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Reading the Signs: Recognizing Early Congestion

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Dan Bensimhon, MD:
This is CE with GLC, and I'm Dr. Dan Bensimhon. I'll begin today by talking about the congestion that patients experience when they have heart failure or chronic kidney disease. One of the things we'll start with is what are the early signs that clinicians should be looking for? There's good focus on titrating guideline-directed medical therapy, but we can't forget the congestion, or the C in CHF.

Congestion is really a hallmark feature of symptoms and prognosis in patients with heart failure. For example, congestion is the most common reason why patients have symptoms. Congestion is the most common reason patients seek medical attention. Congestion is the most common reason for hospital admission. It's associated with reduced quality of life, and we now know that congestion at discharge is associated with worse outcomes and hospital readmissions. Yet congestion is routinely under detected and undertreated. And the question is, why is that?

So what you can see by this slide is previously we used to think that many patients would take extra fluid or salt or have a big meal, and they would progress rapidly to congestion and symptomatic heart failure where they'd need admission.

What we've learned from these invasive testing is that this process often takes place over several weeks of decompensation. And what happens early is we see filling pressures increase, then we see changes in intrathoracic impedance changes, and finally, we see changes in weight gain and symptoms occur.

And that happens late in this progress, in this sort of continuum. So 2 to 3 weeks in is where we see symptoms and weight change, and these patients are just a few days from being admitted for heart failure. So the issue here is that patients develop congestion or begin to develop congestion long before they actually complain of symptoms or see a change in the scale.

And people say, well, you know, you're a heart failure provider or you're a heart failure physician. You've been doing this for 25 years. Why couldn't you detect that?

The problem is the physical exam is not very sensitive, meaning that patients can hide fluid very easily. So if you look at this chart, the sensitivity of elevated JVP is 11%. The sensitivity of dyspnea on exertion is 15%. So there are a lot of people who have congestion who don't have these findings on exam or when you're evaluating them.

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And subsequently, if you look, we now know that in many patients who get admitted for heart failure and they get discharged from the hospital after being diuresed, they begin to feel better, but they still have residual congestion because our physical exam, the patients feel better, and our physical exam is limited at detecting that congestion.

This is the ADHERE registry dating back over 20 years, and we saw that people who got discharged from the hospital, 30% of patients admitted with heart failure either gained weight in the hospital, had no change, or gained weight in the hospital. 50% of patients either gained weight or lost less than 5 pounds.

So we undertreated these patients while they were in the hospital due to not adequately detecting congestion correctly. Fast-forward here to 2013 to the CARRESS trial of ultrafiltration, what we saw by using an orthopnea scale, and this is the DOSE-HF and CARRESS trials, what we found is very similar findings.

In these patients, we found that over 40% were discharged with moderate to severe congestion. And of those patients who were decongested at discharge, almost half of those patients had re-congestion at 60 days that went undertreated or undetected. And what is the outcome of that?

One is our patients have more symptoms. Two is they get readmitted for heart failure frequently, and the average readmission, 30-day readmissions for patients with heart failure in our country is somewhere between 20% and 25%. So 1 in 4 patients who get out of the hospital after being treated for heart failure wind up right back in the hospital and much of this is due to congestion.

But it's not just symptoms; it's just not readmissions. We now have data that when patients are discharged from the hospital with residual congestion, they have a significantly higher 1-year mortality rate than people who are discharged from the hospital fully congested. So it really is important to get these people.

At our center we've taken this very seriously. We've used devices to actually objectively measure congestion. And in our case, we've used a device called a REDS lung fluid detection device. And you can see at every point of care where heart failure patients show up, you can see very high levels of congestion.

And we put green as being fully decongested, yellow being mild to moderately congested, and red being moderately to severely congested. And you can see in the ER, 60% or over 60% of patients are congested. In the heart failure clinic on routine follow-up, 23% of patients have moderate to severe congestion. Another 20-some patients have moderate congestion. And this extends even back into our primary care offices, where 12% have moderate to high levels of congestion, and about another 25% have low to moderate levels of residual congestion. How do we need to treat these patients better?

The guidelines here really give us clear recommendations here, and that is at every level, every time we interact with these patients, whether it be in clinic, in the hospital, immediately post-discharge, in the emergency room, we should really spend the time to assess congestion adequately.

In a recent study published in the *European Heart Journal*, what you see, and there's a follow-up study by Dr. Steven Greene in *JACC Heart Failure*, which looked at why patients get admitted to the hospital for heart failure. And what we know from previous studies is that 90% of people get admitted due to congestion. But what we now know from Dr. Greene's most recent study is that while in the hospital, two-thirds of these patients who are admitted for heart failure, all they get is intravenous Lasix.

They don't get any inotropes. They don't get any IV vasodilators. They're admitted because their oral diuretics didn't work, and now they require IV diuretics. So is there a way that we can either identify this congestion earlier so they don't need IV diuresis, or is there a way to address this need for IV diuretics or IV diuretic-like decongestion? Is there a way to address that without having to admit patients to the hospital?

And then how are we more aggressive about treating congestion so that we improve quality of life, we reduce admissions and readmissions, and even hopefully decrease mortality for our heart failure patients?

Thank you for your time.

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