

Preface

My grandfather was a country doc, back in the first part of the twentieth century, in a small Florida town of a few hundred people. This was a time and place without electricity, cars, internet, or cell phones. And when I was a kid, he would tell me stories of how he walked or rode a horse for hours to get to a patient who had shortness of breath. Once there, crowded into a room surrounded by worried family, examinations were done under kerosene lantern and limited to touch, feel, and the stethoscope. With only history and physical exam, diagnosis was by the terms of Sir William Osler. No X-rays, no ECGs, no fancy echocardiograms, and no BNP levels.

In these years, because pneumonia was a death sentence, my grandfather would pray for signs of heart failure. For if the diagnosis was pneumonia, the only thing to do was to talk to the terrified spouse and tell them that it did not look good and that their loved one would probably be dead in 3 days. And while my grandfather would promise to do everything possible, the odds were long at best. Antibiotics did not exist. Pneumonia was a common final pathway. So this was the mantra of the country doctor. If the patient survived, the doctor was very good, but if not, it was simply fate. Other than providing comfort in their last days, there was little that could change fate.

In this bygone era, the physician could only hope their findings added up to a diagnosis of dropsy. With dropsy, the edematous condition known in today's vernacular as congestive heart failure, there was actually a treatment. This was because in 1785, the English physician William Withering described the use of foxglove for its treatment. As if a miracle, there was actually something that could be done. And thus, it says in my grandfather's textbook, handwritten at Rush Medical College, in his own careful script:

For the treatment of edema with dyspnea due to dropsy, go to the place where foxglove plant grows and select several of the upper leaves. Roll them into a ball and place them into the pill compressor (it looks like a pair of pliers). Squeeze the handles with sufficient force so the result takes on the shape of a pill made from the leaves. Administer one pill by mouth on a daily basis. But (and this is the important part), don't squeeze the pill too tightly, otherwise it will be too hard and pass through the patient unchanged.

We have certainly come a long way in the last 100 years. The changes have been nothing short of astounding, but with irony that is inescapable. Today, pneumonia is curable, and heart failure is the irrevocable death sentence. How is it that congestive heart failure is now the veritable death sentence that slowly drowns its victims in their own secretions, filling the lungs with edema until the patient suffocates and slips into unconsciousness? This is the reality of the twenty-first century. With all our fancy medicines and technology, we can stall for time, but we still cannot change fate.

Congestive heart failure does not discriminate; it takes all with no regard to class, wealth, or age. And it continues to exact its toll on the human race, even though our species has been to the moon and back. From Dame Elizabeth Taylor to the guy who lives under a bridge in a cardboard box, for the last 20 years, the death rate from congestive heart failure has been historically consistent. Except for the lucky few who receive a heart transplant, like pneumonia at the turn of the century, today's diagnosis of heart failure is a death sentence. And while we have made great progress since the description of foxglove, we are only marginally closer to a cure than we were in my grandfather's era.

Heart failure is a diagnosis of deterioration, hospitalization, and discharge, repeating until death. And since a cure does not appear in the offing, what can we do? We can follow the mantra of the twentieth-century physician when faced with pneumonia. Provide comfort and maximize the quality of the patient's remaining days. That is the point of this book. This book outlines the opportunities to maximize the HF patient's quality of life. With rare exception, most people firmly state that days out of the hospital are better than days within. Returning for cyclic revisits to the emergency department and the hospital is a terrible stressor and robs the patient of any quality of life. So it is reasonable that a strategy whose goal is to improve a patient's few remaining days would focus on avoiding hospitalization, lengthening the time between rehospitalizations, and if hospitalization is absolutely necessary, shortening the time spent in the hospital.

This text presents strategies aimed at decreasing the length of time a patient spends engaged in the medical system, whether that be spending the night in the hospital, sitting in the emergency department undergoing evaluation and treatment, or calling an ambulance for a return visit. The goal is to make the patient feel better today while maximizing their quality time and independence outside of the hospital. Hopefully, we have served this mission.

Cleveland, OH, USA

W. Frank Peacock



<http://www.springer.com/978-1-61779-626-5>

Short Stay Management of Acute Heart Failure

Peacock, W.F. (Ed.)

2012, XIV, 350 p., Hardcover

ISBN: 978-1-61779-626-5

A product of Humana Press