multicenter Automatic Defibrillator

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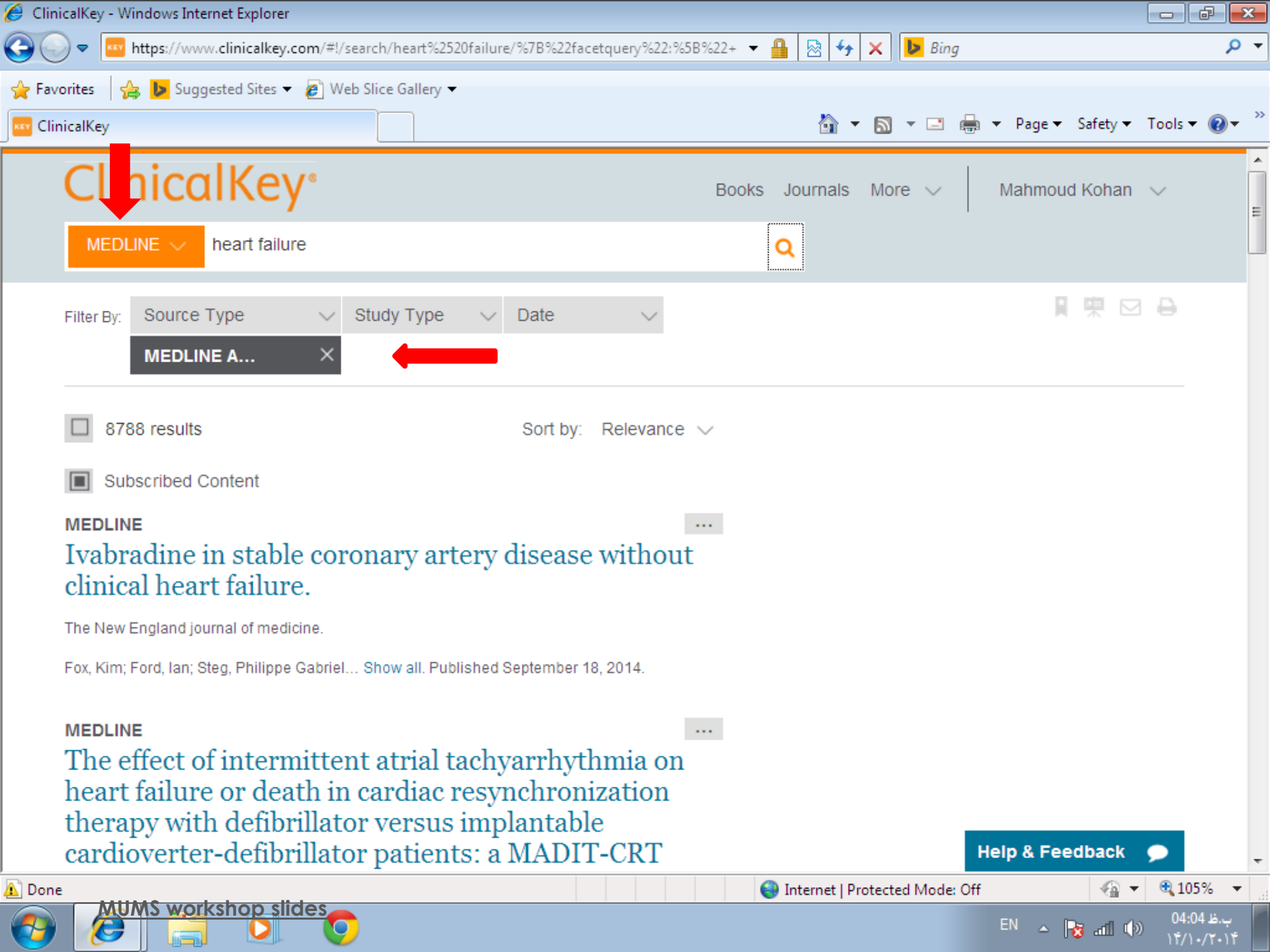
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Ivabradine in stable coronary artery disease without clinical heart failure.

The New England journal of medicine.

Fox, Kim; Ford, Ian; Steg, Philippe Gabriel... Show all. Published September 18, 2014.

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The effect of intermittent atrial tachyarrhythmia on heart failure or death in cardiac resynchronization therapy with defibrillator versus implantable cardioverter-defibrillator patients: a MADIT-CRT

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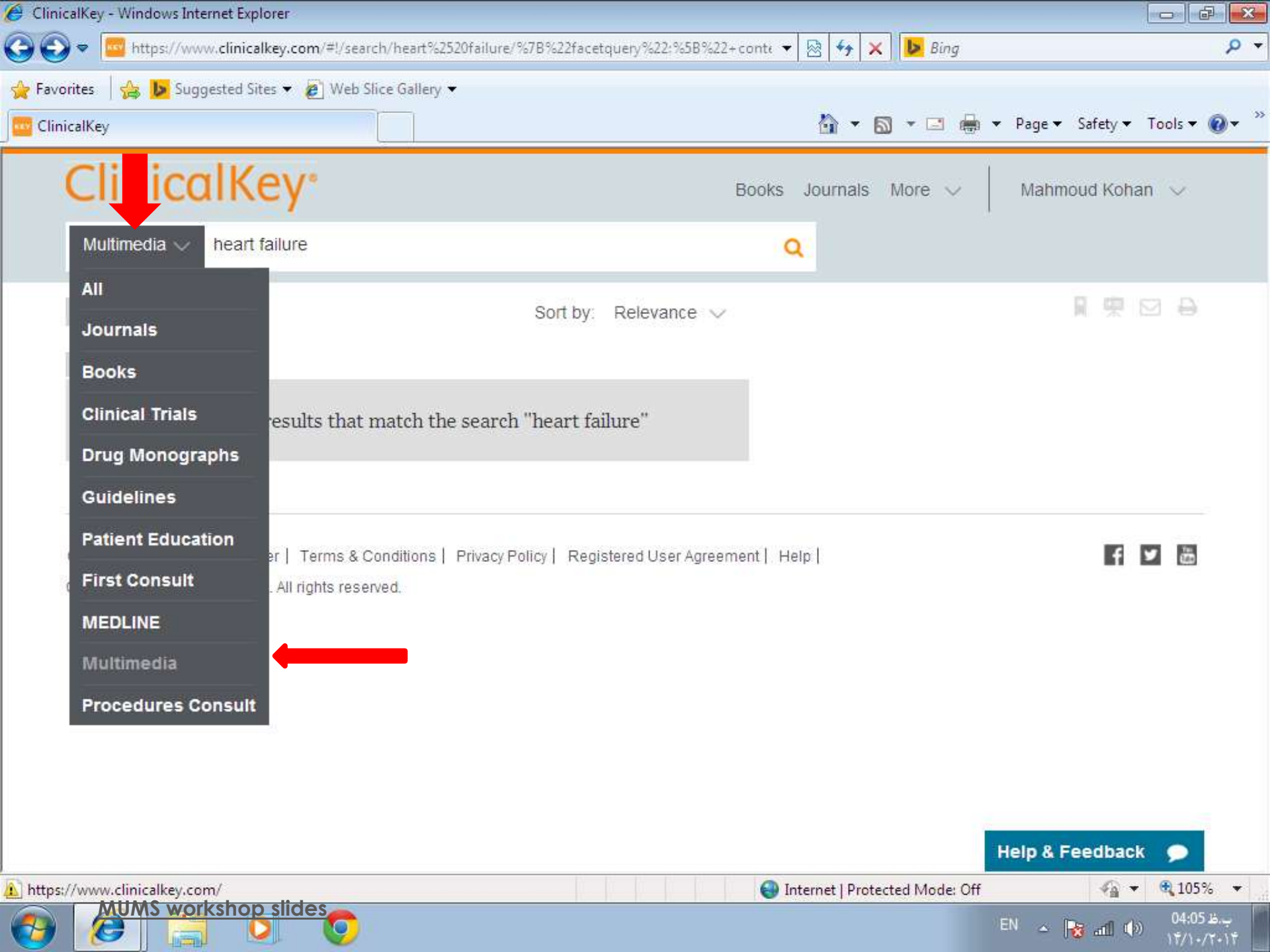
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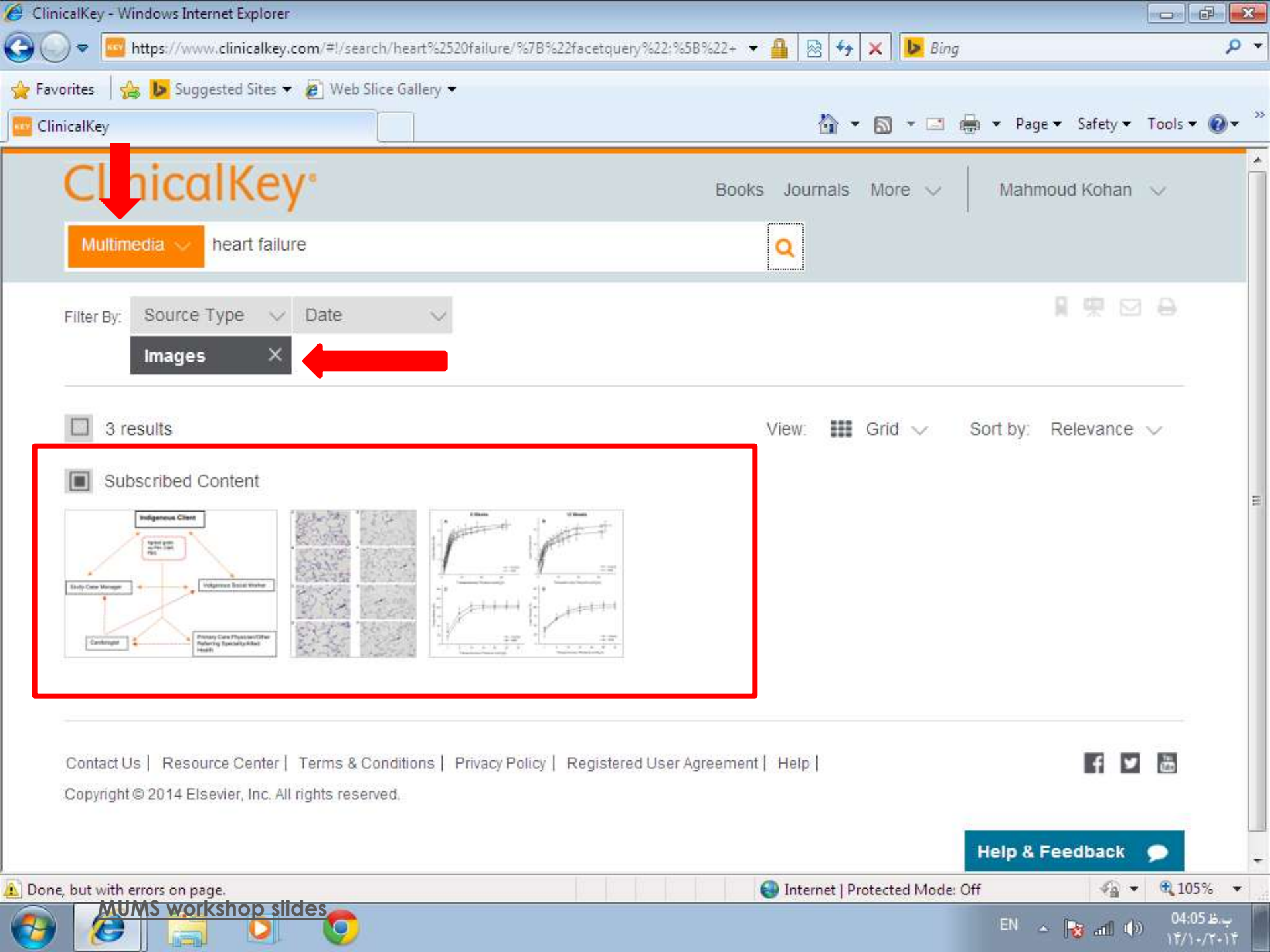
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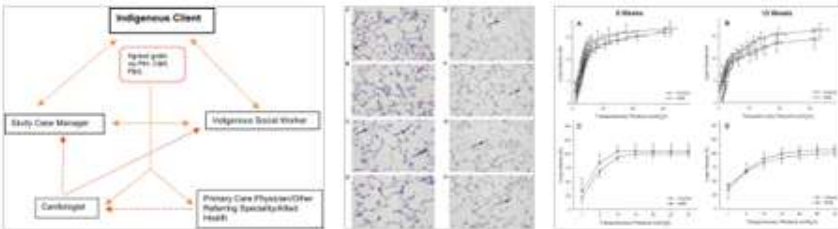
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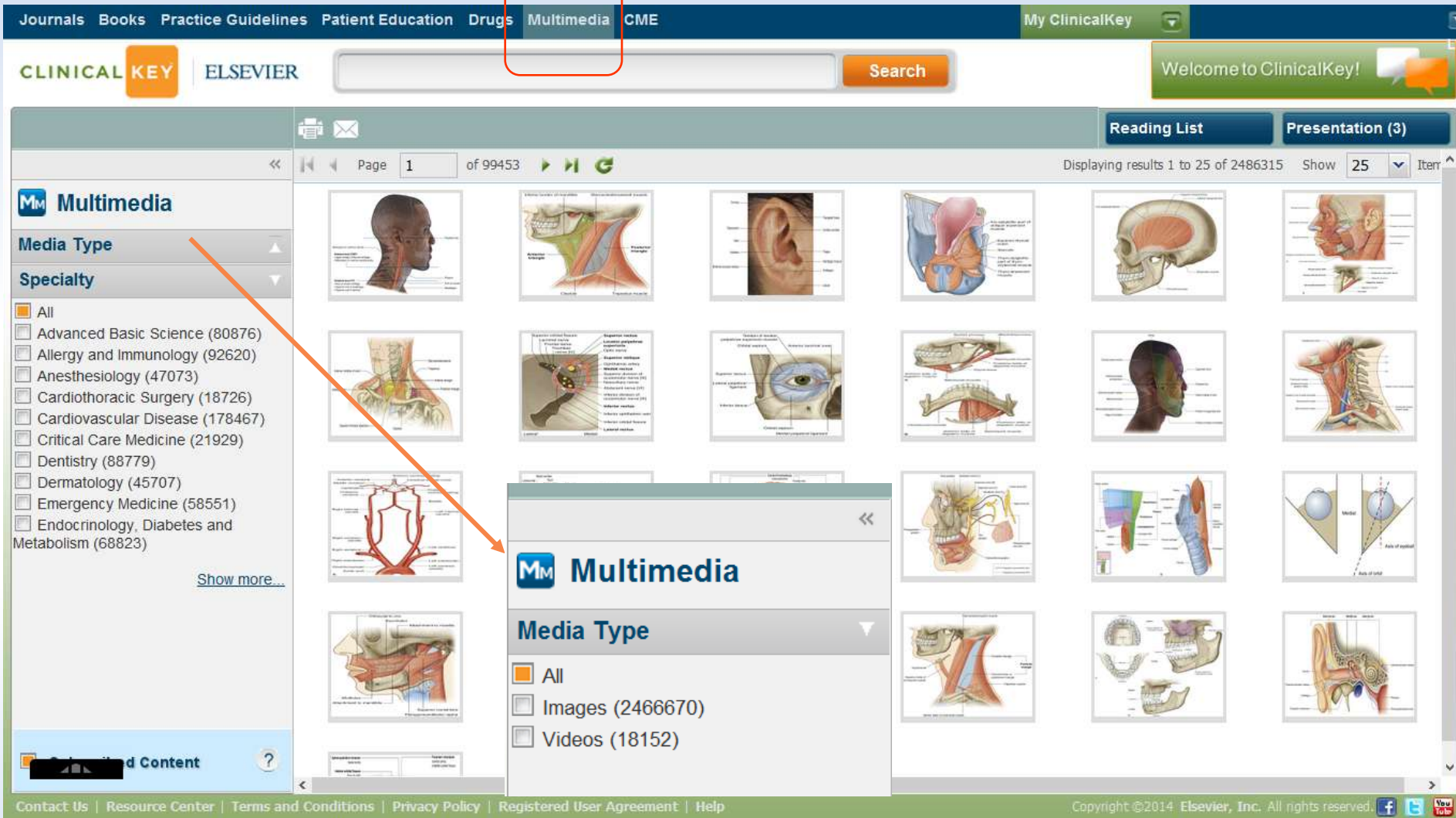
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We explore the menu bar : **MULTIMEDIA**

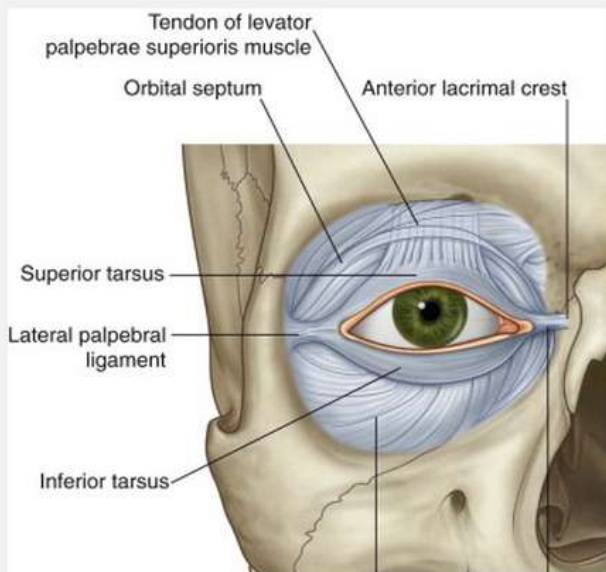


The screenshot shows the ClinicalKey website interface. At the top, the navigation bar includes 'Journals', 'Books', 'Practice Guidelines', 'Patient Education', 'Drugs', 'Multimedia', and 'CME'. The 'Multimedia' tab is highlighted with a red box. Below the navigation bar, the 'CLINICAL KEY' and 'ELSEVIER' logos are visible, along with a search bar and a 'Search' button. A green banner on the right says 'Welcome to ClinicalKey!'. The main content area displays a grid of multimedia items, including anatomical diagrams and images. On the left side, there is a sidebar with 'Multimedia' and 'Media Type' filters. An orange arrow points from the 'Media Type' filter in the sidebar to a detailed filter overlay that shows 'Media Type' with options for 'All', 'Images (2466670)', and 'Videos (18152)'. The footer contains 'Contact Us', 'Resource Center', 'Terms and Conditions', 'Privacy Policy', 'Registered User Agreement', and 'Help'. Copyright information for Elsevier, Inc. is also present.

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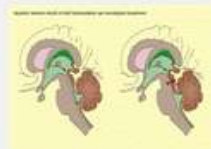
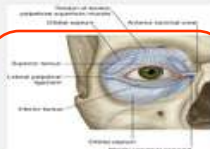
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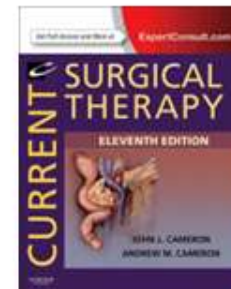
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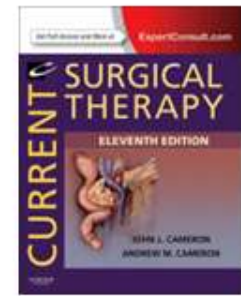
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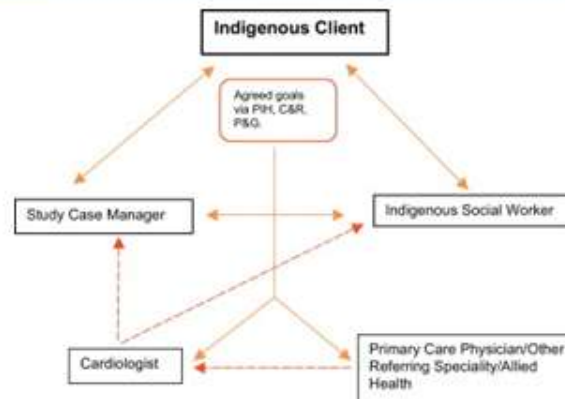
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12 10 8 6 4 2 0 2 4 6 8 10 12



Project management team. Upon diagnosis of heart failure, referral is made to Indigenous social worker and study case manager (Red dotted arrow). Cultural and language issues are raised. Creating a patient focused CDSMP becomes the main goal. A suitable time is organised to complete the Flinders Model. The loop restarts and the patient now becomes the focus and leads the management team (Orange continuous arrow). The physician provides best available evidenced care. Issues raised via CDSMP are the basis for determining allied health and other measures that appear as barriers to this care. All communications and investigations concerning the patients will be provided to the case manager, and filed, who acts as the patients advocate in the CDSMP. (Concept from Ref [40]). (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of the article.)

Australian Indigenous Chronic Disease Optimisation Study (AUSI-CDS) Prospective Observational Cohort Study to Determine if an Established Chronic Disease Health Care Model can be Used to Deliver Better Heart Failure Care Among Remote Indigenous Australians: Proof of Concept—Study Rationale and Protocol
 Iyngkaran P, PRAQR, Heart, Lung and Circulation, Volume 22, Issue 11, 930-939

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