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

# MAKASSAR CARDIOVASCULAR UPDATE XIII 2014

20 - 22 Juni 2014, Hotel Grand Clarion Makassar

## OPTIMAZING THE COMPETENCE OF MEDICAL PRACTITIONERS ON CARDIOVASCULAR CARE IN BPJS ERA

# DAFTAR ISI

Halaman

# SKEMA ACARA

| JAM | ACARA MCVU XIII 2014 | | | | | | | | | |
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| | KAMIS | JUMAT | | | | SABTU | | | MINGGU | |
| | 19 Juni 2014 | 20 Juni 2014 | | | | 21 Juni 2014 | | | 22 Juni 2014 | |
| 07.00 - 07.30 | Workshop Kegawatdaruratan Jantung | Pendaftaran Ulang | | | | Pendaftaran Ulang | | | | |
| 07.30 - 08.00 | | | | | | Diskusi Pagi Neuro | | Diskusi Pagi Renal | | |
| 08.00 - 08.25 | | Tips Pagi | | | | S - IV | | WS Perawat | Diskusi Pagi Pulmonal | Diskusi Pagi Ginekologi |
| 08.25 - 08.30 | | | | | | | | | | |
| 08.30 - 09.00 | | Rehat Kopi & S - I | | | | | | | S - VII | |
| 09.00 - 09.20 | | | | | | | | | | |
| 09.20 - 09.30 | | | | | | S - V | | | | |
| 09.30 - 10.00 | | SMS-I | | | | | | | | |
| 10.00 - 10.15 | | | | | | | | | Rehat Kopi | |
| 10.15 - 10.30 | | | | | | Kuliah Umum dan Peresmian Tele-EKG Rehat Kopi | | | | |
| 10.30 - 11.00 | | Pembukaan | | | | | | | S - VIII | |
| 11.00 - 11.30 | | S- Telemedicine | | | | S - VI | | WS Perawat | | |
| 11.30 - 12.00 | | | | | | | | | SMS - III | |
| 12.00 - 12.30 | | Shalat Jumat | | | | SMS - II | | | | |
| 12.30 - 13.00 | | | | | | | | | Makan Siang | |
| 13.00 - 13.15 | | Makan Siang | | | | Makan Siang | | | | |
| 13.15 - 13.30 | | | | | | | | | Penutupan / Lucky Draw | |
| 13.30 - 13.45 | | S-II | | | | S - East Meet West | | WS Perawat | | |
| 14.15 - 14.30 | | | | | | | | | | |
| 14.30 - 14.45 | | S-III | | | | Lucky Draw | | | | |
| 14.45 - 15.30 | | | | | | Tips n Tricks | | | | |
| 15.30 - 15.45 | | Lucky Draw | | | | Sesak Napas | Nyeri Dada | Obat KV | Sinkop | |
| 15.45 - 16.45 | | Tips n Tricks | | | | | | | | |
| 16.45 - 17.15 | | Sesak Napas | Nyeri Dada | Obat KV | Nyeri Tengkuk | Dandelor | | | | |
| 17.15 - 17.45 | | | | | | | | | | |

Keterangan :

S : Simposium Tunggal

SMS : Simposium Makan Siang

# ACARA ILMIAH

## SIMPOSIUM

I. **Simposium I**

**Panitia**

**Klinis dan Diagnosa Penyakit Jantung Koroner**

Moderator : Prof. dr. Junus Alkatiri, SpPD, SPJP(K)

- **Diagnosa Penyakit Jantung Koroner : Puskesmas dan Rumah Sakit**
  (dr. Almudai, SpPD, SpJP)
- **Penanganan Penyakit Jantung Koroner**
  (dr. Starry Rampengan, SpJP)

II. **Simposium II**

**Panitia**

**Diagnosa dan Penanganan Acute Coronary Syndrome**

Moderator : dr. Juzny Alkatiri, SpPD, SpJP

1. **Diagnosa Klinis Acute Coronary Syndrome**
   (dr. Dafsah Arifa Juzar, SpJP)
2. **Penanganan Acute Coronary Syndrome**
   (dr. Abdul Hakim Alkatiri, SpJP)

III. **Simposium III**

**PT. Merck Sharp & Dohme Indonesia**

**Bringing The Gap The Current Dyslipidemia and Diabeti Management With Dual Inhibitor Concept and Insight Sitaglipti Treatment**

Moderator : Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP(K)

- **Rationale of Inhibiting Cholesterol Abssorption an Production. Why Is It Important.**
  (dr. Pendrik Tandean, SpPD-KKV)
- **Have We Underestimate Hypoglycemia : Reducing The Risk I The Patients With T2DM**
  (Dr. dr. A. Makbul Aman, SpPD-KEMD)

# SUSUNAN PANITIA

## SUSUNAN PANITIA PELAKSANA
## MAKASSAR CARDIOVASCULAR UPDATE XII 2013
## MAKASSAR, 21 – 23 JUNI 2013

### SIMPOSIUM

| | | |
|---|---|---|
| Pembina | : | Dekan FK Unhas<br>Kepala Dinas Kesehatan Sulawesi Selatan<br>Dirut. RS. Dr. Wahidin Sudirohusodo<br>Dirut. RS. Universitas Hasanuddin |
| Penasehat | : | Prof. dr. Junus Alkatiri, SpPD-KKV, SpJP(K) |
| Ketua Panitia | : | Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP(K) |
| Wakil Ketua | : | Prof. dr. Peter Kabo, PhD, SpFK, SpJP |
| Sekretaris | : | Dr. dr. Idar Mappangara, SpPD, SpJP |
| Wakil Sekretaris | : | dr. Juzny Alkatiri, SpPD, SpJP |
| Bendahara | : | dr. Pendrik Tandean, SpPD-KKV |
| SEKSI-SEKSI | | |
| Dana | : | Prof. dr. Junus Alkatiri, SpPD-KKV, SpJP(K)<br>Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP(K)<br>Prof.dr. Peter Kabo, PhD, SpFK, SpJP<br>dr. Khalid Saleh, SpPD-KKV<br>dr. Zaenab Djafar, SpPD<br>dr. Fawzia Arifin Daud<br>dr. A. Inggi Maesatana |
| Ilmiah | : | Dr. dr. Idar Mappangara, SpPD, SpJP<br>dr. Abdul Hakim Alkatiri, SpJP<br>dr. Muzakkir, SpJP<br>dr. Asmaun Najamuddin, SpKFR<br>dr. Burhanuddin Iskandar, SpA(K)<br>dr. Firman B Leksmono<br>dr. A. Alief Utama Armyn |
| Pendaftaran | : | dr. Uswa Malik<br>Farida Hariyati<br>Rizal, SKM<br>Syahruddin ,SSi |
| Acara/ Perlengkapan | : | dr. Juzny Alkatiri, SpPD, SpJP<br>Indri M Wulandari, SE<br>Irma Ariyani, S.Si, Apt<br>dr. Magma Purnawan Putra<br>dr. Gusmawan<br>dr. Sheila |
| Pameran/Keamanan | : | dr. Muhammad Nuralim Mallapasi,SpB, SpBTK<br>dr. Abubakar Zubeidi<br>dr. Titus Kurnia Hariadi<br>dr. Bambang Rahardi |
| Dokumentasi/Publikasi | : | dr. Khalid Saleh, SpPD-KKV<br>Joko Widodo, S.Si, MKes<br>dr. Firman S Dullah<br>dr. Wisudawan<br>dr. Harie Cipta<br>Dadi Ali Muhammad Ridwan |

# SUSUNAN PANITIA

| | | |
|---|---|---|
| Transportasi/Akomodasi | : | dr. Theo Deus<br>Olga Haslim<br>dr. Muh. Husen Latief<br>dr. Farid Hidayat |
| Konsumsi | : | dr. Hikmawati<br>dr. Mirnawati Mappiare<br>Hj. Rosnah, SKM |
| Staff Sekretariat | : | Nana Herawati, S.Kom<br>Zaenal, SE<br>Baso Dedy, Amd |

**SIMPOSIUM TIPS AND TRICKS DAN WORKSHOP**

| | | |
|---|---|---|
| Koordinator | : | dr. Muzakkir Amir, SpJP |
| Ketua | : | dr. Almudai, SpPD, SpJP |
| Sekretaris | : | dr. Mailani Karina Akhmad |
| Pendaftaran | : | Nur Asni, SP<br>H. Ardiansyah, S.Kep, Ns, SpKV |
| Tips dan Triks Sesak Napas | : | Prof.dr. Peter Kabo, PhD, SpFK, SpJP<br>dr. Pendrik Tandean, SpPD-KKV<br>dr. Firman S Dullah<br>dr. Stefan Hendyanto<br>dr. Bambang Rahardi |
| Tips dan Triks Nyeri Dada | : | dr. Abdul Hakim Alkatiri, SpJP<br>dr. Khalid Saleh, SpPD-KKV<br>dr. Muh. Asrul Apris<br>dr. Sheila<br>dr. Magma Purnawan Putra |
| Tips dan Triks Nyeri Tungkai | : | Dr. dr. Idar Mappangara, SpPD, SpJP<br>dr. Muhammad Nuralim Mallapasi,SpB, SpBTKV<br>dr. Abubakar S. Zubeidi<br>dr. Alief Utama<br>dr. William Horas |
| Tips dan Triks s Berdebar | : | Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP(K)<br>dr. Wisudawan<br>dr. Gusmawan<br>dr. Dian Pratiwi |
| Tips dan Triks Sinkop | : | dr. Muzakkir Amir, SpJP<br>dr. Muh. Husen Latief<br>dr. Mailani Karina Akhmad<br>dr. Harie Cipta |
| BLS Sabtu | : | dr. Burhanuddin Iskandar, SpA(K)<br>dr. Julius Patimang, SpA(K)<br>dr. Mirnawati Mappiare<br>dr. Farid Hidayat |

## SIMPOSIUM I
## JUMAT, 20 JUNI 2014

### MANAGEMENT OF CORONARY ARTERY DISEASE IN BPJS ERA

**Starry H. Rampengan, MD, FIHA, FICA, FAHA, FACC, FESC, PhD**
Department of Cardiology and Vascular Medicine
Faculty of Medicine, Univerity of Sam Ratulangi
North Sulawesi

Coronary Artery Disease (CAD) is most commonly due to the arrowing of the coronary arteries sufficiently to prevent adequate blood supply to the myocardium. The narrowing is usually caused by atherosclerosis. Atherosclerosis is a process that can involve many of the body's blood vessels with a variety of presentations. When it involves the coronary arteries it results in coronary artery disease, the cerebral arteries; cerebrovascular disease (transient ischemic attack, stroke), the aorta; aortic aneurysms, the ileo-femoral and popliteal arteries; peripheral vascular disease, the mesenteric arteries; intestinal ischemia.

Coronary artery disease is the single most common cause of death in the developed world, responsible for about 1 in every 5 deaths. It is estimated that more than 16 million Americans have CAD and 8 million have had a myocardial infarction (MI). Every year approximately 1 million will have a new myocardial infarction. Based on data from the Framingham trial nearly 50% of males and 30% of females over the age of 40 will develop coronary artery disease.

Coronary artery disease can present in a variety of ways. The classical presentation is with chest discomfort. Chest discomfort resulting from myocardial ischemia secondary to coronary artery disease is called angina pectoris (squeezing of the chest). Discomfort is diffuse and not localized and may radiate down the arms, as low as the umbilicus and up to the lower jaw. This may be associated with shortness of breath (dyspnea). This discomfort is the result of myocardial ischemia however it is one of the last manifestations to appear. Due to the myocardium's complete reliance on coronary blood flow for energy supply, within a few beats of coronary occlusion, diastolic and systolic dysfunction set in and the electrocardiogram begins to register abnormalities before the patient begins to experience angina pectoris. This explains why patients may describe associated shortness of breath when they experience angina. The association of both symptoms together indicates that the myocardium fed by the narrowed vessel is sizable.

The following are the more frequent clinical consequences of coronary artery disease. Coronary Artery Disease may be manifested in a variety of ways: asymptomatic, stable angina, unstable angina, acute myocardial infarction (MI) or Sudden Death. These "scenarios" may progress from one to another

## SIMPOSIUM I
## JUMAT, 20 JUNI 2014

and their recognition allows for their proper management to preclude any potential lethal consequence. the term acute coronary syndrome refers to unstable angina, acute Non ST elevation myocardial infarction (NSTEMI) and ST elevation myocardial infarction (STEMI). One fourth of acute coronary syndrome patients are diagnosed with STEMI, the remainders have unstable angina or NSTEMI.
Half of all deaths in the developed world and a quarter of deaths in the developing world are due to Cardiovascular Disease which are comprised of hypertension and the diseases caused by atherosclerosis.
The treatment of stable angina has two major purposes by prevention of MI or death, and ischemia reduction also symptom relief.
Prevention of MI and death by using a lipid-lowering agents – for aggressive LDL reduction with goal of LDL <100, or LDL <70 for very high risk patients. Statins are generally considered to be first-line drugs for treatment of dyslipidemia, combined with lifestyle modification. Patients at low to moderate risk for CAD may be treated with lifestyle modification alone, or with medications, according to cardiac risk. Cardiac risk can be estimated using a CAD risk assessment tool (Using this tool, a 10 year cardiac risk of >20% is considered high risk, 10-20% moderate risk, and <10% low to moderate risk.) Aspirin – 81 to 325 mg/d if no contraindications. Clopidogrel if aspirin is absolutely contraindicated. Combination of ASA and Clopidogrel, without interruption, is commonly used for up to one year or more following coronary stent placement. Clinicians should refer to most current clinical recommendations regarding post-stent medications and their use.
Ischemia reduction and symptom relief by using sub-lingual nitroglycerin prn, beta blocker (if no contraindications) to reduce resting heart rate to 50-60 bpm, ACE inhibitor in all CAD patients who also have diabetes or left ventricular systolic dysfunction, if no contraindications. Calcium channel blockers (long-acting) – if contraindications to beta blockers exist, if symptomatic relief cannot be achieved by combination of beta blockers and nitrates, or if vasospastic angina is suspected. Long-acting nitrates – if contraindications to both beta blockers and calcium channel blockers exist. Long-acting nitrates also add to the anti-anginal effects of both beta blockers and calcium channel blockers. Treatment of coexisting medical

conditions–anemia, hyperthyroidism, hypertension, diabetes, smoking, obesity, hypoxia due to lung disease.
Treatment of stable angina can be summarized using the following mnemonic (ABCDE): Aspirin and Antianginal therapy, Beta-blocker and Blood pressure control, Cholesterol lowering, Cigarettes (smoking cessation), Diet and Diabetes, Education and Exercise.
In the era of BPJS, the choice of treatment depends on both the need to relieve symptoms and the need to identify those at increased risk of death. Consider coronary angiography if angina pectoris symptoms are refractory or if



the exercise electrocardiogram is abnormal, especially with poor work capacity. Also, for intermediate and high risk patient with CAD suggest to do agressively coronary angiography and percutaneus coronary intervention (PCI) if needed or coronary artery bypass graft (CABG). It is full covered by Indonesian government.

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