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HEART TALK

Q&A: Doctor to Doctor

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Dr. David Elizardi is what I call a thinking cardiologist. This was an across-the-board trait for all cardiologists a few years back. Now, the emergence and proliferation of various cardiac testing techniques has morphed some in this subspecialty from cerebral thinkers into technocrats, reminiscent of high-IQ teenagers turned loose in a computer game store.

Every physician knows what's meant by the term thinking cardiologist. They are a subset of cardiologists found in most large hospitals and clinics. Some are freshly minted physicians; others have been at it for years. Fortunately, they aren't an endangered species as I can think of a couple or more in almost every hospital in New Orleans, and I'm sure they're widespread across the United States.

The antithesis of a thinking cardiologist is the one who orders the same battery of tests for each new patient regardless of the problem, and reorders the same subset of tests every three to four months. If they're in a group that share data with primary care physicians like myself (not all do, you would be surprised how many specialists never communicate with the

primary care physicians and visa versa), I get five to six pages of repetitive and meaningless copied and pasted, computer-generated notes after each visit, which quickly overstuff my still-paper-charted folders.

If you think electronic records are the solution to this data overload, think again. Filing electronic data in medical records can be akin to writing a letter to the Louisiana Office of Motor Vehicles. I called that staid office a couple of years ago after there was no response to some signed form I had mailed them. The very helpful person who answered the phone found my correspondence right away and fixed my problem. “Just call anytime. We just scan all the correspondence we receive into the system. We don’t read anything. You have to call,” she said when I thanked her for fixing my problem.

Last year in this space, Dr. Elizardi and I shared a dialogue that we called “common questions and different perspectives.” We touched on aspirin, red wine, vitamins, the ideal blood pressure, indications for stress tests and stents. Come, the ritual is afoot.

Lutz: Why treat high blood pressure in the first place? I hear all the time: “I feel fine. Why take some medication that might make me feel bad?”

Elizardi: Blood pressure control is a perennial conundrum, but it certainly isn’t a silent killer. What’s so silent about heart attacks, strokes and congestive heart failure?

Lutz: A speaker at a recent Southern Medical Association meeting said that for every 10 to 20 increase (Ed. Note: blood pressure is measured in millimeters of mercury) in blood pressure above the recommended there was a two-fold increase in heart attacks and deaths. Are the risks with untreated hypertension really this high?

Elizardi: I am not familiar specifically with that data. There is no doubt that the end-organ complications of hypertension increase with lack of blood pressure control.

Lutz: What does recommended blood pressure mean? What is a good blood pressure target for an otherwise healthy person 40 to 60 years old?

Elizardi: The professional guidelines point to targets consistently less than 140/90 mm Hg (also known as 140 over 90). There appear to be even better long-term outcomes with lower numbers. Cognitive function in the elderly is better when blood pressure is more tightly controlled in preceding decades.

Lutz: A local physician I know had several chronologically gifted patients who passed out and/or ended up in emergency rooms when he upped their blood pressure medications to drop their pressures to 120/80 or lower. Is less always better? What are you blood pressure goals for persons over 80?

Elizardi: Unfortunately, some elderly patients loose their reflex mechanisms that keep blood from pooling in the veins in our legs when we stand up, making them susceptible to dangerous drops in blood pressure when erect. This makes it tough to treat to the same goal of 140/90 or lower, which I recommend. You will only know this by carefully titrating medicines upward and taking blood pressure when the patient is standing. That said, I still try to treat to goal, as the risk of stroke goes up a lot when the blood pressure is higher and older folks already start with a high risk of having a stroke. There are definitely some medicines that are notorious for aggravating positional blood pressure drop that can be avoided.

Lutz: Why is blood pressure control so important for persons with diabetes? Do you believe that optimal diabetes control is impossible without attention to diet?

Elizardi: All our fancy medicines cannot fool Mother Nature; so, yes, diet is a key factor. The eyes, brain, heart, kidneys, and legs of diabetics are especially prone to vascular complications, so vigorous blood pressure and lipid control is important. The blood pressure goal is 120-130/70-80, and we shoot for low-density cholesterol less than 70.

Lutz: For hypertension, I tend to prescribe small doses of multiple medications. I tell patients it’s like adding spices to gumbo – a little of this and that is better than a lot of that. What

are your current workhorse medications for treating hypertension?

Elizardi: I fully agree with multiple medications. My workhorses are thiazide diuretics, losartan, amlodipine and carvedilol. All of these are generic and can hold down costs.

Lutz: Statins have taken off like doubloons at Mardi Gras. Should everyone over 40 be taking a statin for primary prevention of coronary artery disease?

Elizardi: Diet is important, but most Americans with at least one risk factor can rarely reduce their low-density cholesterol below 100 with diet alone. Everyone over age 30 to 40 should have a lipid profile to determine their risk level. Those with hypertension, diabetes, tobacco use or a positive family history are more likely to need a statin at a younger age. Since coronary artery disease remains the No. 1 killer in the United States, maybe there's an argument for statins in drinking water.

Lutz: Most of my patients on a statin take generic Zocor, yet its maximum recommended dose recently dropped due to adverse effects. Since Lipitor is now generic, should I change my patients from generic Zocor to generic Lipitor?

Elizardi: The only reason to abandon generic Zocor for Lipitor is to get the low-density cholesterol level into a "guideline range" that 40 milligrams of Zocor cannot achieve. The data are clear that suboptimal cholesterol goals lead to definite progression of identifiable coronary artery disease. And, if they have been stable on 80 milligrams of Zocor for some time, I leave them alone.

Lutz: And what about the medication Zetia? Do you add it for lipid control?

Elizardi: Zetia remains a controversy. It definitely helps lower cholesterol, but outcomes data are lacking.

Lutz: What's new with stents? Is there a move back to more surgical bypass grafting and fewer stents?

Elizardi: Stents have gone into "second generation" and beyond. We will be hearing some new stent names, yet the main issues are the same. It is important to take aspirin and Plavix faithfully for at least a year after a stent in most instances. There are fewer "bare metal stents" going in these days and more "drug-eluting stents." Bypass surgery is still reserved for the most complex anatomy and for many diabetics, so I don't think there are any fewer stents going in these days.

Lutz: And Plavix just became a generic. I get a phone call a week about the switch as it can save over $100 a month. Do you have any reservations on switching any of your patients to generic Plavix?

Elizardi: It is just becoming available. I do not anticipate a problem, and it will certainly save money.

Lutz: And what about that perennial seasonal disorder that strikes this time of year – Mardi Gras heart failure?

Elizardi: It can happen when an older person with usually controlled congestive heart failure celebrates Mardi Gras or any other holiday. It is related to diet, activity and medication omissions. Salt intake increases with party food. More movement means a need for more arthritis medications that increase fluid retention. And lack of easy access to bathrooms along parade routes and at Mardi Gras balls leads to skipping the daily prescribed diuretic.

Lutz: After Hurricane Katrina, several of my patients with congestive heart failure, who evacuated New Orleans for cities in Texas, returned with implantable defibrillators. Should everyone with congestive heart failure have an implantable defibrillator just in case?

Elizardi: When a person's cardiac output is abnormally low, these devices can automatically restart a suddenly stopped heart. This is primary prevention, meaning, hopefully, the device will never need to deliver a shock; but if the electrical system does fail, they can save lives. Current guidelines call for their use when there are mild or more advanced symptoms and limitations during ordinary activity with abnormal heart ejection fractions below 35 percent after six months of maximum medical treatment. Contraindications include multiple other medical problems or a life expectancy not long enough to allow the statistics to work.

Lutz: Anything new on the screening CT scans looking for calcium in the coronary arteries? Medicare still doesn't cover them, but radiologists advertise them frequently for a very low cash price.

Elizardi: Coronary calcium score CT can be useful, but only for a person without diagnosed coronary artery disease. It helps separate the folks who aren't at risk from the ones who are. Those at risk need to reduce their low-density cholesterol levels the most. Unfortunately, these scans are sometimes improperly used to generate unnecessary angiograms and placement of unneeded stents. A CT calcium score alone shouldn't be used as a stepping-stone to a coronary angiogram in the asymptomatic patient.

Lutz: Should my patients on Coumadin be switched to that new drug?

Elizardi: You are talking about Pradaxa, a drug that's easier to dose and more predictable than Coumadin. If a patient is stable on Coumadin and only needs to check their blood test every four to six weeks, they should remain on it. On the other hand, if their Coumadin dose is hard to control, Pradaxa should be considered. Some of this is a money issue, some is a convenience issue and some is a safety issue.