Valvular Heart Team

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"An idealist is a person who helps other people to be prosperous."
Henry Ford (1863 – 1947)

The morality of medical practice is based on beneficence. The benefit is applicable to an organ, however, it is not enough. The safety of the procedure to the patient's life is a concern[1].

The sense of the usefulness of a therapeutic method is well validated by effect extent class I/IIa in a guideline, but he/she can be harmed when the unexpected wins predictability. The high complexity collects unquestionable medical indications that exhibit poor individual prognosis due to severe comorbidities[2].

In this comparison between illness and patient, the contraindication illustrates that the major limitations of physician are the limits of medical science. Fortunately, we live in a moment of endless technological innovations. Readily globalized, they expand the skill bounderies and, at the same time, they give vitality to the classic, for the ongoing development is imperative in medical science.

A new horizon requires interdisciplinarity, which, in turn, demands interpersonal communication. In the interests of the best clinical practice for the patient, the propaedeutics communicates with clinical and scientific evidence that is understood as the clinical reasoning under the tension of the imminence of conduct, listening to the values and preferences of the patient. The efficient communication — to talk, to hear oneself (am I being objective?), to listen and to hear oneself hearing (am I connected?) — energizes the trespassing through the essential ethical tolls: benefit of method, patient safety and human character of medical science[3].

In recent millennium transition, the routine of "discussion of the case" included the gap between the availability of medical science and medical care to the elderly with aortic valve stenosis ineligible for conventional surgical treatment. However, already in the early years of the 21st century, the discomfort of "if we can't do-good, at least let us not do harm" was reduced by the prospects of support to this subgroup of patients by means of transcateter implant of a bioprosthesis.

Keywords

Aortic Valve Stenosis; Cardiac Catheterization; Heart Valve Prosthesis Implantation / methods; Bioprosthesis; Bioethics.

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Due to the initial results, the sentence has changed, following the change of the paradigm, to "we can do-good, but we have to take care of its potential harm". The systematized research[4] proved the positive impact on the "hard" outcome pro-life and raised the likelihood of the certainty of benefit to B level. However, the best survival curve does not invalidate the uncertainties of complications related to innovation, a base of the modern concept of iatrogenesis[5].

Bedside conflicts arise between using an alternative method to conventional surgery to correct aortic valve hemodynamics and, at the same time, envision strong objections to satisfy the purpose both of survival and quality of life. They direct the physician to establish the applicable proportions of science and humanism, strongly advised by soliloquy, with the ontological component of ethics.

The "I do-good to the patient because it crops out from being who I am and not just because I read the code of ethics" makes prudence and zeal flow in indicating/non-indicating/contraindicating depending on the symbolism of the Hippocratic oath. The resulting ordering of adjustments to the benefit ensures value for deliberation.

It is worth remembering that, about 20 years ago, this moral plumbing occurred in establishing balloon catheter of mitral valvuloplasty and encouraged a close and progressive knowledge feedback and skill on the patient with mitral stenosis. Physician, surgeon, interventional cardiologist and echocardiographist got together and converted the field of the then innovation into an efficient relationship benefit/security that made it a rare AI recommendation in guideline of valvular heart disease. Currently, the transcateter implant of bioprosthetic in aortic position causes similar mobilization[6]. The search for answers to the questions brought about by the new therapeutic heritage recommends to appreciate it further than just a procedure. It is preferable to see it as a program comparable to a transplant[7].

The commitment of a collective of experts as far as the learning curve of this change of therapeutic standard in patients with valvular heart disease is concerned neither plastic nor native tissue replacement — is better structured in the formation of an interdisciplinary team to valvular heart disease. The team set-up replaces the one of disciplinary workgroup enough for sustainable routines by the coldness of reports and the monologue opinions juxtaposed.

The interdisciplinary team for valvular heart disease links space and time. These dimensions make the refinement of movements and countermovements easier and to support excellence. Indication/non indication/contraindication may, therefore, be appropriately customized to the symptomatic elderly with aortic valve stenosis, respecting the enormous heterogeneity of the real world twinned by right to dignity.

Transparency in interdisciplinary coordination of complementary *expertises* in patients with valvular heart disease is the raw material for the construction of a platform of clarity of tasks to be fulfilled, limits to be respected and performance levels to be achieved. Interdisciplinary meanings for the professional proficiency make the team an opinion maker.

The interdisciplinary team for valvular heart disease confers nationality. The hierarchy between methods with flexibility in its borders, the tone for subjectivities (body weakness) and inaccurate objectivities (surgical risk scores), critical analysis on personal and literature results and the modulation to the sociocultural and economic develop the necessary fine tuning with Brazilian realities.

The interdisciplinary team for valvular heart disease is greater than the sum of their participants, which does not happen with the working group. The expansion lies in the attitude of each member — sometimes as a disclosure, other as a receiver. I teach, you learn, he improves, we progress, is the conjugation intended from a system connected to attain the highest level of mutual understanding on cost-risk-effectiveness about the trinomial aortic valve stenosis –non valvular cardiac abnormalities – extra cardiac comorbidities.

The interdisciplinary team to valvular heart disease thrusts the clippings out of interest the vertical provisions verticalized by the hyperspecialization turns to a horizontal solidarity position between one another, useful for the needs, preferences ad values of the Brazilian elderly

The interdisciplinary team for valvular heart disease highlights the value of current cardiology as it extracts information from the three imaging giants — ultrasonography, CT scan and MRI — and introduces it into the hammer of decision making present in the calloused hands of sovereign clinic, powerful surgical clinic and the skillful interventionist cardiology.

In short, the interdisciplinary team for valvular heart disease builds a strong interdisciplinarity. When exchanging not only methods but also concepts, the transdisciplinarity[8] becomes closer by using rigor together with fundamental concepts, the opening to the unknown and the tolerance toward the gaps of medical science based on evidence about practices that cannot be disproved by personal experience. The hybrid room is the emblem.

It is known that languages are neither static nor closed. Loan words occur as the result of dominance over a particular segment of society. In this context, the niche of present medical science is influenced by the supremacy of English language literature. TAVI is an anglicism that was quietly incorporated. Just as we should not insist on a Brazilian acronym by repositioning letters — ITVA or IVAT —, It seems reasonable to us to adopt the globalized (and synthetic) name Heart Team to express an interdisciplinary team specialized in cardiology.

The concept of Heart Team was revived less than a decade ago as a methodological imperative deriving from the SYNTAX study[9]. The name gained notoriety for its contribution to the discipline communication and has migrated from research to assistance fields. The Heart Team acquired high organizational value in valvular heart disease, being understood that its absence is an absolute contraindication to the bioprosthetic transcateter implant in aortic position[10].

I propose that the Heart Team expression that (in)vests the shirt on in reliable relationship in a interdisciplinary network and acquires scientific capital facilitator of complex deliberations before the symptomatic elderly suffering from aortic valve stenosis to be termed as Heart Valve Team (VHT).

VHT specificity includes: a) bioprosthesis management techniques and improvement ; b) contributions from imaging methods; c) safety by reducing adversity; d) early and late results, including participation in records; e) propensity to the use transcateter implant under minor surgical risk.

It is appropriate to emphasize that the VHT should not be viewed with an expiration date to be set by taking innovation for granted. The VHT means aggregation in favour for excellence in the attention given to grey areas experienced by patients with valvular heart disease with dubious issues according to valvular and/or non valvular cardiac and /or extra-cardiac complexities.

Finally, the VHT does not reinvent the wheel. VHT rediscovers the union and the gathering of people that give vitality to the analysis of uncertainties, the overcoming of adversity and the extent of the benefit.

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Conception and design of the research, Acquisition of data, Writing of the manuscript and Critical revision of the manuscript for intellectual content: Grinberg M.

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References

1. Singer SJ, Vogus TJ. Safety climate research: taking stock and looking forward. BMJ Qual Saf. 2013;22(1):1-4.
2. Atwater BD, Daí D, Allen-Lapointe NM, Al-Khatib SM, Zimmer LO, Sanders GD, et al. Is heart failure guideline adherence being underestimated? The impact of therapeutic contraindications. Am Heart J. 2012;164(5):750-5.
3. Grinberg M, Tarasoutchi F, Sampaio RO. Roteiro para resolução de valvopatia (Resolva). Arq Bras Cardiol. 2011;97(4):e86-90.
4. Leon MB, Smith CR, Mack M, Miller DC, Moses JW, Svensson LG, et al; PARTNER Trial Investigators. Transcatheter aortic-valve implantation for aortic stenosis in patients who cannot undergo surgery. N Engl J Med. 2010;363(17):1597-607.
5. Ligi I, Millet V, Sartor C, Jouve E, Tardieu S, Sambuc R, Simeoni U. Iatrogenic events in neonates: beneficial effects of prevention strategies and continuous monitoring. Pediatrics. 2010;126(6):e1461-8.
6. Webb JG, Pasupati S, Humphries K, Thompson C, Altwegg L, Moss R, et al. Percutaneous transarterial aortic valve replacement in selected high-risk patients with aortic stenosis. Circulation. 2007;116(7):755-63.
7. Mack MJ, Holmes Jr DR. Rational dispersion for the introduction of transcatheter valve therapy. JAMA. 2011;306(19):2149-50.
8. Sommermann A. Inter ou transdisciplinaridade? Da fragmentação disciplinar ao novo diálogo entre os saberes. São Paulo: Paulus; 2006.
9. Nallamothu BK, Cohen DJ. No ''I'' in heart team: incentivizing multidisciplinary care in cardiovascular medicine. Circ Cardiovasc Qual Outcomes. 2012;5(3):410-3.
10. Vahanian A, Alfieri O, Andreotti F, Antunes MJ, Barón-Esquivias G, Baumgartner H, et al; Joint Task Force on the Management of Valvular Heart Disease of the European Society of Cardiology (ESC); European Association for Cardio-Thoracic Surgery (EACTS). Guidelines on the management of valvular heart disease (version 2012). Eur Heart J. 2012;33(19):2451-96.