

World Congress on Cardiac Nursing and Cardiology

&
6th International Conference on
Global Healthcare

November 04-05, 2019 | Tokyo, Japan

Keynote Forum



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Mansoura University, Egypt

Volumetric overload shocks in the patho-etiology of the transurethral resection prostatectomy syndrome and acute dilution hyponatraemia

The Transurethral Prostatectomy Syndrome (TURS) is defined as severe vascular hypotension reaction that complicates Endoscopic surgery as a result of massive irrigating fluid absorption causing severe acute dilution hyponatraemia (HN) of <120 mmol/l. The vascular shock is usually mistaken for one of the recognized shocks and Volumetric Overload Shock type 1 (VOS1) is overlooked making Volumetric Overload Shock Type 2 (VOS2) unrecognizable. In adults VOS1 is induced by the infusion of 3.5-5 litres of sodium-free fluids and is known as TURS or HN shock. VOS2 is induced by 12-14 litres of sodium-based fluids and is known as the adult respiratory distress syndrome. The most effective treatment for VOS1 and VOS2 is hypertonic sodium Therapy of 5%NaCl or 8.4% Sodium Bicarbonate. The literature on TURS is reviewed and the underlying patho-etiology is discussed.

As Starling's law for the capillary-interstitial fluid transfer, which underlies the principles of fluid therapy, proved wrong an alternative mechanism was found by studying the hydrodynamics of the porous orifice (G) tube akin to capillary. Incorporating the G tube in a chamber (C), representing the interstitial space surrounding a capillary, demonstrated a rapid dynamic magnetic field-like fluid circulation between the C and G tube lumen. The G-C phenomenon is autonomous having both filtration and absorption forces making a true replacement for Starling's law in every tissue and organ of the body.

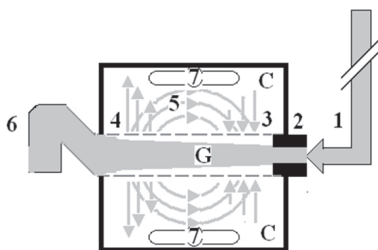


Figure: shows diagram of the porous orifice (G) tube enclosed in chamber (C) based on several photographs demonstrating the magnetic field-like G-C circulation phenomenon. The proximal inflow (arterial) pressure (1) pushes fluid through the orifice (2) creating fluid jet in the lumen of the G tube. The fluid jet creates negative side pressure gradient causing suction maximal over the proximal half of the G tube near the inlet (3) that sucks fluid into lumen. The side pressure gradient turns positive pushing fluid out of lumen over the distal half maximally near the outlet (4). Thus the fluid around G tube inside C moves in magnetic field-like fluid circulation (5) taking an opposite direction to lumen flow of G. tube. The inflow (arterial) pressure (1) and orifice (2) induce the negative side pressure energy creating the dynamic G-C circulation phenomenon that is rapid, autonomous and efficient in moving fluid out from the G tube lumen at (4), irrigating C at (5), then sucking it back again at (3), maintaining net negative energy pressure (7) inside C. The distal outflow (venous) pressure (6) enhances outflow at (4) and its elevation may turn the negative energy pressure (7) inside C into positive, increasing volume and pressure inside C chamber.

Biography

Ghanem was educated in Egypt and qualified in 1968, Mansoura University, Egypt. He gained postgraduate experience in UK where he was promoted in posts up to the consultant level. He practiced as consultant Urologist in UK, Saudi Arabia and Egypt. During his career he reported over 60 articles. He discovered two new types of vascular shocks, proved that one physiological law is wrong and provided an alternative. He resolved the puzzles of 3 clinical syndromes; TURP syndrome, the LPHS and ARDS. He is now on an editorial board member of many journals while he is happily retired in Egypt.

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Suzan Labib

Cairo University, Egypt

Peri-procedural heart rate changes and their relation with MACE in patients undergoing percutaneous coronary intervention: Cross sectional study

Background: This study evaluated the association of peri-procedural heart rate changes with Major Adverse Cardiovascular Events (MACE) in Percutaneous Coronary Intervention (PCI) patients; whether emergency or elective basis. ST Segment Elevation Myocardial Infarction (STEMI) patients were included.

Methods: We recruited 204 patients all through 2018 undergoing PCI. Heart Rate (HR) was measured before cath -lab, in cath lab and after cath-lab. The primary endpoints were all-cause mortality, cardiac death, non-fatal myocardial infarction, stroke and target vessel revascularization during In-hospital stay.

Results: Patients were classified according to their peri-procedural maximum heart rate into two groups ; high HR group with HR > 70 bpm, low HR group with HR ≤ 70 bpm, and according to maximum heart rate difference into two additional groups ; low difference group with peri-procedural heart rate difference ≤ 5 bpm and high difference group > 5 bpm. The maximum heart rate groups and maximum difference in heart rate groups both were statistically nonsignificant when correlated with MACE. The maximum heart rate reached all through procedure correlated significantly with MACE, with P-value 0.029, with mean of [92 bpm] in MACE group. Pre-procedural and post-procedural heart rates were statistically significant when correlated with In-hospital MACE with P-value 0.047 and 0.004 respectively, where the mean of pre-procedural heart rate in MACE group was [83.167 bpm] in MACE group while post-procedural heart rate mean was [94 bpm] MACE group.

Conclusion: Pre and post procedural heart rate correlated significantly with In-hospital MACE. Maximum heart rate reached all through procedure correlated significantly with In-hospital MACE.

Biography

Suzan Labib completed her education from 1992-2003 at Primary and high school (Port said Language School). From 2003-2010, she studied Medicine at Cairo University and graduated with an excellent grade and Honor degree. In 2011, she did her Internship at Cairo university –faculty of Medicine and Training for 1 month at Edinburgh Royal College of Medicine (Plastic Surgery department). From 2011-2012, she was a General practitioner at the Ministry of Health, and also a Resident of Plastic Surgery at Dar El Fouad hospital (JCI accredited) in collaboration with Cleveland clinic. In 2013-2014 she resigned from Plastic Surgery residency and from the Ministry of Health. She started an Anaesthesia residency at Cairo University hospitals for 9 months.at end of this year resigned from Anaesthesia residency. From 2014 -2019 she started Cardiology residency at Dar El Fouad hospital residency program (2.8 yrs). Resigned from residency program and started part-time clinical cardiac Electrophysiology observer-ship (including participation in EP clinics and Cath lab with Professor Dr. Mervat Abo El Maaty head of EP department Dar El Fouad and head of EP department Ain Shams university. And from 2014 -2019 she also applied for Cardiology visiting residency in Cairo university along with a Master's degree in the training program. Training in Cairo university hospital included. 9 months of Cardiology training: Emergency room, CCU management, Non-invasive lab, cath lab, wards. 4 months Cardiology training in National Heart institute: Including ER and CCU management and introduction to the cath lab. 3 months ICU training, 3 months Rheumatology training, 1-month Nephrology training.1-year research (thesis) and finally she is a Specialist of Cardiology –Cairo University since 06/2019.

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Jacob Goldstein

Lady Davis Carmel Medical Center, Israel

The new blood thinners in atrial fibrillation, did they keep their promise a decade later? And what about my risky older patient?

The emergence of new or novel therapeutic oral anticoagulants NOAC or direct as DOAC in the last decade is considered a major contribution especially in management of the vast population suffering from atrial fibrillation AF. This is a revolutionary step in order to improve stroke prevention measures in a large proportion of AF patients at high risk which were not or were undertreated in VKA era in the last 50 years. AF prevalence around 1-2% of population is steadily increasing over time and the percentage goes higher as age over 65 increases. Increased age is more prone to disabling strokes in AF and also to increased bleeding risk following anticoagulation treatment. I try in my talk to review mechanism of these drugs and WHY NOAC = DOAC = TSOAC as - target specific OA are potentially a better choice than classic VKA, What is the OAC general importance in S/SE stroke syst emboli prevention, What the randomized multicenter clinical studies RCT's promised us, and how to decide WHICH DOAC FOR WHOM: according to age, renal function, bleeding risk, If the studies in THE REAL WORLD kept the promise of the RCT's, To discuss BLEEDINGS and REDUCE PARADOX concerning inadequate dosage, Discuss importance of Antidots, and SPECIAL CONDITIONS as interruption due to invasive procedures, therapy in patients after stenting coronaries or MI w AF and other items.

Biography

As a cardiologist head of a Coronary Care unit in my hospital and course co director in a nursing school, participating in a lot of international randomized clinical studies, taking part as faculty in meetings until retiring, I continue nowadays to teach medical students, still treating outpatients and a lot of patients also suffering from AF. I also am a co-editor of our national Israeli Heart Society website reviewing for our members the published studies in the international cardiology field. In my long career I had a few older patients with AF, treated by VKA as primary prevention only, and which passed away because of intracranial bleeds. Therefore, DOAC became a fascinating subject for me.

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