ERECTILE DYSFUNCTION AND HEART DISEASE 2: AT-RISK PATIENTS

AUTHOR Bev Cox, MSc, RGN, is nurse practitioner, Walsgrave Health Centre, Coventry, and clinical lecturer, Education for Health, Warwick.

ABSTRACT Cox, B. (2008) Erectile dysfunction and heart disease 2: at-risk patients. Nursing Times; 104: 47, 60–61. This is the second in a two-part unit on the link between erectile dysfunction and cardiovascular disease. Part 1 outlined the association between the conditions, and relevant research findings. It also suggested how nurses might broach the topic of ED with patients. This part outlines the importance of identifying all patients at risk of CVD, then specifically tackles identifying those at risk by establishing a diagnosis of ED.

CARDIOVASCULAR DISEASE
Statistics from the British Heart Foundation (2008) illustrate the importance of identifying people with cardiovascular risk factors. While deaths from cardiovascular disease (CVD) are decreasing the number of people living with the disease continues to increase, largely as a result of lifestyle behaviours. In order to identify those at risk, nurses need to consider the groups known to have high levels of CVD. These include:
- Men;
- Older people;
- People living in deprived areas;
- Smokers;
- Those who are overweight or depressed;
- Those who have a family history or previous history of CVD;
- Those who have diabetes.

Nurses will inevitably work with people who have some of these risk factors and therefore have the opportunity to raise the issue and offer health promotion advice.

Simple interventions, such as checking waist measurements, can identify those at risk of metabolic syndrome or type 2 diabetes. A waist circumference over 94cm in European men and over 80cm in European women is associated with an increased risk. Waist measurement can be a simple way of highlighting this risk to patients, particularly if special tape measures, such as the ‘traffic light’ tape available from Diabetes UK, are used to show they are outside the healthy range.

Patients seen in primary care for routine blood pressure checks, in weight management clinics or for smoking cessation all have at least one identified risk factor for CVD and should have a formal risk assessment of overall CVD risk carried out.

In acute care, people attending for pre-operative assessment can have brief interventions aimed at reducing CVD risk such as advice on smoking cessation. Inpatients are often open to health promotion and health education as they have experienced recent poor health.

<table>
<thead>
<tr>
<th>TABLE 1. MODIFYING RISK</th>
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<td><strong>RISK FACTOR</strong></td>
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<tr>
<td>Smoking</td>
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<td>Dyslipidaemia</td>
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<td>Hypertension</td>
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<td>Central obesity</td>
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<td>Hyperglycaemia</td>
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<td>Alcohol</td>
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<td>Activity levels</td>
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The Healthcare Commission (2007) stated that primary care services are not doing enough to identify people at risk of CVD. Its State of Healthcare 2007 report suggested that PCTs should be doing more to identify and follow up those at highest risk. It pointed out that many GP practices do not have registers of people at risk of coronary heart disease (CHD) – a form of CVD resulting in significant morbidity and mortality in the UK (Allender et al, 2008). Identifying risk is the first step to reducing it, using medication and supporting people through behavioural changes such as weight reduction and smoking cessation.

Grover et al (2007) showed that adults at risk of developing CHD who had the chance to discuss their risk profile with their doctor achieved greater improvement in cholesterol levels than those who did not have these discussions. The authors concluded that discussing coronary risk with patients is associated with ‘a small but measurable improvement’ in the efficacy of lipid therapy.

IDENTIFYING AT-RISK PATIENTS

There are several ways in which ED can be linked to CVD: it can be a direct result of endothelial dysfunction and underlying atherosclerotic disease; it can be linked to other long-term conditions such as diabetes – itself a known risk factor for CVD; it can occur as the result of drug treatments for CVD; and it can be linked to anxiety and depression, both of which are independently associated with long-term conditions such as CVD and have also been highlighted as risk factors for it. The links between all these conditions can lead to a vicious cycle of risk factors, events and exacerbations relating to both ED and CVD.

It may be relatively easy to ask men with diabetes if they have ED as part of a routine diabetes management review. In any case, people with diabetes are at high risk of CVD so should be receiving the full range of pharmacological and non-pharmacological interventions to reduce risk. In the same way, men who take beta-blockers and diuretics, among other drugs, should be advised about the possibility of drug-induced ED and asked to report any symptoms.

The real challenge, though, comes from actively discussing ED with patients who do not fall into one of these groups. The government is keen to improve access to cardiovascular risk assessment, especially for people aged 40–74, with the planned launch of the vascular screening programme (Vascular Programme, 2008). Therefore, the profile of ED as a cardiovascular risk factor should be highlighted among the public and health care professionals alike.

CVD is also linked to deprivation; people in deprived areas are less likely to have healthy diets, take regular exercise, avoid smoking and drink within safe limits, all of which will raise their risk of CVD. They are also less likely to access preventative healthcare and to engage in health promotion activities. The National Service Framework for CHD (DH, 2000) included the issue of deprivation and how to target those most at risk.

Another challenge for public health is improving access to risk assessment in the community, rather than expecting people to come to health service providers for assessment and intervention. In Birmingham, a pilot study has been set up at community pharmacies to increase the number of people having cardiovascular risk assessments who would not normally access healthcare. The study has already shown that a significant number of people using this service are not even registered with a GP, so those in most need may be those with least access to care.

KEY REFERENCES


The full reference list for this unit is available in Portfolio Pages at nursingtimes.net

REDUCING RISK

Reducing cardiovascular risk involves identifying potential triggers for CVD and treating them with medication and lifestyle changes. Treating these factors can also affect ED itself (Rosen et al, 2005). Known modifiable risk factors and appropriate interventions are outlined in Table 1.

CONCLUSION

Many studies have confirmed that ED is linked to CVD and often precedes cardiovascular events by several years. This means there is a window of opportunity – if practitioners diagnose ED – to identify and treat cardiovascular risk to reduce the risk of MI or stroke.

Using strong communication skills, careful history-taking and identification of men with ED is vital as they rarely choose to discuss the condition with health care professionals. Studies confirm, however, that patients find it appropriate for clinicians to broach the subject and are grateful when they do. It is vital that nurses seek out information about possible ED in male patients in order to treat both the condition itself and the associated cardiovascular risk effectively.

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