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Nebraska ACC

SUPPORTING PHYSICIANS, TRAINEES, AND CARDIOVASCULAR TEAM MEMBERS WITH EDUCATION, ADVOCACY, & NETWORKING OPPORTUNITIES

Chapter News

Andrew M. Goldsweig, MD, MS, FACC, FSCAI, FSVM, RPVI
Governor, Nebraska ACC

The weather outside may be frightful, but there's nothing hotter than the Nebraska ACC!

- Congratulations to our Newsletter Editor-in-Chief **Dr. Anuradha Tunuguntla** who was elected to serve as the **next Nebraska ACC Chapter Governor** from 2023-2026! Thank you to all of the wonderful candidates for all of your hard work on behalf of the Chapter.
- Nebraska ACC **elections for secretary-treasurer** will be held soon. You will receive a separate e-mail with instructions for voting in this election.
- Attend the **ACC.22 Scientific Sessions** April 2-4, 2022 in Washington, DC. Register at accscientificsession.acc.org.
- Cheer the **Nebraska FIT Jeopardy Team** to victory at ACC.22! Meet up with Nebraska colleagues in Washington for **coffee after the first round Jeopardy match**. Details coming soon.
- The Nebraska ACC Advocacy Committee plans to **meet with State Senator Jen Day** (District 49) this spring to discuss telehealth coverage, prior authorization, and pharmacy benefit pricing regulation.
- The Nebraska ACC 4th **Annual Meeting** took place on October 20, 2021 with keynote speaker Dr. David J. Cohen. Photos and a recording of the event are online at www.nebraskacardiology.org/events/annual-meeting-2021. Missed the meeting? Watch it on the website and fill out the form to claim CME! Thank you to the 51 cardiologists, CV team members, and trainees who attended.
- Congratulations to the winners of the 3rd annual **FIT Poster Competition**: Drs. Cason Christensen, Waiel Abusnina, Robert Gavin, and Mahmoud Ismayl. Congratulations to all 37 submitters of accepted abstracts. Thank you to Nebraska ACC Education Committee Chair Dr. J. William Schleifer and FIT Section Chairs Drs. Swethika Sundaravel, Brett Van Briggle, Abhishek Thandra, and Kashif Shaikh for their hard work in planning the event. The abstracts are published online at www.nebraskacardiology.org/2021-annual-virtual-meeting-fit-poster-competition.
- Planning has begun for the Nebraska ACC **2nd Annual Cardiovascular Team Meeting** to be held on May 19, 2022 at the Happy Hollow Club. E-mail CVT Representative Jessica Livingston, MSN, AAAC (livingston@nebraskamed.com) to get involved in future CVT events.
- We want to hear from YOU! Contact Dr. Anu Tunuguntla if you would like to **write for this Newsletter**. The Newsletter features four brief articles quarterly: Chapter News, Cardiology Update (by a cardiologist), FIT Corner (by a fellow in training), and CVT Corner (by a CV team member).
- Please **follow us** on Twitter and Facebook!

Nebraska CHAPTER

1045 Lincoln Mall, Suite 200, Lincoln, Nebraska, 68508 • www.nebraskacardiology.org • (402) 474-4472

CARDIOLOGY UPDATE

Mohamed Ayan, MBBCh, FACC, RPVI
CHI Health

UPDATE TO PULMONARY EMBOLISM TREATMENT!

Pulmonary embolism (PE) is a major cause of morbidity and mortality in the United States and worldwide. Early diagnosis and evaluation by multidisciplinary pulmonary embolism rapid-response team is crucial to determine the best course of action, coordinate the clinical care, and improve outcomes. Once diagnosis of PE is confirmed patient should be categorized based on early mortality risk into high, intermediate (high vs low), and low risk of death, based on the hemodynamics, pulmonary embolism severity index, signs of right ventricular dysfunction, and abnormal cardiac biomarkers. All the patients should be started on anticoagulation.

For patients in the high-risk group, systemic thrombolysis is the treatment of choice with or without hemodynamic support. However, in patients who have high bleeding risk, failed systemic thrombolysis, or shock that is likely to cause death before systemic thrombolysis can take effect (usually within hours), if appropriate expertise is available, catheter assisted thrombus removal with or without catheter directed thrombolysis is recommended.

Patients with intermediate high risk should be monitored closely over the first hours due to the risk of early hemodynamic decompensation. Percutaneous catheter-directed treatment CDT may be considered especially in patients who develop potential signs of hemodynamic instability.

For low-risk patients early discharge with continuation of anticoagulant treatment at home should be considered.

The long-term use of anticoagulation depends on the risk of recurrence. Patients with low risk (major transient/reversible risk factor, for example major surgery, confined in bed in hospital, or trauma with fracture), it is recommended to discontinue anticoagulation in 3 months. Patients with intermediate and high risk of recurrence (unprovoked PE with no identifiable risk factors, recurrence, active cancer, and antiphospholipid antibody syndrome APA) needs long term anticoagulation. The risk of bleeding should also be considered when deciding about extending the anticoagulation. First line treatment includes NOAC over warfarin. Patients selected to receive long term therapy should be offered a reduced dose over full dose of apixaban or rivaroxaban. In patients with high risk of recurrence who are stopping anticoagulant therapy, aspirin is recommended if there is no contraindication to reduced risk of recurrence.

Patient with cancer-associated thrombosis (CAT), oral Xa inhibitors are recommended over low molecular weight heparin for both initiation and treatment phase of therapy. However, in patients with CAT and GI malignancy, there is a higher risk of major bleeding with edoxaban and rivaroxaban compared to LMWH and apixaban. Apixaban should be considered for such patients.

Patients with acute PE in the setting of APS, VKA with a target INR of 2.5 is recommended over DOAC therapy.

There are still evidence gaps that needs further research. For example, the clinical benefits vs. risks of catheter-based reperfusion modalities in patients with intermediate-high-risk PE needs to be evaluated in prospective randomized trials. The role of ECMO in the management of acute high-risk PE still awaits support by additional evidence

In conclusion, the clinical management of patients with PE has changed considerably in recent years with regard to diagnosis, risk stratification and treatment (new evidence on the role of catheter directed therapy and introduction of direct oral anticoagulants [DOACs]). Optimal management strategies for pulmonary embolism should reduce mortality and recurrent venous thromboembolism at the cost of a low risk of bleeding complication.

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FIT CORNER

Shantanu Patil, MD
Cardiology Fellow
Creighton University
School of Medicine

PARENTING DURING TRAINING

Up to half of medical residents and fellows report having their first child during training. The American Association of Pediatrics supports for 8 weeks of paid parental leave regardless of gender. Despite this, most female trainee physicians take only 4 weeks of paid maternal leave on average. Male trainee physicians on average take only 2 weeks on paid paternal leave. This is in part due to residents and fellows being treated as non-employees by the hospital system. Female trainees often cobble together an extended leave by combining vacation time, elective rotations, and research time. After recognizing this fallacy, the American Board of Medicine Specialties (ABMS) announced in July 2021 that residents and fellows be given minimum 6 weeks away for medical leave or caregiving once during training, without having to use vacation or sick leave and without having to extend their training.[1] While this may still not be enough, it is certainly a progress, and we'll have to see how fairly training programs apply this.

Rigorous hours of training and inadequate parental leave impacts family planning decisions resulting in older maternal age in pregnancy which comes with increased risk of pregnancy related complications most common of which are threatened abortion and preterm labor.[2] Trainees often change rotations to avoid fetal exposure risks to radiation or increased maternal stress load because of call responsibility in the weeks immediately before delivery.This often leads to taking higher number of calls post-pregnancy and with increased responsibilities at home can lead to burnout and postpartum depression. Despite increased workload, program surveys have shown no decrease in competency, or change in career plans of cardiology fellows irrespective of gender.[3] However, it was noted that both mothers and fathers had difficulty completing voluntary research because of pregnancy and childcare obligations during training, with mothers reporting the effect twice as much as their male colleagues.3 While studies have shown that child bearing doesn't affect competency of trainees, there is concern that lack of flexibility in training affects parent-child bonding.

New parents often feel their pregnancy as a burden to their co-workers. The natural variability surrounding pregnancy and delivery, and unexpected complications is often not considered while creating a schedule leaving to pull other trainees off "easier" rotations to cover essential rotations and call responsibilities on short notice.

MY PERSONAL EXPERIENCE

Our daughter decided to come 3 weeks earlier than her expected date. I was rotating through the interventional service during that time. My co-fellows graciously helped to cover me during this unexpected time. My program gave me time off immediately along with rearranging my clinic. Returning to work was tough. Now, I had an additional responsibility of a newborn. This would mean tending to a crying baby at night, changing soiled diapers and making sure my wife gets adequate rest so she can care for the baby when I was at work.

It would mean changing my study habits such as listening to audio-lectures rather than

FIT CORNER(CONTINUED)

reading text so I could keep an eye on my curious daughter at the same time.
My wife, who is also a physician, had her multidisciplinary endocrine symposium around the same time as my boards and this would mean trying to plan our day so both of us were able to do our homework after our clinical duties. Despite planning ahead, it can get overwhelming, and it is important to recognize this and ask for help.

CONCLUSION

Trainee wellness is increasingly recognized in graduate programs, but well-being of the pregnant trainee is still the big elephant in the room. Trainees often work till end of pregnancy, scramble for time-off especially if they cover different systems such as the Veterans Administration, suffer preterm labor or pregnancy termination, have a much shorter lactation period than the general population and feel guilty of not providing enough for their kids. During peak covid surge last year, residents and fellows were pulled from their standard duties to care for overburdened hospital system. It is only fair to ask that residency and fellowships program come together to help expectant trainees during their tough times.
Female trainees shouldn't feel punished for deciding to have children and male trainees shouldn't feel guilty to be more involved in childcare. Accommodations for lactation breaks during clinics, interview days, conferences and board exams should be incorporated.[4]
A better system that recognizes plasticity of pregnancy, has a back up plan in cases of unexpected leaves, separates parental leave distinct from vacation, supports part-time return to work, infertility management, and on-site day care can decrease the stigma perceived around pregnancy.[5]

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Mary Kisicki, BSN, RN

CVT CORNER

NEW ACC/AHA GUIDELINES FOR CHEST PAIN EVALUATION & DIAGNOSIS HELP KEEP US ON TRACK

Even amidst a global pandemic, our professional societies continue to prioritize the advancement of Cardiovascular Medicine by reducing the variability in care. This is evidenced by the very first ACC/AHA guidelines for the evaluation and diagnosis of patients who present with chest pain. These guidelines will assist facilities in designing a standardized evaluation approach of this common complaint to ensure that we are able to detect the serious causes versus the underlying benign. Not surprisingly, chest pain is one of the most prevalent reasons for visits nationwide and accounts for nearly 5 percent of all ED

Melissa Lederer, MBA, BSN, RN

CVT CORNER (CONTINUED)

visits. At Nebraska Medical Center, the volume of chest pain patients in 2020 was a whopping 3,051 visits and it looks like we will surpass that number for 2021.
It is important to remember that there are a variety of symptoms that are the equivalent to "chest pain", especially in regards to acute coronary syndrome. These may include pain/pressure to any part of the upper body as well as more vague symptoms of shortness of breath, fatigue, & nausea. The new guidelines incorporate important aspects of evaluating symptoms by including clinical decision protocols (CDPs), structured risk assessments (e.g. HEART), high-sensitivity troponin assays and guidance on when/if further diagnostic testing is indicated. Nebraska Medicine has demonstrated our commitment to these models by our continued accreditation through the American College of Cardiology as a Chest Pain Center. Undoubtedly, these guidelines are important for keeping us on track for incorporating evidenced-based care to all of our patients.

Reference

2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain: A Report of the CC/AHA joint Committee on Clinical Practice Guidelines Am Call Cardio/2021: Oct 28

ACC CV TEAM NEWSLETTER

Did you know? The ACC has a monthly newsletter for CV Team Members. Click on the link below to learn more about what is happening on the national stage!

Read the ACC CV Team Newsletter here!

NEW PHYSICIAN WELLBEING PROGRAM AVAILABLE TO ALL NEBRASKA PHYSICIANS

LIFEBRIDGE NEBRASKA—NEBRASKA'S PHYSICIAN WELLNESS PROGRAM

The Nebraska Medical Association has launched their peer-to-peer physician coaching program LifeBridge Nebraska. LifeBridge Nebraska was developed by physicians, for physicians. It is a FREE coaching program available to all Nebraska physicians, regardless of NMA membership. The NMA hopes Nebraska physicians will reach out as a normal response to acute and chronic stress rather than just "powering through."

Confidential appointments are self-referred without medical diagnoses, insurance billing, or electronic records. Notification is not given to employers, NMA, or the board of medicine. Program participants can expect complete confidentiality –information and/or identity is never disclosed to others without written consent.

Physicians can connect with LifeBridge Nebraska by calling a confidential third party call center at 1-888-569-2036. To learn more and to view coach profiles, please visit nebmed.org/lifebridge. Questions? Please contact Lindsey Hanlon at lindseyh@nebmed.org.

NEBRASKA ACC NEWSLETTER STAFF

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Editor-in-Chief, Nebraska ACC

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