MAKASSAR CARDIOVASCULAR UPDATE XIII 2014

20 - 22 Juni 2014, Hotel Grand Clarion Makassar

OPTIMIZING THE COMPETENCE OF MEDICAL PRACTITIONERS ON CARDIOVASCULAR CARE IN BPJS ERA
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**SKEMA ACARA**

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Keterangan:
- **S** = Simposium Tunggal
- **SMS** = Simposium Makan Siang
ACARA ILMIAH

SIMPOSUUM

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
   1. Diagnosa Klinis Acute Coronary Syndrome
      (dr. Dafsih 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 Diabetes Management With Dual Inhibitor Concept and Insight Sitagliptin Treatment
    Moderator : Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP(K)
    - Rationale of Inhibiting Cholesterol Absorption and Production. Why Is It Important.
      (dr. Pendrik Tandean, SpPD-KKV)
    - Have We Underestimate Hypoglycemia : Reducing The Risk For 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
Kepala Dinas Kesehatan Sulawesi Selatan
Dirut. RS. Dr. Wahidin Sudirohussodo
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
Bendahara : dr. Pendrik Tandean, SpPD-KKV

SEKSI-SEKSI
Dana : Prof. dr. Junus Alkatiri, SpPD-KKV, SpJP(K)
IIlmiah : Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP(K)

Prof.dr. Peter Kabo, PhD, SpFK, SpJP
dr. Khalid Saleh, SpPD-KKV
dr. Zaenab Djafar, SpPD
dr. Fawzia Arifin Daud
dr. A. Inggli Maesatana
Dr. dr. Idar Mappangara, SpPD, SpJP
dr. Abdul Hakim Alkatiri, SpJP
dr. Muzakkir, SpJP
dr. Asmaun Najamuddin, SpKF
Dr. Burhanuddin Iskandar, SpA(K)
dr. Firman B Leksono
dr. A. Alief Utama Armany

Pendaftaran : dr. Uswa Malik
Acara/ Perlengkapan : Farida Hariyati
Pameran/Keamanan : Rizal, SKM
Dokumentasi/Publikasi : Syahruddin, SSI

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Irma Ariyani, S.Si, Apt
Magma Purnawan Putra
Gusmawan
Sheila

dr. Muhammad Nuralim Mallapasi, SpB, SpBTK
Abubakar Zubeldi
Titus Kurnia Hariadi
Bambang Rahardi
Khalid Saleh, SpPD-KKV
Joko Widodo, S.Si, MKes
Firman S Dullah
Wisudawan
Harrie Cipta
Dadi Ali Muhammad Ridwan
SUSUNAN PANITIA

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Olga Haslim
dr. Muh. Husen Latief
dr. Farid Hidayat
Hikmawati
dr. Mirmawati Mappiare
Hj. Rosnah, SKM
Nana Herawati, S.Kom
Zaelal, SE
Baso Dedy, Amd

Konsulsi:
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Almudal, SpPD, SpJP
Hidayati
Mirmawati Mappiare
S.Kom
Zaelal, SE
Baso Dedy, Amd

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Almudal, SpPD, SpJP
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Hidayati
Mirmawati Mappiare
S.Kom
Zaelal, SE
Baso Dedy, Amd

SIMPONIUM TIPS AND TRICKS DAN WORKSHOP

Koordinator: dr. Muzakkir Amir, SpJP
Pada: Almudal, SpPD, SpJP
Rektor: dr. Maimani Karina Akhmad
Ketua: Nur Asni, SP
Pendaftaran: H. Ardiansyah, S.Kep, Ns, SpKV

Tips dan Triks Sesak Napas: Prof.dr. Peter Kabo, PhD, SpFK, SpJP
dr. Pendrik Tandein, SpPD-KKV
dr. Firman S Dullah
dr. Stefan Hendyanto
dr. Bambang Rahardi

Tips dan Triks Nyeri Dada: Dr. dr. Abdul Hakim Alkatiri, SpJP
dr. Khalid Saleh, SpPD-KKV
dr. Muh. Asrul Apris
dr. Shellia
Magma Purnawan Putra

Tips dan Triks Nyeri Tungkai: Dr. dr. Idar Mappangara, SpPD, SpJP
dr. Muhammad Nuralim Mallapasi, SpB, SpBTKV
Abubakar S. Zubeldi
dr. Alief Utama
William Horas

Tips dan Triks s Berdebar: Prof. Dr. dr. Ali Aspar Mappahya, SpPD, SpJP(K)
dr. Wisudawan
gusmawan
dr. Dian Pratiwi

dr. Muh. Husen Latief
Maimani Karina Akhmad
Hari Cipta

MD Labu: dr. Burhanuddin Iskandar, SpA(K)
dr. Julius Patimang, SpA(K)
Mirmawati Mappiare
Farid Hidayat
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 ilio-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.

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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

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

References


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