REVIVED-BCIS2
Newsletter
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REVIVED

News

Site initiation was held at the Freeman Hospital, Newcastle marking the first of the new site initiation procedures. The aim is to have more targeted information for both clinicians and nurses and to reduce the amount of time to the first patient being recruited into the trial.

A nurses teleconference was held on 19th May which brought to light some of the difficulties with screening. The main issue that came up was the time it takes to go through all the different screening lists. The CTU are working to find a more efficient way of screening so your feedback is welcome.

22 patients recruited

Congratulations to Neville Kukreja, Claire Barratt and the rest of the team at the Lister Hospital, Stevenage on recruiting their first patient.

Site Progress Summary

Sites currently screening and recruiting (12):

St Thomas', London

Royal Wolverhampton Hospital

Birmingham Heartlands Hospital

King's College Hospital, London

Edinburgh Royal Infirmary

Golden Jubilee National Hospital

Royal Bournemouth Hospital

Lister Hospital, Stevenage

Glenfield Hospital, Leicester

Kettering General Hospital

Manchester Royal Infirmary

Liverpool Chest and Heart Hospital

Recently initiated (1):

Freeman Hospital, Newcastle

Screening but awaiting R&D approval (1):

Northern General Hospital, Sheffield

Awaiting site initiation (1):

James Cook Hospital, Middlesbrough

Reviewing documentation (17):

Southampton General Hospital

Trent Cardiac Centre, Nottingham

Queen Alexandra Hospital in Portsmouth

Royal Free Hospital, London

Papworth Hospital, Cambridge

Pinderfields Hospital, Yorkshire

Royal Belfast Victoria Hospital

Royal Brompton Hospital, London

Derriford Hospital, Plymouth

Sunderland Royal Hospital

Harefield Hospital, Middlesex

London Chest Hospital

Hammersmith Hospital, London

St George's Hospital, London

Wythenshawe Hospital, Manchester

Victoria Hospital, Blackpool

Leeds General Infirmary

Acute heart failure admissions

One potentially overlooked source of patients for REVIVED is acute heart failure admissions. In many cases, a heart failure admission will trigger a repeat echocardiogram and in some cases angiography and/or a viability study. This is often a good opportunity to identify potential patients, even if they may not be eligible for randomisation immediately; if it is a new diagnosis of heart failure, patients will need to first be initiated and optimised on medical/device therapy, but if the LVEF remains poor after optimisation (the echo may need to be repeated), they may be eligible at a later date. It is important that such patients are captured on a research database ("possibles log") when they are first identified and subsequently reassessed for eligibility (sometimes several weeks later).

The team at St Thomas' estimate that the majority of patients enrolled in/considered for REVIVED, have come to light after a heart failure admission, with several presenting initially to a referring hospital. Many of these patients have undergone angiography during or shortly after this admission and then been referred to the JCC (MDT) meeting for discussion, which is when they are flagged up as a potential for REVIVED. In the cases randomised or definitively excluded so far, there has been a delay of up to 12 weeks before a decision is made, during which time patients have undergone titration of medication, device insertion, viability studies etc. and remained on the "REVIVED possibles log", which is reviewed and updated regularly.

A question that has often been asked by recruiting centres about such patients is whether a minor troponin rise (that is often associated with heart failure admissions) means they are not eligible for REVIVED. An acute coronary syndrome within the previous 6 weeks would preclude patients from being randomised *during that period,* but the diagnosis of an ACS is left to the clinical team and is not based on troponin levels alone. If the clinical team have not diagnosed an ACS in a patient admitted with heart failure symptoms, they could be considered for REVIVED.

Some centres have also said that patients undergo angiography after/during a heart failure admission and if found to have significant coronary disease, proceed to have PCI at the same sitting even when they have not received a diagnosis of ACS or presented with severe angina. As the current guidelines and evidence do not mandate this approach, it would be entirely reasonable to defer the decision on revascularisation and to discuss the case at a later MDT meeting – when they could also be considered for enrolment in REVIVED. If this is routine practice among your colleagues, you may have to convince them to modify their approach, even if just for the duration of REVIVED!

Divaka Perera, Chief Investigator

FAQs

Q. What is the advice on including patients with CTOs?

A. If there is a high risk of the procedure being a failure, do not include the patient but if it is likely that the procedure will be a success, there is no reason to exclude the patient.

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