

FOUNDATION FOR LAY EDUCATION ON HEART DISEASES, INC.
(a World Heart Federation associate national member)

13th NATIONAL ANNUAL CONVENTION ON PREVENTIVE CARDIOLOGY
FOR PHYSICIANS

Theme: "MULTIPLE ORGAN FAILURE *PREVENTION*
through pathophysiologically- based management of HYPOTENSION"

January 25-26, 2013
Makati Medical Center Auditorium, Tower B
Makati City

P R O G R A M M E

Day 1,
January 25, 2013
Friday

0730 – 0800 REGISTRATION
VISIT THE EXHIBITS

0800 – 0830 Introduction to the Course

Adolfo Bellosillo, MD

Symposium I **The Blood Pressure A**

0830 – 0900 Definitions and clinical significance:
arterial blood pressure; systolic and diastolic blood pressure;
mean arterial pressure; pulse pressure; total peripheral resistance;
arterial capacitance; blood pressure determinants

Alberto Atilano, MD

0900 – 0930 The peripheral circulation and its control :
The role of the vascular smooth muscle;
The intrinsic and extrinsic control of the peripheral blood flow
The role of the chemoreceptors, the hypothalamus, the vasomotor
Center, and the pulmonary reflexes

Ken Villanueva, MD

0930 – 1000 STRESS DOWNLOAD
VISIT THE EXHIBITS

Symposium II **The Blood Pressure B**

1000 – 1030 Hypotension and Shock; definition and etiologic factors and
how each causes hypotension

Vincent Valencia, MD

1030 – 1100 Oxygen delivery to the tissues: cellular respiration and generation
of ATP Transport of oxygen and carbon dioxide; cell regulation and
mediators of systemic defense response

Norbert Lingling Uy, MD

1100 – 1130	Determinants of oxygen delivery to the tissues; clinical expressions of shock syndrome as they affect the organ systems (particular the heart, the lungs, the kidneys, the central nervous system, the gastrointestinal tract, the hemotologic system)	Leandro Bongosia, MD
1130 – 1200	QUESTIONS AND ANSWERS ON SYMPOSIA I AND II	
1200 – 1400	GASTRONOMIC REFILL VISIT THE EXHIBITS OPENING CEREMONY	

Symposium III Multiple Organ Failure A

1400 – 1430	Definition and pathogenesis; control of circulation to specific organ systems (cerebral, coronary, pulmonary, renal and splanchnic)	Eleanor Lopez, MD
1430 – 1500	Non-invasive Circulatory hemodynamic monitoring through Impedance Cardiography	Adolfo Bellosillo, MD
1500 – 1530	STRESS DOWNLOAD VISIT THE EXHIBITS	

Symposium IV Multiple Organ Failure B

1530 – 1600	Shock associated with acute myocardial infarction; pathogenesis, salvaging of the myocardium, treatment of ventricular dysfunction	Noel Rosas, M D
1600 – 1630	Septic Shock Host factors, hemodynamic response to sepsis; management	Janice Caoili, MD
1630 – 1700	QUESTIONS AND ANSWERS RE SYMPOSIA III AND IV VISIT THE EXHIBITS	

Day 2 January 26, 2013 Saturday

0730 – 0830	REGISTRATION VISIT THE EXHIBITS	
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Symposium V Multiple Organ Failure C

0830 – 0900	The respiratory system as a cause for shock and as a target organ	Camilo Roa, MD
0900 – 0930	The kidney responses to hypotension and as a cause for shock syndrome	Froilan de Leon, MD
0930 – 1000	The central nervous system and shock	Levi Rejoso, MD
1000 - 1030	STRESS DOWNLOAD VISIT THE EXHIBITS	

Symposium VI **Multiple Organ Failure D**

1030 – 1100	Hematologic consequences of Shock	Jess Relos, MD
1100 – 1130	Dysfunction of other organs: the liver, the pancreas and the rest of the gastrointestinal tract	Benjamin Benitez, Jr., MD
1130 – 1200	The endocrine system as a cause for shock and as it responds to The state of shock due to any cause	Eduardo Aquino, MD
1200 – 1230	QUESTIONS AND ANSWERS ON SYMPOSIA V and VI	
1230 – 1400	GASTRONOMIC REFILL VISIT THE EXHIBITS MUSICAL REFRAIN	

Symposium VII **Multiple Organ Failure D**

1400 – 1430	The sympathetic amines in shock and ventricular failure dopamine and dobutamine; epinephrine and nor epinephrine; Isoproterenol; phosphodiesterase inhibitors as inotropes	Simonette Ganzon, MD
1430 – 1500	Volume resuscitation: indications, how monitored and guidelines	Wilfredo Ypil, MD
1500 – 1530	STRESS DOWNLOAD VISIT THE EXHIBITS	

Symposium VIII **Case presentations and discussions**

1530 – 1700 **Case I** – Marlon Co, MD – discussant

A 45-yr old man was admitted for an executive check-up. . While in the hospital, the patient began complaining of recurrent substernal chest pain at rest relieved by sub-lingual nitroglycerin. He had a strong family history of cardiac disease and diabetesMellitus.

Physical examination: BP 105/60; HR – 130/min.; anxious, in obvious discomfort; pale and diaphoretic; Neck: no jugular venous distention; carotids – slow upstroke; Lungs: clear to auscultation; Heart: PMI – 5th ICSLMCL; apex beat – normal; no ventricular over-activity; no thrill; S1- normal; P2 – not accentuated; No S3; No S4, no murmurs Extremities: moist and cool, no pedal edema. Laboratory findings: CBC and electrolytes – normal; Chest radiography: normal; 12 lead ECG: S-T segment elevation with small q over leads III and AVF Swan-Ganz: RA – 20; RV – 35/18; PA – 35/20; Pulm. Capillary wedge – 17

Questions:

1. What is the patient's diagnosis?
2. What are in the clinical data that makes one arrive at the diagnosis?
3. Discuss the procedures that can confirm the diagnosis
4. Discuss the development of the shock state of the patient?
5. How would you manage the shock?
6. Special precaution/s in the management of the case

Case 2 – Efren Vicaldo, MD

A previously healthy 25-year man was seen at the ER for fever, chills and productive cough of 3 days duration and inspiratory chest pain. He was not into prohibited drugs and he had no history of HIV infection.

Physical examination: T – 101.2 Pulse – 120; RR – 32; BP – 80/60; Skin showed poor turgor and buccal mucosa was dry; no pharyngeal lesions; no neck lymphadenopathy; Chest: right basilar rhonchi with egophony and dullness to percussion; Heart: Grade II/VI systolic ejection murmur over the base ; Extremities: cold and clammy; Laboratory findings: WQBC 25,000 with polysegmenters of 70% and 10% bands; Toxic granulations; Swan-Ganz catheter: RA – 8; PA – 28/14; PWP – 11; C.I. – 3.8/L/min/m.sq.

Questions:

1. What is the impression?
2. Discuss the hemodynamic factors involved in the drop in BP in reference to time
3. What are the humoral substances often involved in this kind of shock?
4. What are the factors compounding the problems of reduced tissue perfusion in patients with this type of shock?
5. Outline your management approach to the problems of this patient.

Case 3 – Mariano Lopez, MD – discussant

A 60 year old male with history of hypertension and coronary artery disease was admitted to a hospital because of progressive easy fatigue, orthopnea and paroxysmal nocturnal dyspnea.

On day 1 of his hospital stay, the nurse noted the patient to have become, restless, disoriented and confused. A medical resident on duty was called and noted the heart at 66/min and the blood pressure of 117/82. An astute medical resident physician that he was, he suspected immediately some hemodynamic compromise going on to explain the abnormal behavior of the patient.

Immediately, he ordered hemodynamic monitoring through impedance cardiography the results of which showed:

HR – 66 BP 117/82 Mean arterial pressure – 93 (N of 84-100)
Cardiac index – 0.6 (N – 2.5-4.7); Cardiac output – 1.0 (4.1-7.8);
Stroke index – 9 (35-65); stroke volume – 16 (60-105)
Peripheral vascular resistance index– 11171 (1337-2483);
Peripheral vascular resistance – 6803 (742-1378)
Acceleration index – 28 (70-150); Velocity index – 9 (33-65)
Thoracic fluid content – 85.8 (20-50)
Left cardiac work index – 0.7 (3.0-5.5); Left cardiac work – 1.2 (5.4-10)

Questions:

1. Explain the behavioral manifestations and the apparent normal vital signs
2. With access to the results of the hemodynamic monitoring through impedance cardiography, how would you approach the management?

1700 – 1730

QUESTIONS AND ANSWERS

1730

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VISIT THE EXHIBITS