Perhimpunan Dokter Spesialis Kardiovaskular
Indonesia (PERKI) Cabang Makassar
Didukung oleh :
Bagian Kardiologi dan Kedokteran Vaskular Fakultas Kedokteran UNHAS
Makassar Cardiac Centre

MAKASSAR CARDIOVASCULAR UPDATE XIV 2015

12 - 14 Juni 2015, Hotel Grand Clarion Makassar

PENANGANAN PENYAKIT JANTUNG DAN PEMBULUH DARAH : A – Z

DAFTAR ISI

Halaman

SKEMA ACARA

JAM	JADWAL MCVU XIV 2015									
	JUMAT			SABTU				MINGGU		
	Coronary (CR)			High Risk Group (HRG)				Heart Failure (HF)		
	13 Juni 2015			13 Juni 2015				14 Juni 2015		
07.00 - 07.30	Pendaftaran Ulang									
07.30 - 08.00				Pendaftaran Ulang						
08.00 - 08.15	Tips Pagi			Diskusi Pagi (Cardio Renal)	Diskusi Pagi (Cardio Renal)	Diskusi Pagi (Cardio Geriatri)		Diskusi Pagi (Cardio Pulmonal)	Diskusi Pagi (Cardio Ginekologi)	Diskusi Pagi (Cardiac Infective)
08.15 - 08.30										
08.30 - 08.00	Rehat Kopi & S I (Diagnostic HF-S)			S - IV (Pengenalan High Risk Group Cardiovascular)			WS Perawat	S - VIII (Diagnostic HF)		S.Paralel 8
08.30 - 08.30										
08.30 - 10.00	S - II (Patomekanisme ACS)			S - V (Patomekanisme HRG)				S - IX (Patomekanisme HF)		S.Paralel 9
10.15 - 10.30										
10.30 - 11.00	Pembukaan			Rehat Kopi				Rehat Kopi		
11.00 - 11.30	SMS - I			S - VI (Manajemen HRG)	S.Paralel 6		WS Perawat	S - X (Gizi dan Komplikasi HF)		S.Paralel 10
11.30 - 12.00										
12.00 - 12.30	Shalat Jumat			SMS - II				SMS - III (Deteksi dan Penanganan HF)		
12.30 - 13.00										
13.00 - 13.30	Makan Siang			Makan Siang				Makan Siang		
13.30 - 14.00	S - III (Komplikasi ACS)		Workshop Deteksi Aritmia	Home Care kota Makassar dan Launching Home Care Serangan Jantung			WS Perawat	Penutupan / Lucky Draw		
14.00 - 14.15										
14.15 - 14.30				S - VII (HRG Katup)						
14.30 - 14.45	Lucky Draw									
14.45 - 15.00	TnT Sesak Napas	TnT Nyeri Dada	TnT Obat KV	TnT Nyeri Tungkai	TnT Berdebar	Lucky Draw				
15.00 - 15.15										
15.15 - 15.30						TnT Sesak Napas	TnT Nyeri Dada	TnT Sinkop	TnT Non Cardiac	Workshop Berdebar
15.30 - 16.30										
16.30 - 16.45										
16.45 - 17.15										

Keterangan :

S : Simposium Tunggal
SMS : Simposium Makan Siang
TnT : Tips dan Trik
WS : Workshop

ACARA ILMIAH

SIMPOSIUM

I. Simposium I

Panitia

Diagnostik Coronary

Moderator : dr. Pantrik Tandean, SpPD-KKV

- Diagnosa Penyakit Jantung Koroner di Rumah Sakit
  (dr. Almuta, SpPD, SpJP)
- Diagnosa PJK di Tingkat Layanan Primer
  (dr. Irmansyani Sudirman, SpJP)

II. Simposium II

Panitia

Patomekanisme Coronary

Moderator : Dr. dr. Rina Masadah, SpPA, MPhil

1. Patomekanisme Aterosklerosis
   (Dr. dr. Gatot S. Lawrence, MSc, SpPA, DFM)
2. Penanganan Penyakit Jantung Koroner Sehari-hari
   (Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP)

III. Simposium III

Panitia

Komplikasi Coronary

Moderator : dr. Irmalita, SpJP(K)

- Penanganan Klinis Syok Kardiogenik.
  (dr. Siska Suridanda Danny, SpJP(K))
- Penanganan Klinis Aritmia Lethal
  (Dr. dr. Starry H. Rampengan, SpJP(K))
- Nutrisi pada Penderita Penyakit Jantung Koroner Sehari-hari
  (Dr. dr. Haerani Rasyid, MKes, SpPD-KGH, SpGK)

1. **Diagnosa Gagal Jantung di Tingkat Layanan Primer**
   (dr. Janry Antonius Pangemanan, SpJP(K))
2. **Deteksi dan Penanganan Gagal Jantung Sistolik**
   (dr. Siti Elkana Nauli, SpJP)

ACARA ILMIAH

XI. Simposium Paralel VIII
PT. Boehringer Ingelheim
The Three Dimensions of Modern Blood Pressure Management
Moderator : Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP

1. **The Importance of 24-Hour BP Control For Managing CV Risk**
   (Prof. Dr. dr. Syakib Bakri, SpPD-KGH)
2. **Blood Pressure Variability Over 24-Hour: Implications And Treatment With Single Pill Combination**
   (Dr. dr. Muzakkir Amir, SpJP)

XII. Simposium IX
Panitia
Patomekanisme Heart Failure
Moderator : dr. Muhammad Nuralim Mallapasi, SpB, SpBTKV

1. **Penanganan Umum Gagal Jantung**
   (dr. Siti Elkana Nauli, SpJP)
2. **Patomekanisme dan Perubahan Hemodinamik Gagal Jantung**
   (Dr. dr. Starry H. Rampengan, SpJP(K))

XIII. Simposim Paralel IX
PT. Pfizer Indonesia
Moderator : dr. Abdul Hakim Alkatiri, SpJP

1. **Managing Blood Pressure Variability & Morning Hypertension with 24 Hours Amlodipine from Target Organ Damage**
   (dr. Pendrik Tandean, SpPD-KKV)

2. Tindakan Awal Sesak Napas pada Anak dengan Penyakit Jantung Bawaan
(dr. Julius Patimang, SpA, SpJP)

Sabtu, 13 Juni 2015

1. Cara Praktis Diagnosa dan Penanganan Gagal Jantung
(Dr. dr. Starry H. Rampengan, SpJP(K))
2. Tindakan Awal Sesak Napas pada Anak dengan Penyakit Jantung Bawaan
(dr. Burhanuddin Iskandar, SpA(K))

ACARA ILMIAH

TIPS DAN TRIK

2. Nyeri Dada Tiba-tiba
Jumat, 12 Juni 2015
1. Mengenal Nyeri Dada Cardiac Non Penyakit Jantung Koroner
(dr. Abubakar S. Zubeidi, SpJP)
2. Penanganan Nyeri Dada Cardiac Non Penyakit Jantung Koroner
(dr. Abubakar S. Zubeidi, SpJP)

Sabtu, 13 Juni 2015

1. Mengenal Nyeri Dada Selain Penyakit Jantung Koroner
(dr. Firman S Dullah, SpJP)
2. Penanganan Nyeri Dada Emergency Selain Penyakit Jantung Koroner
(dr. Bima Bintoro, SpJP)

3. Obat Kardiovaskular
Jumat, 12 Juni 2015
1. Tips Rasional Pemilihan Obat Kardiovaskular
(Prof. dr. Peter Kabo, PhD, SpFK, SpJP)
2. Tips Penanganan Efek Samping Obat Kardiovaskular

DIAGNOSIS AND MANAGEMENT OF ACUTE DECOMPENSATED HEART FAILURE

Starry H. Rampengan
Bagian Ilmu Penyakit Jantung dan Pembuluh Darah
Fakultas Kedokteran Universitas Sam Ratulangi Manado
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Acute decompensated heart failure (ADHF) has emerged as a major public health problem over the past 2 decades. The major symptoms of ADHF shortness of breath congestion and fatigue, are not specific for cardiac and circulatory failure. They may be caused by other condition which mimic heart failure (HF), complicating the identification of patient with this syndromes. Various forms of pulmonary disease, including pneumonia, reactive airway disease and pulmonary embolus, may be especially dificult to differentiate clinically from HF.

For millions of people throughout the world, acute heart failure is a lifethreatening medical emergency, and it is one of the most common reasons for admission to hospital. One in 10 patients with acute heart failure dies in hospital, and one in three dies within the year following an episode.

The symptoms of acute heart failure are distinct from those of a heart attack. Breathlessness, fatigue, and swelling of the lower legs or ankles are surprisingly often not recognized by patients and clinicians as the life-threatening symptoms of declining heart function. The underlying causes of acute heart failure are varied, and patient sex hibit different patterns and severity of symptoms. This means that many patients experience complex transitions between different healthcare providers and facilities.

Acute decompensated heart failure is a clinical syndrome, with reduced cardiac output, tissue hypoperfusion, increase in the pulmonary capillary wedge pressure (PCWP), and tissue congestion. The underlying mechanism may be cardiac or extra-cardiac, and may be transient and reversible with resolution of the acute syndrome, or may induce permanent damage leading to chronic heart failure. The cardiac dysfunction can be related to systolic or diastolic myocardial dysfunction (mainly induced by ischaemia or infection), acute valvular dysfunction, pericardial tamponade,

abnormalities of cardiac rhythm, or pre-load/after-load mismatch. Multiple extra-cardiac pathologies may result in acute heart failure by changing the cardiac loading conditions for example (i) increased after-load due to systemic or pulmonary hypertension or massive pulmonary emboli, (ii) increased pre-load due to increased volume intake or reduced excretion due to renal failure or endocrinopathy, or (iii) high output state due to infection, thyrotoxicosis, anaemia, Paget's disease. Heart failure can be complicated by co-existing end-organ disease. Severe heart failure can also induce multi-organ failure, which may be lethal. Appropriate long-term medical therapy and, if possible, anatomical correction of the underlying pathology may prevent further ADHF syndrome 'attacks' and improve the poor long-term prognosis associated with this syndrome.

The American College of Cardiology Foundation/The American Heart Association divides patients based on presenting clinical profile into three main groups: volume overload, manifested by pulmonary and/or systemic congestion, usually due to increases in blood pressure (BP), severely reduced cardiac output often with hypotension, and combined volume overload and cardiogenic shock. Rapid identification of patients with acute heart failure is the first step in providing effective care. Diagnosis can be challenging because symptoms vary at presentation, and many different factors can cause an episode of acute heart failure. Poor recognition of the signs and symptoms of acute heart failure frequently leads to delays in diagnosis and treatment.

Diagnosis of acute heart failure relies on a combination of clinical evaluation, patient history, electrocardiography, cardiac imaging, and laboratory tests. Diagnosis in the emergency room can prove a challenge, as symptoms may be life-threatening, so diagnosis and treatment are usually carried out together. Rapid diagnosis and assesment for ADHF patient must be done in two minutes at emergency room. In this situation,the key aims of therapy are torelieve symptoms, stabilize blood pressure, maintain blood oxygen levels, and prevent organ damage. Patient history can prove a useful guide to diagnosis, as approximately 65% of patients with acute heart failure also have pre-existing chronic heart failure.

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