Cardiac Care During
COVID19

# Case:

- 42 yo male, married with 3 children, works as IT specialist
- Past Medical History: diabetes (diet controlled), +ve Family Hx CAD, non smoker
- HPI: <u>1 week</u> prior to admission: patient working from home, developed chest pain while walking up stairs in house, lasted 20 minutes and spontaneously resolved

# Case:

- **4 days:** prior to admission: onset of 5/10 chest pain with nausea and diaphoresis, intermittent but mostly continuous with occasional resolution
- **Day of admission**: pain increased to 10/10 in severity with severe shortness of breath, patient finally agreed to go to Markham-Stouffville ER due to severity of pain
- **ER**: seen in triage, ECG demonstrated Anterior STEMI (5 mm ST-elevation in V2-V6), Code-STEMI activated and patient sent directly to cath lab at Southlake

# Case:

- **<u>Cath Lab</u>**:
  - 100% LAD occlusion, 90% distal RCA (1 drug-eluting stent to LAD, second to RCA)
  - Patient was in severe congestive heart failure
- **<u>CCU</u>**:
  - LV function assessment – Severe LV dysfunction, Ejection Fraction ~20%,
  -  HR (sinus tachycardia, 120 BPM suggestive of significant hemodynamic compromise)

- Patient now requiring significant heart failure therapy, may require ICD for primary prevention for ventricular arrhythmias, will likely need advanced heart failure therapies

# ISSUES:

1. Fear of COVID19 directly responsible for delayed presentation with now severe, long lasting consequences (significant CHF)

2. Will have prolonged CCU stay and overall hospital LOS which could further impact bed shortages.

3. Will have worse outcomes now if ***does*** contract COVID19

# COVID Fear is driving Morbidity/Mortality

- ER visits in general down 30-50%
- CP as primary CC down 60%
- Opiate overdoses up due to drug use alone/isolation
- Late presentations of other surgical conditions (perf appy, ascending cholangitis, pancreatitis, SBO)
- Late presentation of Infectious illnesses (cellulitis, abscess, c.difficile etc)
- Strokes presenting outside of window of opportunity to treat

# Cardiac Care Specifically

- 40-60% reduction in admissions (globally)
- Late presentation is now the norm
- Elective procedures on hold
- Some patients have mis-information around use of ACE/ARB inhibitors and ASA and have stopped these medications
- Some patients may no longer be able to afford their medications
- Eating/exercise/stress

# Primary Care to the Rescue

- We have the trust of our patients
- We have the ability to reach out to our patients
- Unlike COVID with limited treatment options there are effective life saving treatments for CAD and many of the other conditions that are in the shadow of COVID
- We are in this for the long haul so we should set up systems now in order to avoid further M+M which has played out on the global stage

# Virtual Cardiac Care

- Reach out to patients (social media, mail outs, email, phone calls)
- Home telemed programs
- “Listen to your patient, he is telling you the diagnosis” -Osler
- Send people to the ER
- Send people to Cardiology
- Diagnostics through ER/Cardiology or local resources per established protocols (or make some protocols)