SHA 74. Silent ischemia in patients with diabetes

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Individuals with both type 1 and type 2 diabetes mellitus (DM) are known to be at high risk for developing coronary artery disease (CAD). The risk is two to three times greater in those with DM compared with those without, and is especially high in women with DM. An additional problem in individuals with DM is that, even with severe underlying CAD, many individuals may have atypical symptoms or be totally asymptomatic, a condition referred to as silent or asymptomatic myocardial ischemia.

Asymptomatic myocardial ischemia is frequently found in individuals with known CAD, even in individuals without DM, and is associated with a poorer long term prognosis. The Asymptomatic Cardiac Ischemia Pilot Study demonstrated that asymptomatic ischemia was associated with three times the risk of nonfatal myocardial infarction and six times the risk of myocardial infarction or death.

However, asymptomatic myocardial infarction also occurs in a substantial number of individuals without known CAD, particularly those with DM. These individuals have not been diagnosed with CAD and do not have the benefit of anti-anginal therapies or aggressive CAD risk reduction. In the recent Detection of Ischemia in Asymptomatic Diabetics (DIAD) study, 21.6% of older adults with type 2 DM, none of whom had any clinical evidence of CAD, had evidence of myocardial ischemia on single photon emission computed tomography (SPECT) myocardial perfusion imaging. This finding was consistent with earlier studies in the population with type 2 DM.

In asymptomatic patients with either type 1 or type 2 DM, asymptomatic myocardial ischemia is also associated with major cardiac events. Importantly, the presence of cardiac autonomic neuropathy, long theorized to have a role in asymptomatic CAD, substantially increases the risk of subsequent cardiac events, with those individuals with both asymptomatic myocardial ischemia and cardiac autonomic neuropathy, being at highest risk.

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SHA 75. The missed essence: Holistic nursing care

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Objectives: • To discuss the holistic patient and family care concepts. • To describe the family impact on the patient response to treatment. • To define the patient and the family influence on out come of care. • To enlist the patient and family needs. • To outline useful interventions for families in the acute care.

Methods: Clinical observation and Literature review.

Results: There is a critical need for nursing to shift back to holistic care practice provided to patient especially in acute care sittings.

Conclusion: Globally, the health care setting is moving with fast speed, towards high technology driven critical care. The result is often a shift in attention from the patient and family holistic care, to technology and treatment necessary for maintaining the physiological functioning of the patient. Technical skills have gained great emphasis along with professional competency and reaction to critical emergencies. Consequently, an intrinsic component of the nursing profession, holistic care, is often missing (Urden et al., 2006). Nursing holistic care stresses that the human body, the mind, and the spirit are interdependent and undividable (Urden et al., 2006). The aim of the following case study is to empower the nurses to 'engage in' and 'transform' the care provided to the patient, and their family, in a holistic manner.

Tracks: Cardiac Nursing.

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SHA 76. ARDS (H1N1) after cardiac surgery: A word of caution

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Objectives: An outbreak of a respiratory illness proved to be caused by novel swine-origin influenza A (H1N1) virus (S-OIV) was identified in Mexico in March 2009. Since then there was exponential increase in the number of the reported H1N1 cases world wide reaching the pandemic level. Saudi Arabia is one of the countries which reported confirmed H1N1 cases of mild illness, However, This report describe the first reported cases of confirmed H1N1 Influenza A causing Acute Respiratory Distress Syndrome (ARDS) after cardiac surgery.

Methods: A total of five patients developed sever respiratory distress syndrome after cardiac surgery. Three cases after adult and one case after pediatric cardiac surgery. All patients presented similarly with dyspnea, respiratory distress and bilateral patchy pneumonia early after cardiac surgery. Other common findings there were lymhopenia, no fever, and normal creatine kinase level. The diagnosis confirmed using reverse transcriptase polymerase chain reaction of nasopharyngeal aspirates.

Results: All patients recognized early and treated using mechanical ventilation, high dose of methylprednisolon, Tamiflu and broad spectrum antibiotics. However, the pediatric patient required Extra Corporeal Membrane Oxygenator for ventilator support for 1 month. All patients fully recovered and discharged home.

Conclusion: Acute respiratory distress syndrome is an extreme form of acute lung injury that is characterized by inflammation of the lung parenchyma and by increased micro vascular permeability. ARDS after cardiac surgery is usually associated with multi organ failure and carries an overall mortality of more than 50%. Therefore, we wish to raise the awareness that patients after major cardiac surgery may represent a vulnerable group to develop H1N1 respiratory distress syndrome without any classical flu manifestation. We believe that the early recognition, mechanical ventilation and corticosteroids therapy may have played a role in the early recovery of these patients.

Tracks: Cardiovascular Surgery.

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SHA 77. Respiratory ECMO for H1N1 ARDS post cardiac surgery

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Objectives: To describe the ECMO perfusion technical challenges over 4 weeks period, in treating a sever form of ARDS in a child after cardiac surgery.