Symptoms and Dissatisfaction. Context in the Quality of Life of Patients with Valve Difference

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"Goals cannot be measured by the size of our bank account. They can only be measured in the quality of lives that our people lead." Lyndon Baines Johnson (1908-1973), 37th President of the USA, the first to employ the expression quality of life, in 1964.

"Man has but three events in his life: to be born, to live, and to die. He is not conscious of his birth, he suffers at his death and he forgets to live." Jean de La Bruyère (1645-1696), French moralist.

Initial remarks

Patients are categorical: valvopathy makes a difference in their quality of life.

Cardiologists are authoritative: the quality of life of patients with valvopathy makes a difference in the treatment employed.

Bioethics induces the preservation and restoration of the quality of life of patients with valvopathy with the beneficence of Cardiology, the non-maleficence of the cardiologist's expertise and the right of physicians and patients to autonomy.

Preamble

As regards the clinical approach to valvopathy, quality of life, an expression that has only recently been incorporated to Cardiology, is worthy of critical scrutiny.

Quality of life is employed as a synthesis[1-5]. However, the expression usually fails to take into consideration certain values and perceptions of patients. It remains in the margin of Cardiology's strict point of view, and may be subject to interpretation biases. Patients who fail the pre-employment health assessment due to a heart murmur, and who have to "run" every day to try to find a job, would not agree if their quality of life were described as "good" in their medical records just because he or she is asymptomatic.

Brazil is a multiethnic society and the "valve difference" impacts people in a different manner with respect to personal, family, professional and economic aspects. Each patient enjoys a unique biopsychosocial situation.

Key words

Quality of life; heart valve diseases / psychology.

It is in view of the patient's complaints, under the influence of his/her valve difference, and of his context of life[6], that cardiologists decide which technical recommendations[7] he should make and when, how and where he should apply them.

Cardiologists, human beings who have a mission towards suffering human beings, relate to the complaints presented as clearly by patients as expected, and these complaints will guide them. But this is not always so, this being the reason why the anamnesis comprises several stages. There is the risky obscurity of things which are barely unveiled, thus posing challenges to prudence and zeal in the treatment.

Contumaciousshypochondriac and hyposensitive patients and those with few or multiple complaints disturb allopathic logic and stir up anti-negligence and anti-imprudence responsibility.

When there is uncertainty, it can be difficult to decode the multiple aspects of quality of life and distinguish which elements require the ethical commitment to the"... maximum care and the best of our professional ability..." article 2 of the Medical Code of Ethics".

In the context of patients' dissatisfaction with their valve difference, we focus on symptom/functional class and tend to overlook other reasons for dissatisfaction which negatively impact patients' lives.

In the clinical practice of valvopathies, quality of life does not replace functional class[8] or dissatisfaction with differences[9], and the expression is therefore not appropriate to harmonize the specifics of each patient with the diffuse availability of Cardiology.

Considering that

...The concept of quality of life is subject to several interpretations[1,5];

..."Good" quality of life is not equivalent to functional capacity class I/II ;

...Functional capacity class III/IV is one of the aspects indicative of "poor" quality of life associated with valve difference;

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...There is a clear distinction between the functional inability to climb up a flight of stairs which has clinical value as regards making a treatment decision and understanding the patient's discontentment with obligations such as adhering to test routines and to periodical prophylaxis with benzathine penicillin, which sound strict to the patients' ears;

...Patients make spontaneous adaptations and think that they have preserved their "good" quality of life. For instance, the self-imposed limitation of climbing each flight of stairs slowly which is only reported to the physician after the worsening of his condition, months later, at the emergency room;

...The strength required to lift the gate of the bridge between "poor" quality of life and "good" quality of life stems from the merit of the risk-benefit ratio of what is within the scope of Cardiology,and that this bridge is paved by the technical and scientific resources of Cardiology; ;

...It is the excessive risk of interventions that usually causes the rejection of beneficial initiatives relative to certain dissatisfactions with the morbidity of valve-related differences. For instance, for those women in functional class I who do not want to run the risk of gestational events in view of mitral stenosis;

...Incapacitating symptoms/functional class III/IV are the fundamentals, according to universal consensus, for the decision to lift the gate and move across the bridge towards "good" quality of life[10];

The proposition

We propose to avoid using the expression Quality of Life as the major criterion for the adoption of therapy in valvopathies.

We propose that the concept of Quality of Life be defined twofold a) Patient's Dissatisfaction with his Valve-related Difference, for broad considerations about his biopsychosocial infinite universe; b) Symptoms/Functional Class due to Valve difference, for specific considerations on items which are of interest to Cardiology.

Reinforcement 1

The classical surveillance of symptoms/functional class in patients with a valve difference prevails over the Manichaeism underlying good or poor quality of life to specify the establishment of the beneficence/non-maleficence of the methods made available by Cardiology.

In the clinical management of valvopathy, the propedeutical – and frequent - use of the expression quality of life by cardiologists with therapeutic purposes should there fore be reviewed.

A strong reason for this is that decision-making factors require the filtering out of aspects relating to the complex qualification of life, according to professional pragmatism.

The patients' elements of dissatisfaction with his valve difference should be seen as arising from his valve difference and from the symptom/functional class. This contributes to strengthen the concept of complementarity embodied in the two faces of the same coin: tails, the majesty of Cardiology, science and discipline that has to be employed, and heads, the face of the patients with valvopathy, human beings who are the possessor of rights and the object of duties committed to knowledge, training and attitude.

Key words

In the clinical practice of valvopathy, a symptom is the variable that has the power to provoke a domino effect of simplistic Manichaeism. Symptoms succeed each other, functional capacity class I/II, functional capacity class III/IV; tests succeed each other; drug therapies succeed each other, events too; good and poor prognoses are made. No to valve intervention. Yes to valve intervention.

Symptoms are the raw material of guidelines. The ACC/AHA 2006 Guidelines for the Management of Patients with Valvular Heart Disease[10] have an argument against the use of the expression Quality of Life in the good bedside practices in valvopathy management. The expression quality of life appears only twice in its almost 150 pages: on page e-40 "Because the goal of therapy is to improve the quality of life rather than longevity, symptoms are the most important guide for determining whether or not AVR should be performed" in aged patients with aortic stenosis; page e-80 "Surgery is indicated in patients with life-threatening congestive heart failure or cardiogenic shock due to surgically treatable valvular heart disease with or without proven infective endocarditis if the patient has reasonable prospects of recovery with satisfactory quality of life after the operation." Additionally, none of the articles that compose the fantastic set of more than 1,000 references has the expression "quality of life" in its title.

The words symptom/asymptomatic, however, appear around 600 times, and the expression functional class appears approximately 60 times, of which a reasonable percentage is in association with symptom/asymptomatic.

The key words for decision making in the management of patients with valvopathies are therefore symptom and functional class, preferably in connection with each other.

A flash on quality of life

Bioethics addresses quality of life, birth and death[11].

The expression quality of life is an essentially human social representation of life that goes beyond physical well being. Each time period, culture, social stratum has its own scale of values. When adapting to the real conditions of the development of societies, idealized standards tend to emphasize concepts relating to comfort and well being as seen by the upper classes.

We should bear in mind that Quality of Life includes not only concrete quantitative and qualitative factors, but subjective factors alike, such as feelings and virtues[5].

Unbalances between these factors are common and disease influences the conduction of idealized plenitudes. Changes towards the valuing of goods, or towards philosophical considerations may be catalyzed by the clinical condition of patients.

If we apply the WHOQOL-100 issued by the World Health Organization[12], designed to assess the quality of life to patients with valvopathy and ask them to consider the last two weeks, we will obtain many answers such as very or extremely worried, dissatisfied or very dissatisfied, little or very little able to those questions relating to enjoying life, feeling optimistic towards the future, being bothered by difficulties in doing everyday activities, depending on medication or medical assistance, having access to good quality medical care, ability to carry out daily activities.

Research carried out in the outpatient facility of Incor's Valvopathy Clinic found that 59% of the interviewees considered that valvopathy had turned their life into a war against the disease.

Reinforcement 2

The real life of cardiologists does not allow them to focus on those aspects devoid of technical and utilitarian connotation.

Because of their limited availability of time and their perception of their mission, they resort to a hardened professional conformism and overlook the aspirations of patients with valvopathy.

"Therapeutic successes" (Cardiology's point of view) are usually found side by side with "unsuccesses in life" (point of view of patients with valvopathy). Oral anticoagulation because of metal prosthesis implantation provides many of such cases.

Projections of their own values lead professionals to ponder and decide that after all, "this is the best way". This is the case of some assessments on the risk-benefit of interventions on functional capacity class II valvopathy.

An automatic "there is no other way to prevent clinical manifestations or to improve the prognosis" justifies "minor distress" suffered by patients with valvopathy, although such distress may be rated as "not minor" in the patients' self-assessment of quality of life. This is the case of the young successful sportsman, who is advised by his cardiologist not to practice competitive sport until he meets the criteria established by Cardiology at some uncertain time in the future.

In clinical practice, the healthcare team should strive to find a balance between being technically solidary and indifferent to the patients' dissatisfaction which do not comprise management initiatives.

Understanding the biopsychosocial scenario of valve differences requires a multidisciplinary approach and expertise from different fields to broaden the understanding of the patient's real life and contribute to fill in the gaps which are inherent to the relationship between physicians and patients.

Looking at the "heart surrounded by feelings" expands the patients dialog with Cardiology and contributes to a better assessment of the risk-benefit of communication. With a greater perception about points that need clarification, messages become more therapeutic and less etiopathogenic. This is the case of CDE (chart 1), a patient who, though "asymptomatic for heart disease" feels a paralyzing anguish due to the imminence of syncope after researching on the Internet. It is the case of EFG, a patient who, although also asymptomatic, hates to be sentenced to perpetual oral anticoagulation therapy. Many of these complaints are not directly verbalized to the cardiologist who only learns about them through psychologists and social assistants, which then provides an opportunity for adjustment in the patient-physician communication.

Therefore, the large potential interference of disease on life marks the natural history of valve differences, but its little penetration in the realm of Cardiology prevents the use of quality of life as a marker of strategic moments.

The marker for fruition of the beneficence/non-maleficence of therapeutic methods is the binomial symptoms/functional class.

The heart in one's mouth
Anamnesis and bioethics

In the clinical practice of valve disease, cardiologists should make the clinical condition fit into the four functional capacity classes. This allows the identification of treatment based on the diffuse biostatistics provided by Cardiology.

However, the functional class is often times established under a light that sometimes dazzles and favors illusions amidst the shadows. The blurred limits established by the four categories of the New York Heart Association (9 reviews from 1928 to 1994, with the NYHA incorporated to the AHA)[8] determined a Manichaeist reduction: two categories, functional capacity class I/II and functional capacity class III/IV, have become the rule.

For those who prefer to use the expression poor quality of life as a criterion in the clinical practice of valve disease, functional capacity class III/IV would suffice, thus dismissing other dissatisfactions, but the continuum of functional capacity class I/II is not synonymous with good quality of life.

Even under the point of view of cardiology alone, functional capacity class II is pseudo-homogeneous, in view of the decline of the ability to adapt to valve difference[13]. Different clinical views are required between the first stage, that we could call post-class I and the final stage, pre-class III. In the latter, the first stages of the worrying symptoms bring together the patients' dissatisfactions with their quality of life due to their valve disease and the beneficence of Cardiology.

There is lack of organized criteria in the pre-III stage of functional class II that would allow the stethoscope to sound the alarm and make the scalpel work. The efficiency of the alarm depends on a long term alliance between physician and patient, based on sound communication between them that would allow a long-term view on the impact of valve disease on patient's life.

Readiness is not linked to the core of professional practice, which includes the murmur auscultated that allows the diagnosis of valve disease, and includes other data of physical examination which allow the identification of consequences and comorbidities, or the additional tests that document the condition and complement the information.

In most cases, none of them allow us to assert to what extent the condition impacts the lives of patients with valvopathy. This

is why physicians should avoid the technical and utilitarian compulsion of extending the signs identified upon examining patients for symptoms, as if objectivity and subjectivity were totally intertwined.

In the clinical practice of valvopathy, functional classes from I to IV should be combined with the objective assessment from A to D, as recommended by the committee of the last review of the New York Heart Association[8]. A patient with severe aortic insufficiency, without dyspnea, fatigue, palpitation or anginal pain during ordinary activities fits into functional capacity class I, and objective assessment D. And with no alteration of variables such as auscultation of murmur and heart sounds, left ventricular diameter and function between the "day before" and the "day after", the management approach should be eventually changed. What would be the factor that would trigger such a change? The manifestation of symptoms that compromise life!

It is the symptom that literally speaks louder, it is the complaint of a patient with valvopathy[14,15]. This is the raw material that patients provide us with; after we work on it, it fits into the functional class framework, which is a real "receptor" of treatment.

Thus,more than a unilateral assessment determined by the stethoscope or by the transducer, it is the bilateral verbal communication between patient and physician that, in clinical practice, allows pondering on the temporal risk-benefit relationship of propedeutical and therapeutical interventions.

The value of the sharp mental image that emerges from the words of patients is in agreement with bioethics[16]: the anamnesis is a robust link in the chain of beneficence/non-maleficence applicable to patients with valve difference.

The anamnesis is the ritual of memory. The word actually comes from "memory", which takes us to the patient's record, our professional alter ego.

This century-old ritual is part of our mission, is what is expected from us, the intermediation between the gods of the 21st century, embodied in scientific evidence, and the patients who believe in honesty, confidentiality, and efficiency, the blessings that can restore their quality of life.

The corollary of interest to bioethics is that the merit of the anamnesis as regards the management of valve disease is that it values the active participation of patients in the decision making process. This is the version of bioethics of the expression "to have one's heart in one's mouth".

Functional test Anti-neglicence? Anti-imprudence?

In the clinical practice of valvopathy, the information obtained during the anamnesis is sometimes regarded as indisputably objective information about the report of a syncope and sometimes as subjective information on distress during exertion.

The complaint may impact cardiologists in different manners and generate contradictions in view of physical signs or images – very frequent in cases of mitral valve disease[17]. Non-routine tests can be performed such as the cardiopulmonary test and pharmacologic stress echocardiogram[18,19]. The objective information they provide is invaluable to ensure that decisions regarding valves are neither negligent nor imprudent when there is contradictory information.

The indication of these complementary tests to endorse therapy decisions should be restricted to selected cases, and should not overlap the purpose of authorizing the practice of physical activity.

In the clinical practice of valvopathy, we believe that an ethical alarm sounds whenever a functional test speaks for the patient. Careful consideration is the rule due to the tendency to let reason prevail according to medical objectivity.

Within the bipolarity of Cardiology, where Cardiology is available to patients and patients are available to Cardiology, increasing the number of functional tests performed would turn maximum oxygen consumption, ventilatory anaerobic threshold and transvalvular gradient level at a certain heart rate into inspectors of the patient's perception about himself. We would run the risk of replacing the human warmth of anamnesis for the scientific coldness of the laboratories. This would be so in the case of functional tests performed with patients with 1 cm^2 of mitral area, who "reports" to be oligosymptomatic, and has a sinus rhythm, with no sign of disproportionate pulmonary arterial hypertension, no history of thromboembolism, and that, because of our anti-negligence zeal could be "contradicted" by a behavior that is reactive to a hemodynamic condition that is not part of his everyday life. There is no evidence to prove that acting this way would be beneficial to his life prognosis.

"Reasonable" explanations for contesting the fact that the patients do not verbalize their symptoms would mean entering the marshy realm of misperception, sedentary lifestyle, and hiding of information on the part of the patient due to fear of the consequences of exposing such information.

Departing from a theoretical premise, hypothetically assumed for 1 cm^2 of mitral area, i.e. from physiopathology to symptom, instead of going the other way around, brings out the possibility of feelings of disrespect, and does not necessarily contribute to obtain the patient's consent to disputable changes in treatment.

It is pertinent to paraphrase the opening sentence of Anna Karenina by Leon Tolstoy (1828-1910): patients with valvopathies are all alike; but each one is symptomatic in his own way.

The consideration is valid. How paternalistic should cardiologists be when patients do not show any intention of changing their quality of life? Let's set aside the efforts towards establishing a dialogue in pursuit of the "truth, and nothing but the truth". Should we tie patients to Cardiology's biostatistical realities and consider ourselves to be careful because of this? Or should we tolerate his attitude and understand that the copy-paste of anamnesis was simply unable to change his script?

Opinions vary depending on the values of the two sides of the coin we mentioned above, and inform the critical analysis of certain recommendations of treatment for asymptomatic patients with valve disease.

One of these recommendations is from the Working Group on Valvular Heart Disease[20], a British-French-Spanish workgroup that

assumes that sedentary lifestyle or certain limitations of activity can compromise the classification of patients as asymptomatic. The article recommends that before considering whether the patients is truly (our bold print) asymptomatic, it is frequently (our bold print) useful to perform a functional assessment. In other words, in the dictionary of the study's authors, asymptomatic translates into absence of symptoms after the induction of tachycardia (80% of the predicted heart rate).

In Brazil, where there is so much rheumatic fever, we believe that the provoked spirometric flow that comes out of the patient's mouth should not silence his spontaneous words.

Reinforcement 3

Increasing the value of exercise in laboratory conditions to maximize objectivity and correlate the measurements so obtained with measurements of morphological severity of patients with mitral stenosis would imply changing the pillar of the current therapeutic binomial -- clinical observation of progression of valve disease versus intervention. It would tend to shift from symptom/anamnesis to degree of valve lesion/functional test.

We would also run the risk of imprudently pushing forward a disastrous trip in the wrong way across the bridge mentioned above, that is, from the "good quality of life" side to the "poor quality of life" side. In other words, we would cause the risk to unnecessarily turn into an event due to a diffuse view of what would be beneficial to the patient.

Let us remember the sets of cases – not so frequently found in statistics, but that are nonetheless tragic for the lives of those who suffered from mitral insufficiency manifested after mitral valvoplasty with a balloon catheter. The intervention may have been pushed forward not only due to its "low risk" but maybe due to excessive enthusiasm in a learning curve, and in the subsequent and immediate implantation of a valve prosthesis.

The analysis of the recommendation for mitral valve stenosis of the ACC/AHA 2006 Guidelines for the Management of Patients with Valvular Heart Disease brings to mind a concern: if the anamnesis of a patient with mitral valve area >1.5 cm^2 should raise doubts about a greater probability of functional capacity class II, and if exercise in the hemodynamics laboratory should identify more intense repercussions (pulmonary arterial systolic pressure >60 mmHg, pulmonary capillary pressure > 25 mmHg and transvalvular mitral gradient >15 mmHg), the decision of performing an intervention will fall on the morphology favorable to mitral valvopathy with a balloon catheter. If it is considered, it's under level of recommendation IIb, evidence C, that is to say, beneficence is not clear in view of the risks. To strengthen our position, we would say that there is risk of imprudence because the risk-benefit relationship at the moment is unfavorable.

The future of past quality of life

The subdivision of quality of life into symptoms/functional class and dissatisfaction with valve difference is useful to foster initiatives focusing on careful consideration and prudence with respect to the future. Many such initiatives are expressed in guidelines.

Some choices such as surgically repairing a valve that would have no indication for surgical repair if it were an insolated disease just because the patient is being operated, or choosing the type of prosthesis according to the psychosocial profile of the patient, or promoting valvoplasty are decisions that cause the symptom/functional class marker to have two faces.

The first face looks backwards, to the past, and determines the transformation of the natural history of valvopathy into its postoperative history, an effect of the symptom that the set of dissatisfactions of the patient with the valve difference had not brought about. The second face looks forward, to the future, by the effect of preventing or reducing dissatisfactions, an objective that goes beyond the reversal of symptoms.

Cardiologists therefore behave as the plural agents of Cardiology, the guardians of a wide open range of options of the specialty, acting beyond bureaucratic actions.

Certain aspects of future quality of life which do not benefit from technically correct institutional routines could have been implemented if personalized decisions had been considered.

This is the reason why it is desirable that the points of reference for treatment/prognosis should not be restricted to restoring "good" quality of life in terms of equivalence to functional capacity class I/II. They should take into account individual influences on dissatisfactions with valve difference.

Final reinforcement

The combination of the Aristotelian ethical method[21] with the subdivision of quality of life gives rise to a pedagogical effect which is useful for bedside behavior in valve disease clinical practice.

The first stage is the definition of the conflict triggered by the valve difference in terms of symptom yes/functional class I/II or III/IV. The second stage includes schematizing the components of diagnosis, including dissatisfactions in general. The third stage implies understanding the reasons for objective and subjective manifestations from a biopsychosocial point of view, and selecting the treatment available, adjusting it to obtain the best benefit between the two considered as the focus of quality of life.

Chart 1 illustrates a breakdown of the qualification of the biopsychosocial impact on the life of patients with valvopathy under different angles of assessment.

Chart 1 - Physician-patient points of view on quality of life in the clinical practice of valvopathy.

Patient: ABC, 32, has had a mitral prosthesis for 8 years, absence of important signs on physical examination and moderate thickening of prosthesis on echocardiogram.

SYMPTOM/FUNCTIONAL CLASS due to Valve Difference: Asymptomatic-FC I/II.

DISSATISFACTION OF PATIENT due to Valve Difference: Dissatisfied with the approaching of the estimated date of valve replacement. The patient feels irritable and finds it difficult to concentrate at work. The idea brings to his mind the 15 days spent in the ICU postoperatively, of which the patient remained intubated and semiconscious for 10.

HIS CARDIOLOGIST: "Good" quality of life.

ACC/AHA 2006 GUIDELINES: Replacement to be

determined by symptoms or events.

COMMENT: The patient was kept under observation, and was told to pay attention to any symptoms. Clinical, laboratory (intravascular hemolysis) and imaging reassessment was deemed useful for documentation purposes, but had a low potential for determining the ideal time of replacement. The physician preferred to discuss the pros and cons of prosthesis with the patient, in view of his dissatisfaction with the reoperation.

Patient: BCD, 26, with mitral valve stenosis, mitral valve area=1.3cm^2, left atrium=58mm, moderate pulmonary arterial hypertension and chronic atrial fibrillation. He has made use of Warfarin for two years, with good adherence and efficacy (INR usually between 2.0 and 2.5) and benzathine penicillin (irregularly).

SYMPTOM/FUNCTIONAL CLASS due to Valve Difference: Dyspnea when he overengages in certain non-routine activities, occasional palpitation--FCI/II.

DISSATISFACTION OF PATIENT due to Valve Difference: Dissatisfied with the oral anticoagulation ritual, with its medicines and laboratory routine. He had also been advised against the operation of an inguinal hernia that has bothered him for a long time. He is also dissatisfied with the benzathine penicillin injection, which brings discomfort, and goes without it for 2 or 3 months, ignoring the two episodes of rheumatic fever suffered at 12 and 15 years of age.

HIS CARDIOLOGIST: "Good" quality of life.

ACC/AHA 2006 GUIDELINES: Consider mitral valvoplasty with a balloon catheter if the mitral morphology is favorable (class level I). If not, consider surgical intervention if pulmonary sistolic arterial pressure is >60 mmHg (class level IIa).

COMMENT: The facility where the patient was served does not include valve intervention in oligosymptomatic patients with mitral stenosis, even when the echocardiographic score is favorable to the intervention, although in special circumstances individual cases may be discussed. The patient was maintained under clinical treatment, firstly because an intervention would not determine any change in the need for oral anticoagulation therapy, and secondly because the ratio between the risk of mitral intervention and the benefit of herniorraphy was deemed inadequate.

Patient: CDE, 49, with calcified aortic stenosis, major concentric left ventricular hypertrophy, mean aortic transvalvular gradient=55 mmHg, maximum aortic transvalvular speed =4m/s and preserved left ventricular function.

SYMPTOM/FUNCTIONAL CLASS due to Valve Difference: Asymptomatic--FCI/II.

DISSATISFACTION OF PATIENT due to Valve Difference: Dissatisfied with the prospect of suffering a syncope at any time since he looked for a second opinion on the Internet.

HIS CARDIOLOGIST: "Good" quality of life.

ACC/AHA 2006 GUIDELINES: In the absence of symptoms and with lower left ventricular function, the presence of valve calcification as a marker of surgical intervention would be class IIb.

COMMENT: The cardiologist explained to the patient that he does not ignore the potential syncope when he recommends that the patient have an expectant attitude. He pondered that, despite the emotional impact, the "preventive" implant of an aortic valve prosthesis was not convenient. Risk-benefit analysis carried out by the physician and the patient not always match. Conflicts may arise due to different viewpoints on the implant of prosthesis: the physician's anti-imprudence approach, that directs his focus to transoperative immediate morbidity and late morbidity of the valve replacement and the patient's anti-negligence approach, due to his anguish concerning syncope.

Patient: DEF, 35, with mitral valve prolapse, absence of signs of mitral insufficiency as well as of morphological aspects suggestive of redundancy and myxomatous degeneration.

SYMPTOM/FUNCTIONAL CLASS due to Valve Difference: cyclic manifestation of precordial pain and tachycardic palpitation that incapacitate her for hours. They're felt especially at rest and have become increasingly frequent—FCIII/IV.

Dissatisfaction of Patient due to Valve Difference: Dissatisfied with the panic she feels due to the unexpected manifestation of symptoms. She believes the diagnosis has impaired her family life. The symptoms trigger a presentiment of imminent death.

HER CARDIOLOGIST: "Good" quality of life.

ACC/AHA 2006 GUIDELINES: Consider acting on non-cardiological diagnosis, fostering change in lifestyle and using beta-blocker.

COMMENT: Valuing the relationship between physician and patient is key to minimizing dissatisfaction of mitral valve prolapse. During their conversation, some facts came up: a) the patient had researched the Internet and read "all" about her condition in English, French and German; b) her father had died suddenly, few days after his doctor had congratulated him in her presence for his excellent results in a series of tests performed as a result of precordial distress that included "similar" symptoms to hers; c) she had read a report on a case of sudden death of a patient with mitral valve prolapse, which caused a nocebo effect, since the report reflected to a high degree what had happened to her father, which deeply affected her.

Patient: EFG, 59, with a mitral metallic prosthesis in place for ten years, absence of important physical and echocardiographic signs.

SYMPTOM/FUNCTIONAL CLASS due to Valve Difference: Asymptomatic--FCI/II.

DISSATISFACTION OF PATIENT due to Valve Difference: Dissatisfied with his ad eternum dependence on the anticoagulation ritual that includes medicines and laboratory routines. He feels that the tablet is his "life insurance", and is frightened by the thought of needing yet another "heparin bridge", which he had undergone twice: when he underwent cholecystectomy and rhinoseptoplasty.

HIS CARDIOLOGIST: "Good" quality of life.

ACC/AHA 2006 GUIDELINES: Maintain INR between 2.5-3.5.

COMMENT: The other face of the coin when compared with the case of ABC.

Patient: FGH, 39, with aortic insufficiency associated with Marfan's disease, systemic arterial diastolic pressure=0 mmHg, diameter of aortic root=5.2 cm and preserved left

ventricular function.

SYMPTOM/FUNCTIONAL CLASS DUE TO VALVE DIFFERENCE: Dyspnea on minor exertion, always accompanied by the feeling that his heart would go out through his mouth--FCIII/IV and, sometimes dizziness and precordial pain.

DISSATISFACTION OF PATIENT DUE TO VALVE DIFFERENCE: Dissatisfied with the fast progression of the symptoms, he still refuses to accept the surgical intervention, which he has refused since he was asymptomatic. The intervention had been indicated because of his aortopathy. The symptoms actually reduced his anti-intervention conviction. But it was an image test performed with urgency on the day the precordial pain had worsened, which resulted negative for aortic dissection, that made him feel close to consenting to the intervention, although he felt comfortable with the pharmacological treatment of heart failure.

HIS CARDIOLOGIST: "Poor" quality of life.

ACC/AHA 2006 GUIDELINES: Reconstruction of the aorta and aortic valve replacement indicated for any degree of aortic insufficiency in the presence of aortic diameter or aortic root diameter >5 cm.

COMMENT: Incapacitating symptom yes, incapacitating symptom no. This is the duality that usually allows unequivocal agreement on surgical treatment as much for the physician as for the patient. ACC/AHA 2006 algorithms use symptoms as the only subjective data. Statistical realities associated with the aortopathy of Marfan's disease represent an item of exception to the interdependence of incapacitating symptoms-class III/IV to the surgical treatment of chronic aortic insufficiency.

PATIENT: GHI, 44, with rheumatic aortic insufficiency; pulse pressure of 120 mmHg, presence of Austin Flint's murmur and preserved left ventricular function.

SYMPTOM/FUNCTIONAL CLASS DUE TO VALVE DIFFERENCE: Every once in a while he gets tired a little more, but this symptom disappears after a 30 minute rest--FCI/II. He refuses to impose limitations to his everyday activities.

DISSATISFACTION OF PATIENT DUE TO VALVE DIFFERENCE: He is apparently satisfied, and lives well with his cardiopathy. He adheres well to the recommendations. He does not verbalize difficulties in his personal and professional life because of his valve difference.

HIS CARDIOLOGIST: "Good" or "poor" quality of life? He requests reassessment of imaging and cardiopulmonary test

ACC/AHA 2006 GUIDELINES: When there is doubt regarding symptoms, consider performing exercise testing. If the result is symptom(+),valve replacement is a recommendation class level I. If, on the other hand, he is symptom (-) and associated with normal left ventricular function, clinical management is advised.

COMMENT: Defining subjectivities in the patient's everyday life by using the objectivity of laboratory tests is controversial as it might cause a routine of tests to "replace the anamnesis".

The cardiologist felt uncertain about the report of the anamnesis and decided to avail himself of the resources of Cardiology as a reference to draw conclusions about the real dimension of symptoms. The imprecision about whether the quality of life was "good" or "poor", created a conflict and, because of his professional responsibility vis a vis the anti-negligence and anti-imprudence approach of a recommendation for surgery, he felt the need to obtain additional information from his area of technical knowledge.

The values obtained by spirometry associated with exercise testing reassured the cardiologist. Once he had concluded that the patient had a "good" quality of life, he adopted an expectant treatment approach.

When the anamnesis causes uncertainties, the crafting of the balance between clinical-surgical approach may either tend to a pragmatic anti-negligent attitude, that determines the anticipation of the indication for surgery or to going beyond the ideal point, by a presumptious hierarchization of anti-imprudence. In this regard, the imprecision of the translation of the patient's subjectivity into the physician's objectivity overlap the blurry boundaries between functional classes.

PATIENT: HIJ, 33, with mitral stenosis, left atrium diameter=46mm and mitral valve area=1.2 cm^2. One year after an uneventful gestation, HIJ presented acute pulmonary edema triggered by paroxistic atrial fibrillation. Efficient electrical cardioversion enabled the patient to return to Functional Class I.

SYMPTOM/FUNCTIONAL CLASS DUE TO VALVE DIFFERENCE: Asymptomatic--FCI/II

DISSATISFACTION OF PATIENT DUE TO VALVE DIFFERENCE: After being taken aback by the episode of acute pulmonary edema, the patient, who lived well with her cardiopathy, became very apprehensive with her valvopathy. She feels very insecure about the efficiency of the anti-arrhythmia medication. She feels guilty for having suspended the application of benzathine penicillin since she became pregnant, and she started to use it again every 21 days. She has looked for three "second opinions".

HER CARDIOLOGIST: "Good" quality of life.

ACC/AHA 2006 GUIDELINES: Mitral valvoplasty with balloon catheter in patients with moderate or severe mitral stenosis, with recent atrial fibrillation, is controversial if the patient is asymptomatic from other points of view.

COMMENT: The physiopathological interpretation of the sudden change in Functional Class determines the approach in patients with valvopathy. Crossing an obstructive threshold of the effective flow through the mitral orifice has a different meaning with respect to the "functional test" indicated by the fast ventricular response to acute atrial fibrillation.

When there is imminent risk to life, the perspective of dissatisfaction with the patient's valve difference overlaps the triad composed by patient, cardiologist and Cardiology. Focus must be given to the relationship between present (clinical manifestation of acute pulmonary edema) and past (mitral stenosis). The relation between present and future (prevention of a new episode) remains in the background.

The impact of the highest possible degree of discomfort due to valvopathy led to sequelae which were "not exactly cardiac". The continuation was uncertainty with a morbid future.

Although the patient reached an extreme level of clinical severity , which required emergency measures, the oscillation of the consequences of the valve difference did not impose initiatives to redefine beneficence/non-maleficence of the therapeutic routine on the part of the cardiologist.

Although the patient felt the trauma of having had an acute pulmonary edema in her everyday life, the label "good" quality of life persisted in subsequent visits, and therefore there was no academic criterion for intervention on the primary cause.

Toconsider a valve intervention would sound imprudent, since according to the line of management in the clinical practice of valvopathy, risk-benefit analysis focus on clinical consequences rather than of the fundamental difference, this being the reason for the usually long maintenance of the natural history.

The episode represented, for HIJ, yet another chapter of her dissatisfaction with the difference which became part of her life since the rheumatic episode in her adolescence. Although transient, the aggravation was sufficient to elevate the baseline level of dissatisfaction with her condition.

Potential Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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