Noninvasive Remote Telemonitoring for Ambulatory Patients With Heart Failure and Emergency Department Services. Response

To the Editor,

It was with great interest that we read the letter from Llorens et al. about the risk profile and predisposing factors leading to hospitalization for heart failure (HF) in the 30 days following a visit to the emergency room for HF.

Our results in the CARME study cannot be extrapolated to the population described by Llorens et al. Our study was not conducted in the emergency room context nor following admission in all cases; only a small percentage of patients had required hospitalization in the previous year and recruitment was not immediate. In fact, most participants were outpatients who regularly attended scheduled appointments in the HF unit. This contrasts with other published series that recruited patients immediately following discharge.

Llorens et al. reveal the importance of being able to detect the subgroups of patients at greatest risk of readmission. We were unable to identify the patient profile that benefited most from telemonitoring, although our results may indicate that patients with HF who receive better treatment and health education are those who benefit most from telemonitoring—but this remains a speculation. As we recognized when describing the limitations of our study, to determine which patients would benefit more from any specific telemonitoring system we would have needed a broader-based sample that enabled us to conduct subgroup analyses. Although the CARME study obtained highly positive results in terms of fewer admissions and fewer days’ hospitalization for HF, the review of the literature on noninvasive telemonitoring showed that results vary; hence the great importance of selecting those patients at higher risk of readmission. For example, the discrepancies between recently published studies (eg, Chaudhry et al.) or conference presentations (eg, the Telemedical Interventional Monitoring in Heart Failure trial) and the generally positive data described in the Cochrane review. The ability to detect the patients at greater risk of readmission does not necessarily imply they are really those who would benefit most from a telemonitoring program. However, subgroup analysis in some studies does suggest those who would benefit most might well be the patients who are most seriously affected. Consequently, although Llorens et al.’s hypothesis that patients with a history of chronic HF decompensated by precipitating factors like anemia or high blood pressure could benefit more from a telemonitoring program is of interest, more studies are needed to establish precisely which patients should be selected for this type of intervention, and even which type of intervention would most benefit each patient.

FUNDING

Dr. Mar Domingo received a grant from Philips to carry out the CARME study and collect the data.

Mar Domingo, Josep Lupón,* and Antoni Bayes-Genis

Unitat d’Insuficiencia Cardíaca, Hospital Universitari Germans Trias i Pujol, Badalona, Barcelona, Spain

*Corresponding author:
E-mail address: jlpun.germanstrias@gencat.cat (J. Lupón).

Available online 5 August 2011

REFERENCES


doi:10.1016/j.rec.2011.06.005

SEE RELATED ARTICLE:
DOI: 10.1016/j.rec.2011.05.024

Malnutrition and Heart Failure

Desnutrición e insuficiencia cardiaca

To the Editor,

We would like to congratulate Bonilla et al. on their study on malnutrition and mortality in hospitalized patients, which was recently published in Revista Española de Cardiología. We would also like to make some practical observations.

From a methodological point of view, we would like to point out that there may have been a sample selection bias. The study selection criteria excluded patients who were not able to stand up to be weighed or measured or who were not able to undergo the Mini Nutritional Assessment® (MNA®) due to functional deterioration prior to admission or which developed during the hospital stay. The exclusion of patients with worse function probably resulted in a prevalence of malnutrition that was lower than the actual situation. Given that the demographic and comorbidity characteristics were not compared between the included and excluded patients, we cannot discount the possibility that there were differences, which constitutes a study limitation. We also think that it would be appropriate to clarify whether skinfold and circumference measurements were taken by one or several observers, as this could affect reproducibility and consistency.

The authors assessed the impact on survival of several isolated comorbidities. However, they did not measure the impact on survival of the comorbidities as a whole (Charlon index) or of the patients’ functional situation, which have been reported in other
studies. There is a well-known relationship between nutritional state, functional deterioration, and comorbidity, and so we cannot discount the possibility that these factors acted as confounding variables that went unanalyzed.

Furthermore, the studies used to validate the nutritional screening tool (MNA®) were performed on patients over 65 years old. Although there are some studies in other age groups, this method is recommended and validated only for this one, as its creators have acknowledged and the European Society for Clinical Nutrition and Metabolism guidelines indicate. In this study, more than 16% of the patients were younger than 65 years. The MNA® consists of 18 items and can be completed in less than 15 min. To simplify and improve its use, the MNA® screening has been revalidated (Short Form MNA®), using data from 28 previously published studies. The new Short Form MNA® incorporates 3 nutritional situation cut-off points, which allows patients to be classified with only 6 questions. Furthermore, calf circumference can be used when the body mass index is not available. As such, the complete MNA® no longer needs to be used, and the new Short Form MNA® reduces the nutritional screening time to less than 5 min and is currently recommended for clinical use.

As the authors note, it is important to detect malnutrition or risk of malnutrition early, because mortality quadruples. The MNA® (and the new Short Form MNA®) is a simple, reproducible tool, validated for people over 65. It identifies risk of malnutrition before significant changes in weight or albumin levels occur, which allows direct nutritional intervention, monitoring of compliance, and assessment of the effectiveness of the nutritional intervention. We agree with the authors that nutritional support and/or monitoring can improve prognosis for these patients. There is evidence that the administration of nutritional supplements reduces mortality in older malnourished patients, meaning that it is important to detect malnutrition in these patients.