MAKASSAR CARDIOVASCULAR UPDATE XIV 2015

12 - 14 Juni 2015, Hotel Grand Clarion Makassar

PENANGANAN PENYAKIT JANTUNG DAN PEMBULUH DARAH : A – Z
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<tr>
<th>No.</th>
<th>Judul Judul</th>
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<td>1.</td>
<td>Sambutan Ketua Panitia</td>
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<td>2.</td>
<td>Daftar Isi</td>
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<td>3.</td>
<td>Skema Acara MCVU XIV</td>
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<td>Susunan Panitia Pelaksana MCVU XIV</td>
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## SKEMA ACARA

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<td>Coronary (CR)</td>
<td>High Risk Group (HRG)</td>
<td>Heart Failure (HF)</td>
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**Keterangan:**
- S : Symposium Tunggal
- SMS : Symposium Makan Siang
- TnT : Tips dan Trik
- WS : Workshop
ACARA ILMIAH

SIMPOSILUM

I. Symposium I
   Panitia
   Diagnostik Coronary
   Moderator: dr. Pendidik Tandean, SpPD-KKV
   - Diagnosis Penyakit Jantung Koroner di Rumah Sakit
     (dr. Aminudin, SpPD, SpJP)
   - Diagnosis PJK di Tingkat Layanan Primer
     (dr. Imarnayani Syahirman, SpJP)

II. Symposium 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. Symposium III
     Panitia
     Komplikasi Coronary
     Moderator: dr. Irmalita, SpJP(K)
     - Penanganan Klinis Syok Kardiogenik.
       (dr. Siska Suridanda Danny, SpJP(K))
     - Penanganan Klinis Kardiogenik (Dr. dr. Starry H. Rampengan, 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. Simposium 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. Bimo 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
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 conditions which mimic heart failure (HF), complicating the identification of patient with this syndrome. Various forms of pulmonary disease, including pneumonia, reactive airway disease, and pulmonary embolus, may be especially difficult 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 exhibits 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 assessment for ADHF patient must be done in two minutes at emergency room. In this situation, the key aims of therapy are to relieve 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.