5th IHEF CARD
The 5th Indonesian Symposium on Heart Failure and Cardiometabolic Disease

in conjunction with :
WHFS25
World Heart Failure Society Congress 2025

Perkembangan Diagnosis dan Tatalaksana Gagal Jantung di Indonesia
Memorial Lecture dr Nani Hersunarti

Bambang Budi Siswanto MD, PhD, Prof, FAsCC, FAPSC, FESC, FACC
Board of World Heart Failure Society
Fellow of International Society Heart Research Australasian Section
Fellow of Victor Chang's Heart Institute St Vincents Hospital UNSW Sydney
Fellow of Japanese Council for Medical Training Toranomon Hospital Tokyo Metropolitan

Pendidikan Kardiologi di RSCM 1975

DEPARTEMEN KARDIOLOGI FKUI

Harapan Kita National Cardiac Center 9 November 1985

5th IHEF CARD
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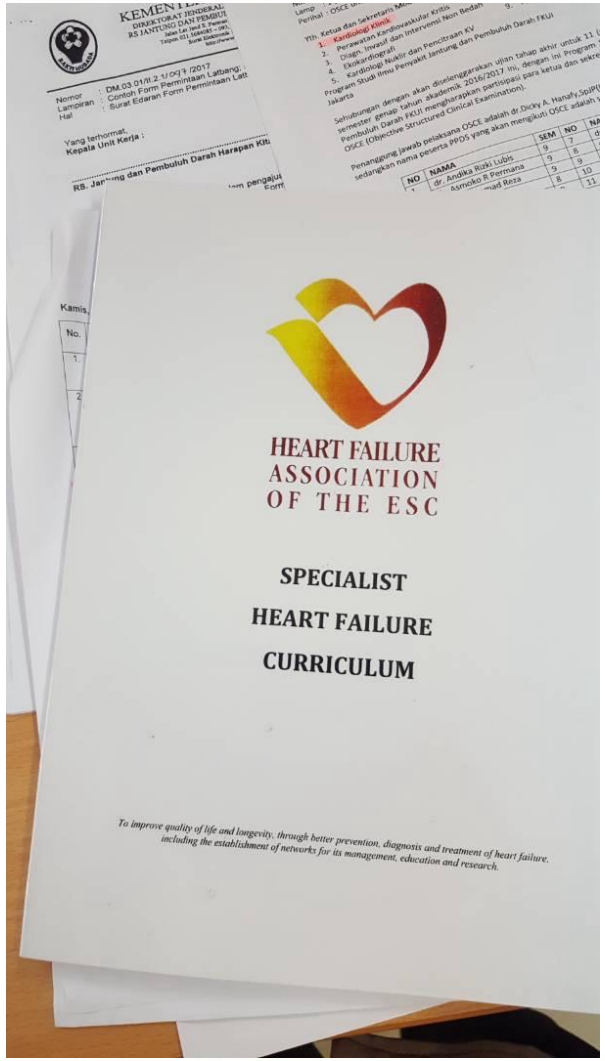
The commencing of CARDIOLOGY in Indonesia

HARAPAN KITA
National Cardiac Center in 9th Nov 1985

- Dept Cardiology
  - Clinical cardiology
  - Non-invasive
  - Diagnostic and Intervention Cardiology
  - Intensive Care Unit
  - Cardiac Rehabilitation
- Cardio-thoracic surgery

Cita-cita almh. Dr. Nani Hersunarti mengembangkan spesialis Advanced Heart Failure



Almh. Prof. Lily Ismudiati Rilantono bersama Alm. Prof Michael O. Rourke yang berjasa mencari beasiswa Victor Chang Heart Institute

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Formal training in Advanced Heart Failure started in January 1996 at St Vincent's Hospital Sydney

Supervisor: Prof Michael O'Rourke, Phillips Spraat, Anne Keogh, Peter Mac Donald, Michael Fennely, Andrew Sindone, Christ Hyward.

The University of New South Wales
at St Vincent's Hospital
Sydney, Australia

This Certifies that

Bambang Budi Siswanto M.D.

has satisfactorily completed
training in the field of

Hypertension, Heart Failure and Cardiac Transplantation

at **St Vincent's Hospital** *from* **January 5th, 1996**

to **December 23th, 1996**

Phillip Spratt M.D.
Director

Victoria Street, Darlinghurst, NSW, Australia 2010
Phone: 61 2 339 1111 Fax: 61 2 332 4267 Results Fax: 61 2 361 2505

Director
Phillip Spratt

Cardiac Surgeons
Phillip Spratt
Julie Mundy
Alan Farnsworth

Cardiologists
Anne Keogh
Peter Macdonald

Thoracic Physician
Allan Glanville

Clinical Nurse Consultant
Annemarie Kaan

Pathologists
Steve Rainer
Vince Munro

Data Coordinators
Cate McCosker
Liz Young

Outpatient & Donor Coordination
Anne Harvison
Sue Campbell
Gabrielle Lord
Annabel Fay

Social Worker
Frances Taylor

Heart Failure Clinic Services at NCVC-HK **Started in 1999**

(after learn from Suita, Sydney, Curritiba, Tokyo)

Australia

CARDIOLOGIST
ASSOCIATE PROFESSOR
UNIVERSITY OF NEW SOUTH WALES

Dr Bambang Budi Siswanto MD
Fax: 62 21 475 9636

30 August 1999

Dear Bambang

Re **HEART FAILURE SERVICE**
Rumah Sakit Harapan Kita

Thankyou so much for your email of 23 July. I am sorry I have not replied before now, but you know how frantically busy it can get at St Vincent's!!

Firstly, I unfortunately did very little good for Dr Sukma Merati who I saw only occasionally, but your thanks are well received!

Regarding a heart failure program at Harapan Kita, I think it is a great idea. To get this into place, I suspect it would be easier to have 2 people (one of course should be yourself) committed to the idea. With 2 physicians you have much more strength and the capacity to always offer continuous clinical cover, even when someone is away or ill or on conference learning new treatments (the same as Prof Peter Macdonald and I).

I am personally interested in helping you set up such a program which would be very important for Indonesia. Once you have formalised such a program and have a good number of patients, you could join in the clinical trials of new agents and therapies which are supported by international drug companies very often.

Having said I would like to help, I am in the situation in the next 18 months of being unable to commit time to this, since I have taken up the position of President of the International Society for Heart and Lung Transplantation, and this will take up much time. I have already had to resign from several Boards and Councils to free up time, and have employed another cardiologist to help with my work for this period.

But I am supportive of your initiative, and would ask that you try to find a colleague with great interest or better still a passion for heart failure, who can help you build such a service. It would be more credible, if this person, as you did, also travels overseas to Australia, America or Europe to train specifically in the field.

It is quite possible that Pfizer may help somewhat with funding, and I would be happy to try to negotiate this on your behalf.

My best regards to you and your wife and child.

Kindest regards

Anne Keogh
MBBS MD FRACP
Cardiologist

Prof Peter Macdonald

Qualifications

MBBS FRACP PHD MD FCSANZ

Specialty

Cardiology

Department

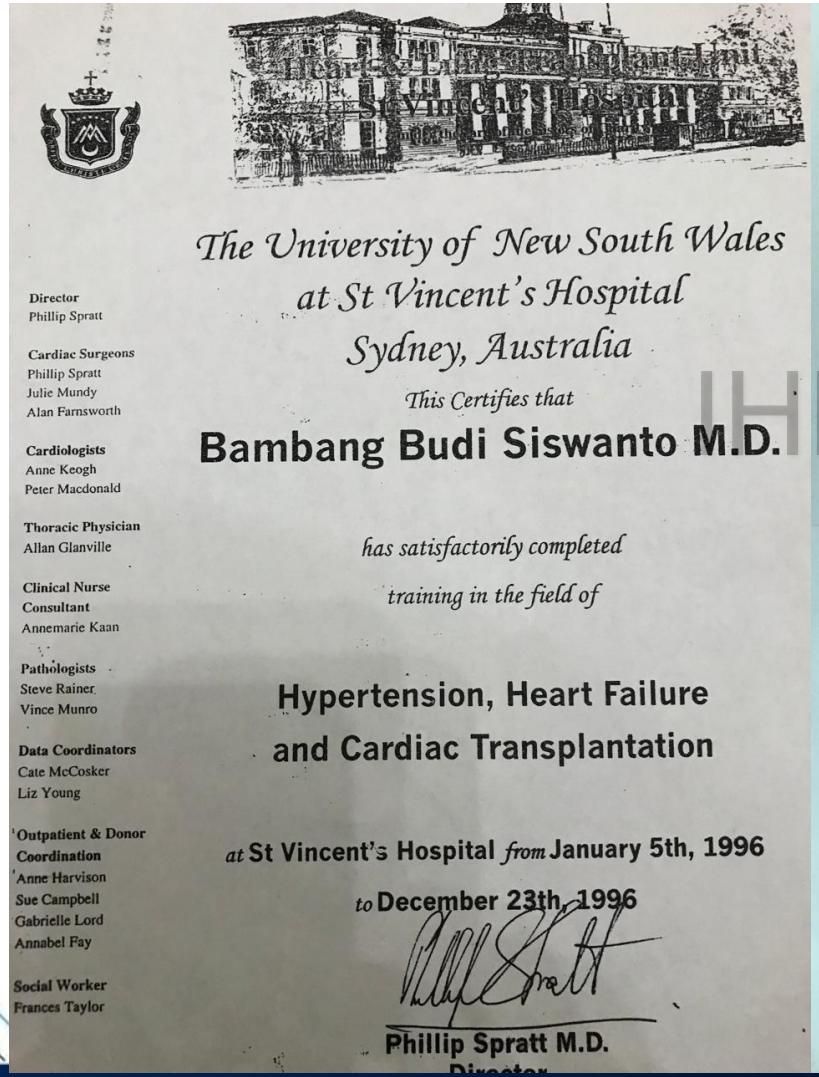
Cardiology

Prof David Muller dari St Vincent's Hospital Sydney membantu jadi proctor pemasang Mitral Clips di Indonesia

Lim E.	Medical Oncology	8
Mallat M.G.	Anaesthetics / Pain Management	80
McCarty J. R.	Anaesthesia	80
McLean G.S.	Psychiatry	80
Muller D.W.M.	Cardiology	80
McGuinness J.J.	Anaesthesia	80
McKell M.	Anaesthesia	80
O'Hare E.E.	Anaesthesia	80
O'Rourke M.F.	Cardiovascular Hypertension	810
Plit M.	Respiratory Physician	806
Roby H.	Anaesthesia	808
Rimmer S.J.	Thoracic Medicine	806
Roy D.A.	Cardiology	803
Roy P R.	Cardiology	803
Scarf M.G.	Anaesthesia	808
Smith B. C.		

Cardiovascular hypertension Prof Michael O Rourke datang membantu Prof Victor Chang operasi pertama CABG di Indonesia

Usulan pendidikan Fellowship Advanced HF sudah sejak 2015 diusulkan



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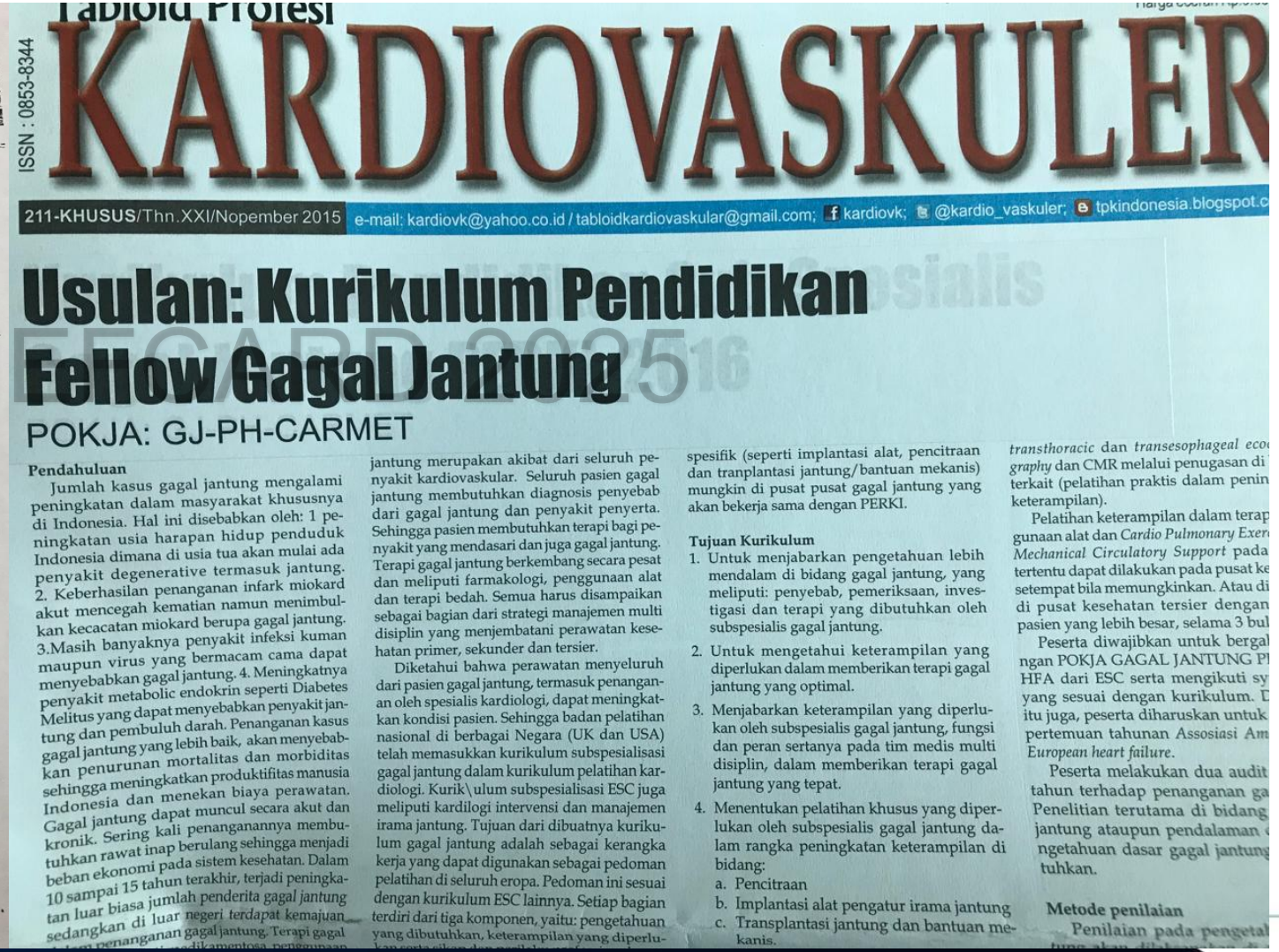


Tabloid Profesi

ISSN : 0853-8344

KARDIOVASKULER

211-KHUSUS/Thn.XXI/Nopember 2015 e-mail: kardiovk@yahoo.co.id / tabloidkardiovaskular@gmail.com; kardiovk; @kardio_vaskuler; tpkindonesia.blogspot.c

Usulan: Kurikulum Pendidikan Fellow Gagal Jantung

POKJA: GJ-PH-CARMET

Pendahuluan

Jumlah kasus gagal jantung mengalami peningkatan dalam masyarakat khususnya di Indonesia. Hal ini disebabkan oleh: 1 peningkatan usia harapan hidup penduduk Indonesia dimana di usia tua akan mulai ada penyakit degenerative termasuk jantung. 2. Keberhasilan penanganan infark miokard akut mencegah kematian namun menimbulkan kecacatan miokard berupa gagal jantung. 3.Masih banyaknya penyakit infeksi kuman maupun virus yang bermacam cama dapat menyebabkan gagal jantung. 4. Meningkatnya penyakit metabolic endokrin seperti Diabetes Melitus yang dapat menyebabkan penyakit jantung dan pembuluh darah. Penanganan kasus gagal jantung yang lebih baik, akan menyebabkan penurunan mortalitas dan morbiditas sehingga meningkatkan produktifitas manusia Indonesia dan menekan biaya perawatan. Gagal jantung dapat muncul secara akut dan kronik. Sering kali penanganannya membutuhkan rawat inap berulang sehingga menjadi beban ekonomi pada sistem kesehatan. Dalam 10 sampai 15 tahun terakhir, terjadi peningkatan luar biasa jumlah penderita gagal jantung sedangkan di luar negeri terdapat kemajuan dalam penanganan gagal jantung. Terapi gagal jantung merupakan akibat dari seluruh penyakit kardiovaskular. Seluruh pasien gagal jantung membutuhkan diagnosis penyebab dari gagal jantung dan penyakit penyerta. Sehingga pasien membutuhkan terapi bagi penyakit yang mendasari dan juga gagal jantung. Terapi gagal jantung berkembang secara pesat dan meliputi farmakologi, penggunaan alat dan terapi bedah. Semua harus disampaikan sebagai bagian dari strategi manajemen multi disiplin yang menjembatani perawatan kesehatan primer, sekunder dan tersier.

Diketahui bahwa perawatan menyeluruh dari pasien gagal jantung, termasuk penanganan oleh spesialis kardiologi, dapat meningkatkan kondisi pasien. Sehingga badan pelatihan nasional di berbagai Negara (UK dan USA) telah memasukkan kurikulum subspesialisasi gagal jantung dalam kurikulum pelatihan kardiologi. Kurik\ulum subspesialisasi ESC juga meliputi kardilogi intervensi dan manajemen irama jantung. Tujuan dari dibuatnya kurikulum gagal jantung adalah sebagai kerangka kerja yang dapat digunakan sebagai pedoman pelatihan di seluruh eropa. Pedoman ini sesuai dengan kurikulum ESC lainnya. Setiap bagian terdiri dari tiga komponen, yaitu: pengetahuan yang dibutuhkan, keterampilan yang diperlu-

spesifik (seperti implantasi alat, pencitraan dan tranplantasi jantung/bantuan mekanis) mungkin di pusat pusat gagal jantung yang akan bekerja sama dengan PERKI.

Tujuan Kurikulum

1. Untuk menjabarkan pengetahuan lebih mendalam di bidang gagal jantung, yang meliputi: penyebab, pemeriksaan, investigasi dan terapi yang dibutuhkan oleh subspesialis gagal jantung.
2. Untuk mengetahui keterampilan yang diperlukan dalam memberikan terapi gagal jantung yang optimal.
3. Menjabarkan keterampilan yang diperlukan oleh subspesialis gagal jantung, fungsi dan peran sertanya pada tim medis multi disiplin, dalam memberikan terapi gagal jantung yang tepat.
4. Menentukan pelatihan khusus yang diperlukan oleh subspesialis gagal jantung dalam rangka peningkatan keterampilan di bidang:
   a. Pencitraan
   b. Implantasi alat pengatur irama jantung
   c. Transplantasi jantung dan bantuan mekanis.

transthoracic dan *transesophageal eco graphy* dan CMR melalui penugasan di terkait (pelatihan praktis dalam penin keterampilan).

Pelatihan keterampilan dalam terap gunaan alat dan *Cardio Pulmonary Exer Mechanical Circulatory Support* pada tertentu dapat dilakukan pada pusat ke setempat bila memungkinkan. Atau di di pusat kesehatan tersier dengan pasien yang lebih besar, selama 3 bul

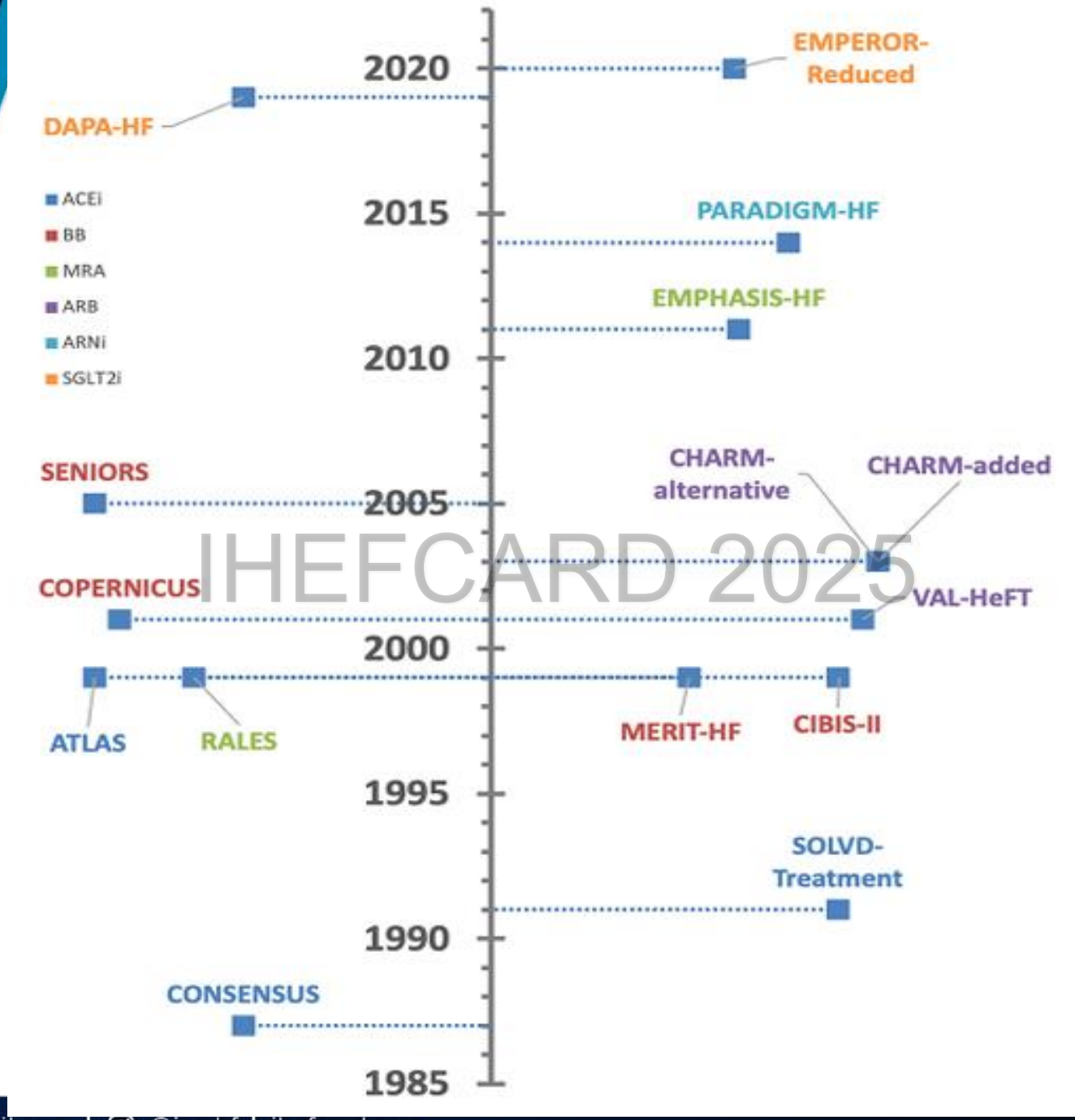
Peserta diwajibkan untuk bergal ngan POKJA GAGAL JANTUNG P HFA dari ESC serta mengikuti sy yang sesuai dengan kurikulum. D itu juga, peserta diharuskan untuk pertemuan tahunan Assosiasi Am *European heart failure*.

Peserta melakukan dua audit tahun terhadap penanganan ga Penelitian terutama di bidang jantung ataupun pendalaman ngetahuan dasar gagal jantung tuhkan.

Metode penilaian

Penilaian pada pengeta

History of GDMT



CONSENSUS TRIAL (1987)

Enalapril vs placebo
253 patients with HF (NYHA IV)

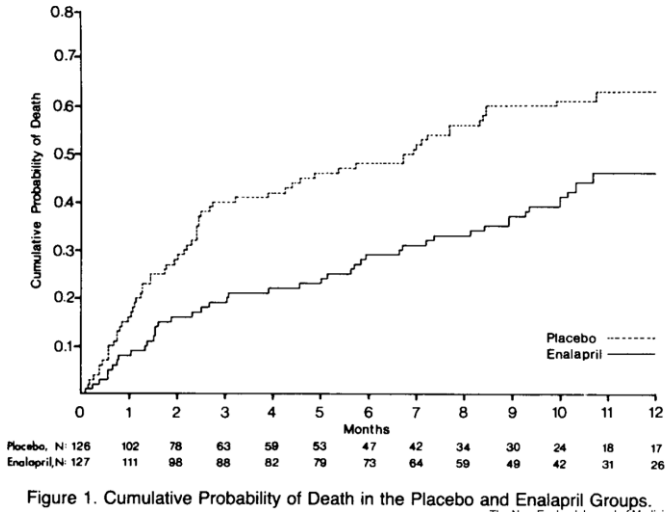
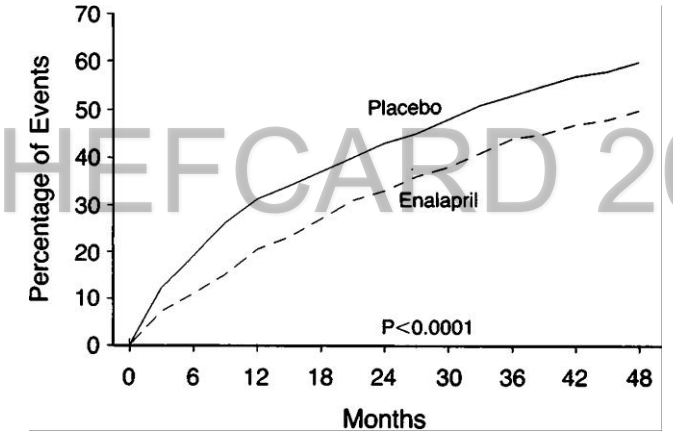


Figure 1. Cumulative Probability of Death in the Placebo and Enalapril Groups.

At 1 year, mortality remained lower in the enalapril group (36% vs 52%), a 31% relative risk reduction (P=0.001)

SOLVD (1991)

Enalapril vs placebo
2569 patients with HF (NYHA II/III)



Enalapril significantly reduced all-cause mortality and hospitalisation due to heart failure

MERIT-HF (1999)

Metoprolol CR/XL vs placebo
3991 patients with HF (NYHA II-IV), EF<40%

Table 2. Effect of Metoprolol CR/XL and Placebo on Combined End Points*

Combined End Points	Metoprolol CR/XL Group, No. of Patients (n = 1990)	Placebo Group, No. of Patients (n = 2001)	Total	Risk Reduction, % (95% Confidence Interval)
Total mortality or all-cause hospitalization	641	767	**1408**	19 (10-27)
Total mortality or hospitalization due to worsening heart failure	311	439	**750**	31 (20-40)
Death or heart transplantation	150	218	**368**	32 (16-45)
Cardiac death or nonfatal acute myocardial infarction	139	225	**364**	39 (25-51)
Total mortality or hospitalization or emergency department visit due to worsening heart failure	318	455	**773**	32 (21-41)

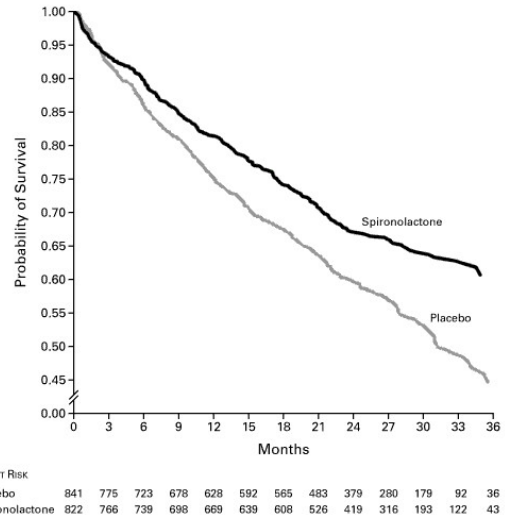
*Only the first end point that occurred in each patient was counted. $P<.001$ for all comparisons. CR/XL indicates controlled release/extended release.

19% Risk reduction of total mortality or all-cause hospitalizations

31% Risk reduction of total mortality and hospitalization due to worsening heart failure

RALES (1999)

Spironolactone vs placebo
1663 patients with HF EF<35% (were being treated with ACEi, loop diuretic, or digoxin)



30% reduction in the risk of death (relative risk of death among the patients in the spironolactone group, 0.70 by a Cox proportional-hazards model; 95 percent confidence interval, 0.60 to 0.82; P<0.001)

VALHeFT (2001)

Valsartan vs placebo
5010 patients with HF (NYHA II-IV)

TABLE 2. INCIDENCE AND RELATIVE RISK OF THE PRIMARY END POINTS.

EVENT	VALSARTAN GROUP (N=2511)	PLACEBO GROUP (N=2499)	RELATIVE RISK (CI)*	P VALUE†
	no. with event (%)			
Death from any cause (during entire trial)	495 (19.7)	484 (19.4)	1.02 (0.88–1.18)	0.80
Combined end point	723 (28.8)	801 (32.1)	0.87 (0.77–0.97)	0.009
Death from any cause (as first event)	356 (14.2)	315 (12.6)		
Hospitalization for heart failure	346 (13.8)	455 (18.2)		
Cardiac arrest with resuscitation	16 (0.6)	26 (1.0)		
Intravenous therapy	5 (0.2)	5 (0.2)		

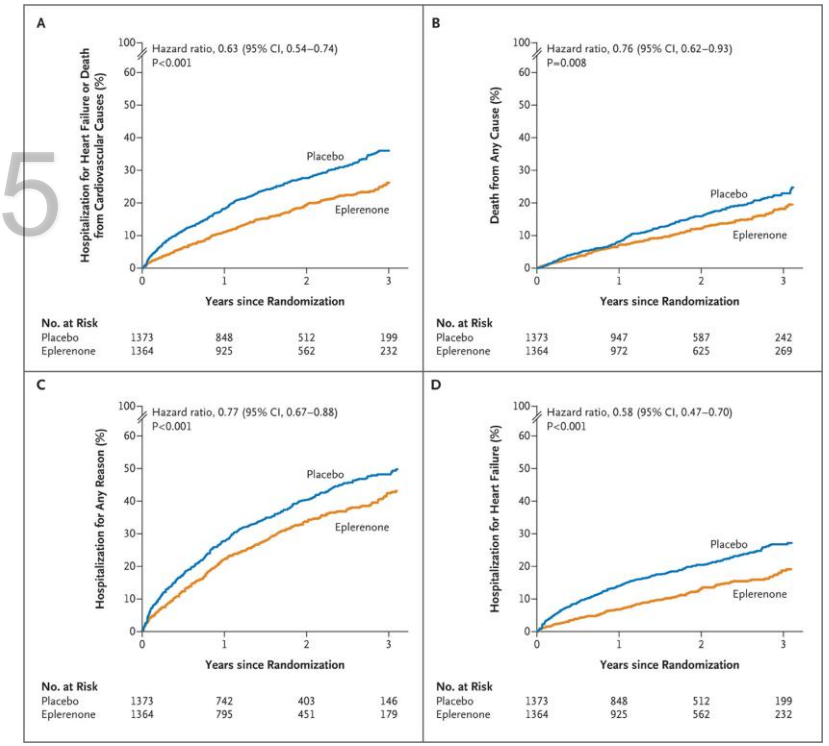
*The 98 percent confidence interval (CI) was calculated for the mortality end point (death from any cause), and the 97.5 percent confidence interval was calculated for the combined mortality–morbidity end point.

†P values were calculated by the log-rank test from time to first event.

The combined end point of mortality and morbidity was significantly reduced among patients receiving valsartan as compared with those receiving placebo (P=0.009)

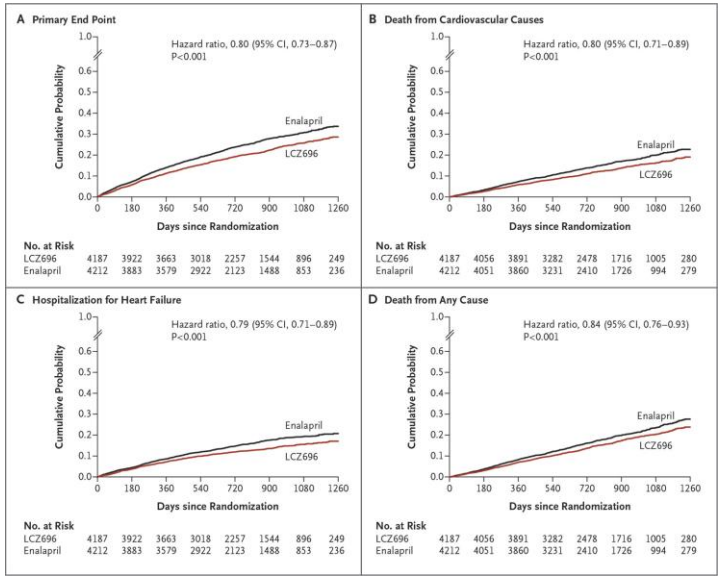
EMPHASIS-HF (2011)

Eplerenone vs placebo
2737 patients with HF (NYHA II), EF<35%



PARADIGM-HF (2014)

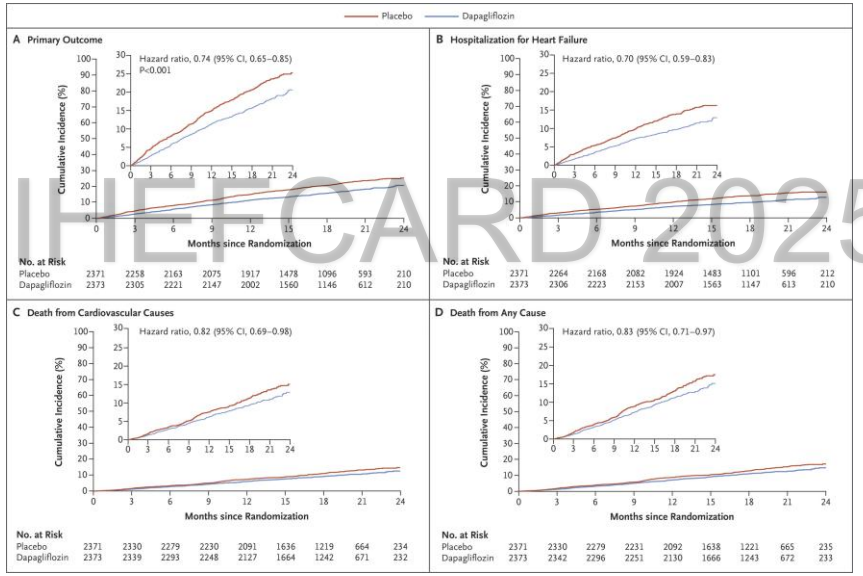
ARNI vs enalapril
8442 patients with HF EF<45%



sacubitril/valsartan significantly reduces the risk of the primary endpoint, cardiovascular death, hospitalization for heart failure, and death from any cause compared to enalapril, with hazard ratios ranging from 0.79 to 0.84 (all **P < 0.001**).

DAPA-HF (2019)

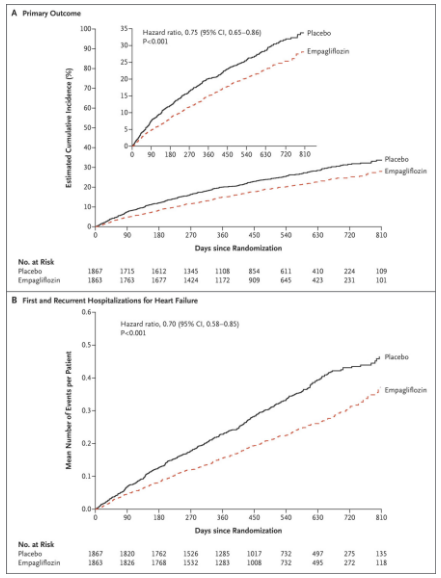
Dapaglifozin vs placebo
4744 patients with HF (NYHA II-IV), EF<40%



reduced the risk of the primary composite outcome to placebo in heart failure patients, with hazard ratios ranging from 0.70 to 0.83 (all statistically significant).

EMPEROR-REDUCED (2020)

Empaglifozin vs placebo
3,730 patients with HF (NYHA II), EF<35%



reduced the risk of the primary outcome (HR 0.75; 95% CI, 0.65–0.85) and total (first and recurrent) hospitalizations for heart failure (HR 0.70; 95% CI, 0.59–0.83) compared to placebo in patients with heart failure.

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Training NTproBNP bagi cardiolog di Asia oleh Prof. James Januzy, Jr

NT pro BNP mulai dipakai di Indonesia dibawa oleh **Prof Mark Arthur Richards**

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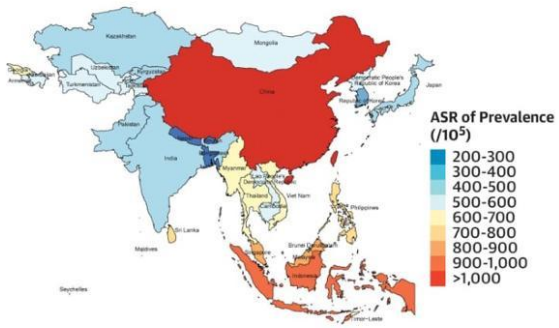
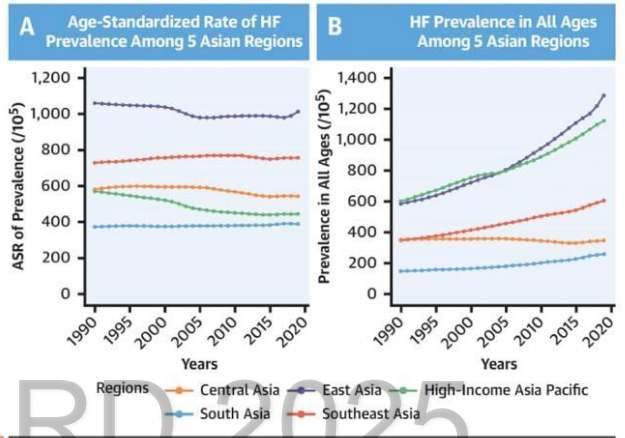
Indonesia tertinggi dalam crude mortality

CENTRAL ILLUSTRATION: Epidemiology and Burden of Heart Failure in Asia

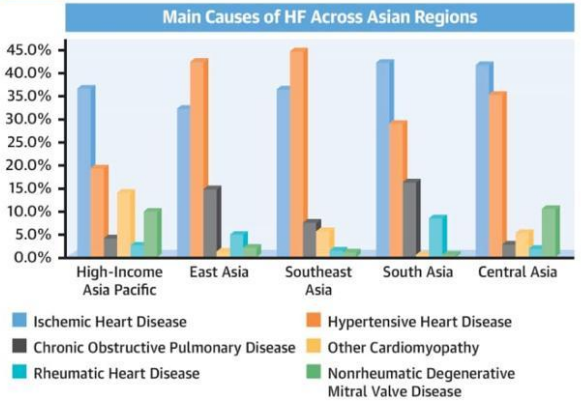
The Prevalence of HF in Asia is High: China, Indonesia, and Malaysia Are the 3 Highest Nations in Terms of Age-Standardized Prevalence



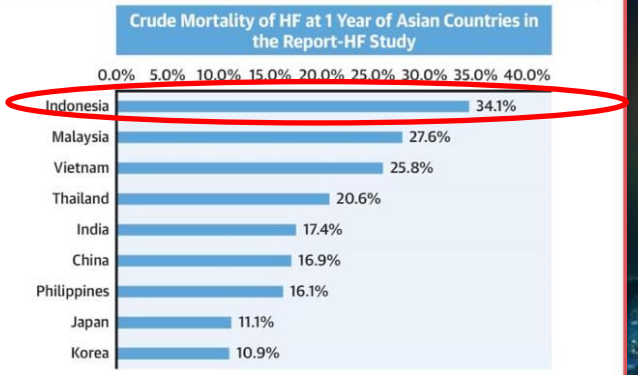
The Absolute Numbers of HF Prevalence Increased in Asia: The Age-Standardized Prevalence of HF Were Only Increased in Southeast Asia and South Asia



The Leading Causes of HF Worldwide and in Asia Are Ischemic Heart Disease and Hypertensive Heart Disease



The 1-Year Mortality of Asian HF Patients Is Still High, Especially in Southeast and South Asia: CV Death is the Primary Cause of Death for HF



Feng J, et al. JACC: Asia. 2024;4(4):249-264.

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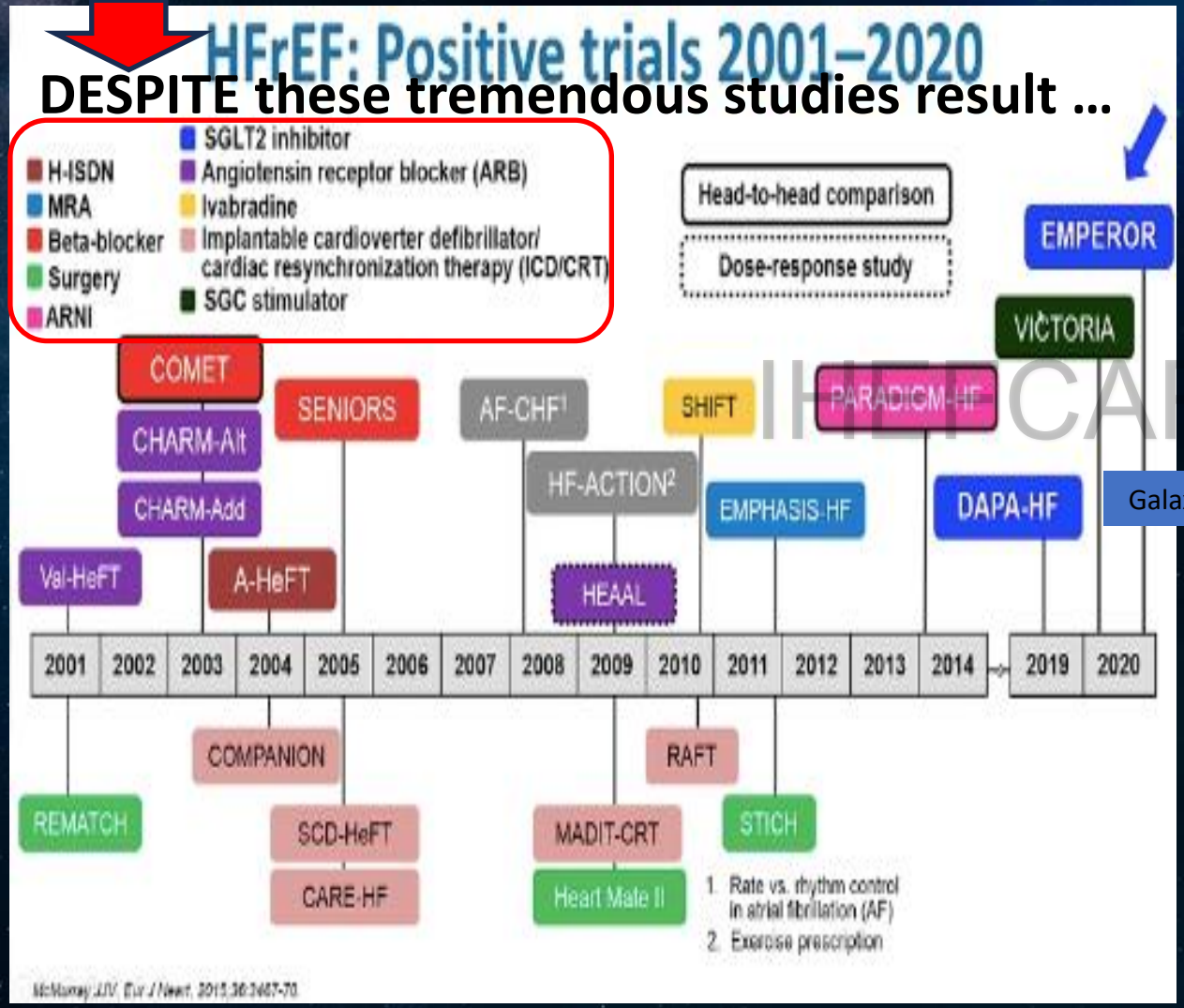
Unmet need for HF patients….why?

DESPITE these tremendous studies result …



INDONESIA ? DISPARITY ? RICH vs POOR?
URBAN vs RURAL?

Patient related factors (30%)
Poverty

Physician/ Pharmacyst related factors (50%)

System related factors (20%)
BPJS

Clinical inertia
Underutilized GDMT
(Ignorance)

Verhestraeten C, et al. Heart Failure Reviews (2021)

Launching Tolvaptan di Indonesia

Perintisan sistem Triase di UGD Harapan Kita

Launching ARNI


KELUAR
KARDIFKUI
KARDIFKUI
KARDIFKUI

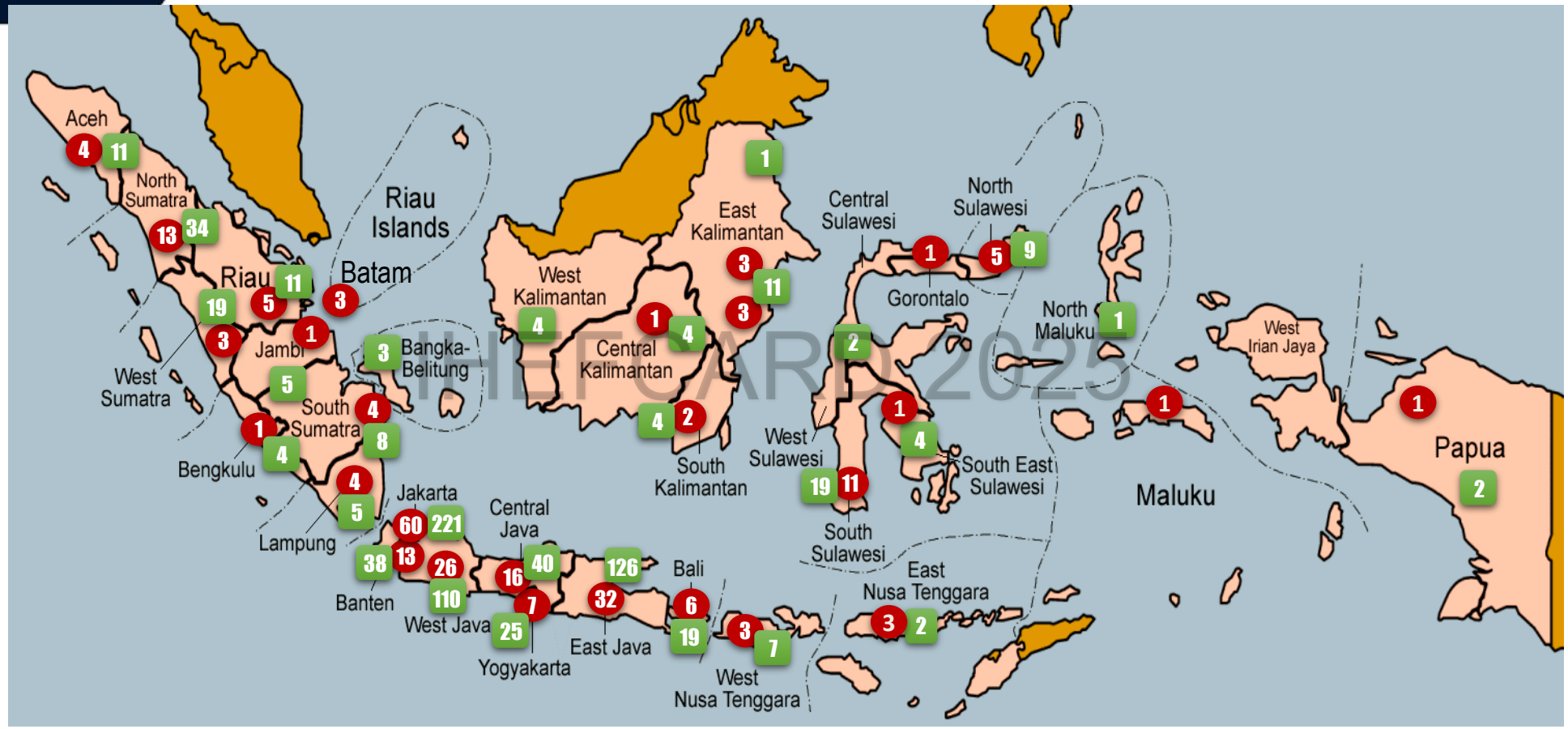
Launching Empagliflozin pada HUT PJNHK

Prof Marteen J Crammer bersedia membimbing dua dokter dari Indonesia di Utrecht

Prof Pieter Douvendans dan Prof Marteen Crammer dari Utrecth membantu staf departemen menjadi PhD by publication

Mengembangkan pentingnya Triage di UGD

Heart Failure Clinic di Indonesia vs Cath-Lab & Interventional Cardiologist



Number of Heart Failure Clinic Services ?
Total: 295 Cath Labs in 250 hospitals

Number of Cardiologist
Total: more than 1500 (2025)
Interventional Cardiologist 250 Certified Heart failure Specialist 5

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Indonesia sebagai Tuan Rumah First Asia Pulmonary Hypertension Scientific Meeting

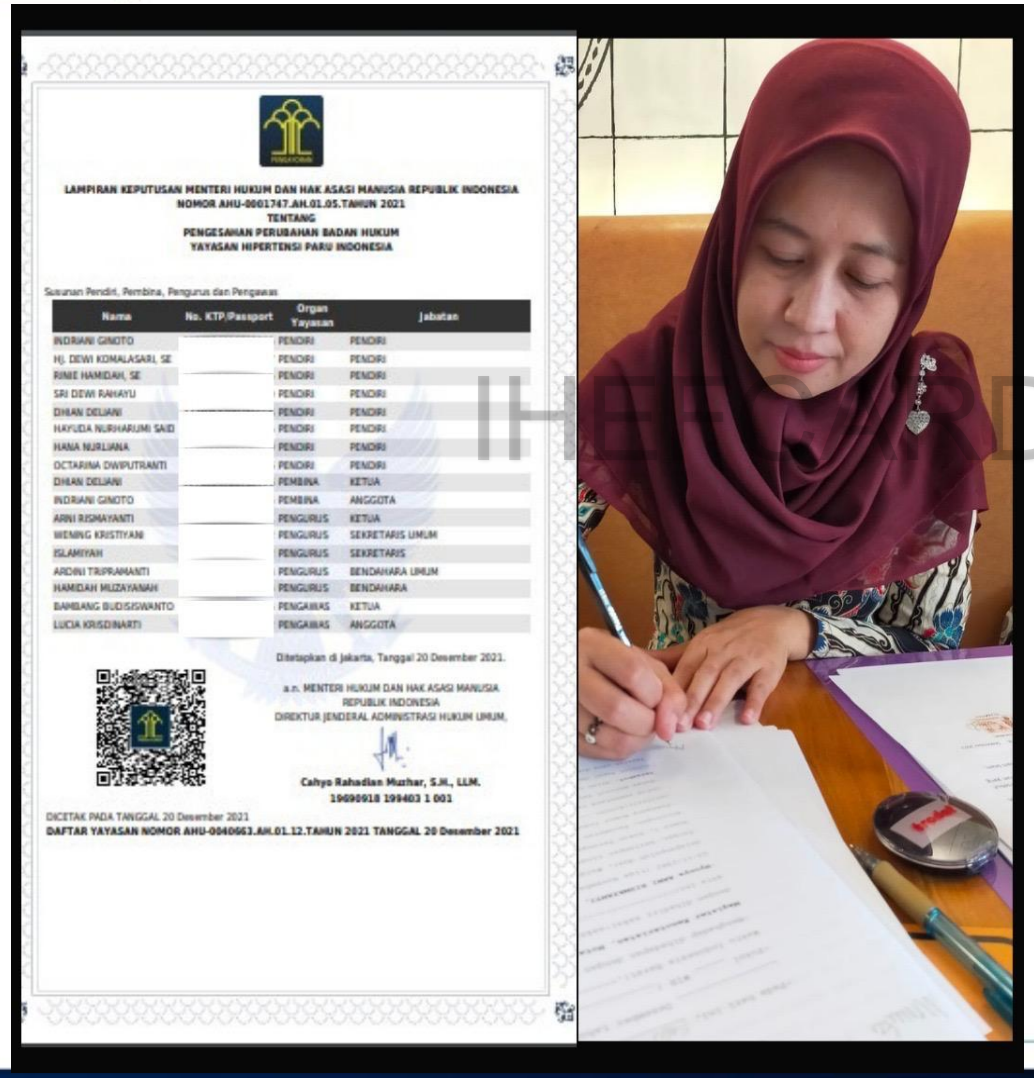
5th HEF CARD
The 5th Indonesian Symposium on Heart Failure and Cardiometabolic Disease

in conjunction with :
WHFS25
World Heart Failure Society Congress 2025

Tim Indonesia diundang training CTEPH dan BPA di NUHS

0811-1900-8855 | pokjahf@gmail.co

Yayasan Hipertensi Paru Indonesia (YHPI)



LAMPIRAN KEPUTUSAN MENTERI HUKUM DAN HAK ASASI MANUSIA REPUBLIK INDONESIA
NOMOR AHU-0001747.AH.01.05.TAHUN 2021
TENTANG
PENGESAHAN PERUBAHAN BADAN HUKUM
YAYASAN HIPERTENSI PARU INDONESIA

Susunan Pendiri, Pembina, Pengurus dan Pengawas

Nama	No. KTP/Paspor	Organ Yayasan	Jabatan
INDRIANI GINOTO		PENDIRI	PENDIRI
Hj. DEWI KOMALASARI, SE		PENDIRI	PENDIRI
RINIE HAMIDAH, SE		PENDIRI	PENDIRI
SRI DEWI RAHAYU		PENDIRI	PENDIRI
DHIAN DELIANI		PENDIRI	PENDIRI
HAFUDA NURHARUMI SAID		PENDIRI	PENDIRI
HANA NURLIANA		PENDIRI	PENDIRI
OCTARINA DWIPUTRANTI		PENDIRI	PENDIRI
DHIAN DELIANI		PEMBINA	KETUA
INDRIANI GINOTO		PEMBINA	ANGGOTA
ARNI RISMAYANTI		PENGURUS	KETUA
WIEMING KRISTIYANI		PENGURUS	SEKRETARIS UMUM
ISLAMIYAH		PENGURUS	SEKRETARIS
ARDWI TRIPRAMANTI		PENGURUS	BENDAHARA UMUM
HAMIDAH MUZAYANAH		PENGURUS	BENDAHARA
BAMBANG BUDISISWANTO		PENGAWAS	KETUA
LUCIA KRISDINARTI		PENGAWAS	ANGGOTA

Ditetapkan di Jakarta, Tanggal 20 Desember 2021.

a.n. MENTERI HUKUM DAN HAK ASASI MANUSIA
REPUBLIK INDONESIA
DIREKTUR JENDERAL ADMINISTRASI HUKUM UMUM,

Cahyo Rahadian Muzhar, S.H., LL.M.
19690918 199403 1 001

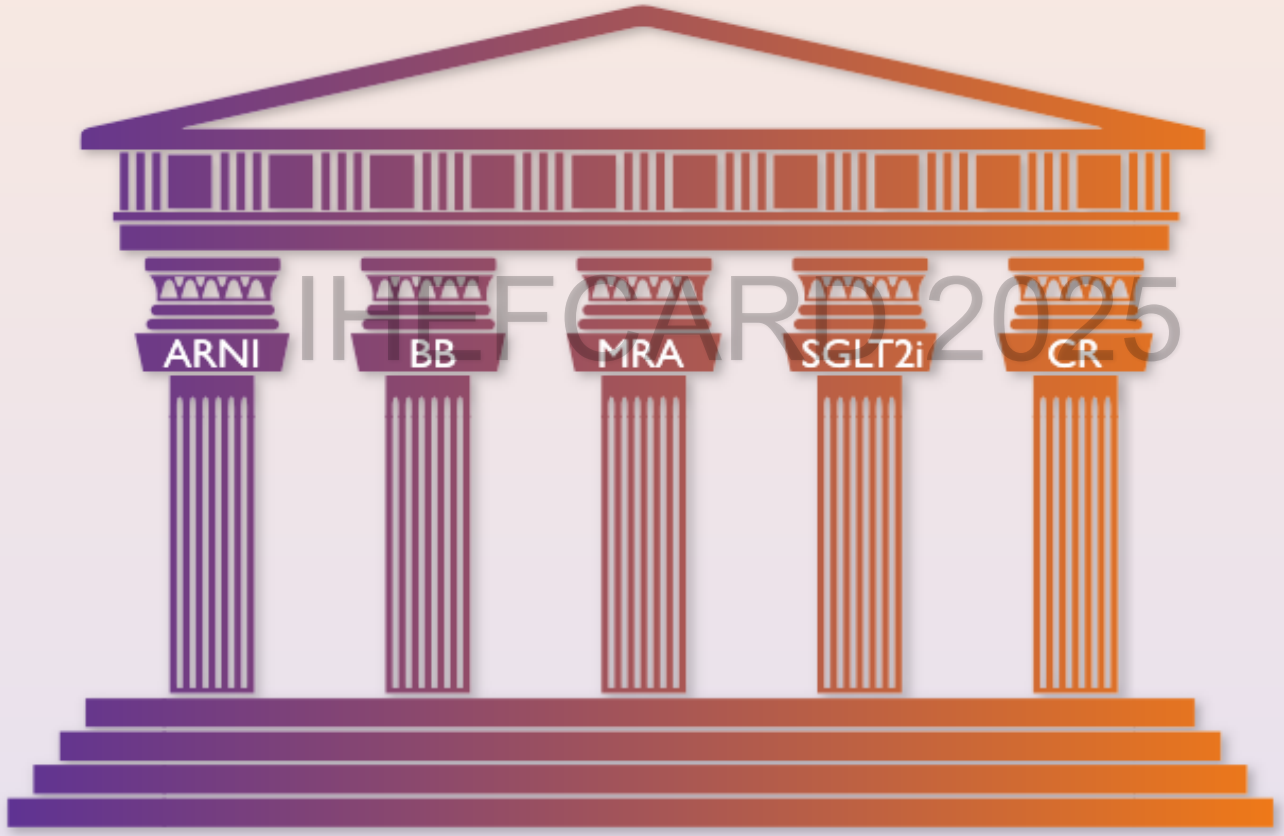
DICETAK PADA TANGGAL 20 Desember 2021
DAFTAR YAYASAN NOMOR AHU-0040663.AH.01.12.TAHUN 2021 TANGGAL 20 Desember 2021

Prof. Hirata dan Prof. Yu Tanugichi OnSite show case BPA di cath lab Kobe Hospital

Cardiac rehabilitation for heart failure (HF) improves health-related quality of life and contributes to reduced hospitalization and is Class I / level A evidence by international (US & EU) Guidelines

Despite this, referral to cardiac rehabilitation for HF is suboptimal and currently ranges from **5% to 50%** across countries

Cardiac rehabilitation should be the 5th pillar in HF management alongside drug and medical device provision



Choice of cardiac rehabilitation delivery models (centre-based/home-based ± digitally supported) should be developed and be available to patients in the future

5th HEF CARD
The 5th Indonesian Symposium on Heart Failure and Cardiometabolic Disease

in conjunction with :
WHFS25
World Heart Failure Society Congress 2025

Rehab in Heart Failure Team

0811-1900-8855 | pokjahf@gmail.

Diagnostic HF dengan Machine Learning Echocardiography dikembangkan dalam penelitian S3 Dr. dr. Lies Dina Liastuti, Sp.JP

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The Great Asian Mismatch: Training Versus Care in Heart Failure

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Selangor, and Kuala Lumpur, Malaysia

ABSTRACT

The prevalence of heart failure (HF) in South-East Asia is relatively higher than in Western countries, and yet there is a lack of established fellowship programs within the region to help cultivate HF specialists. Part of this may be due to a misunderstanding that HF training and curricula require the incorporation of advanced therapies, such as ventricular assist device implantation and heart transplantation, which are rarely performed in this region. Developing a structured curriculum tailored to the needs of HF care in South-East Asia may help to provide for this subspecialty the much-needed and long-overdue recognition it deserves. Collaboration between local societies and their international counterparts is an important starting point. Customization of local and regional curricula, depending on local needs and capabilities, allows for the gap in this Great Asian Mismatch to be bridged and to ensure that equitable training is delivered for all. (*J Cardiac Fail 2022;00:1–4*)

Key Words: Heart failure, curriculum, training, cardiology.

How to Become Heart Failure Fellow expert in Indonesia?

Cardiologist

Fellowship training in Indonesia ???

Fellowship Program

Fellowship training Singapore & IJN

Fellowship training Sydney / Melbourne /Japan/Korea

International Fellowship Program

Certificate of Training

Indonesian College Of Cardiology: Certificate of Advanced Competency

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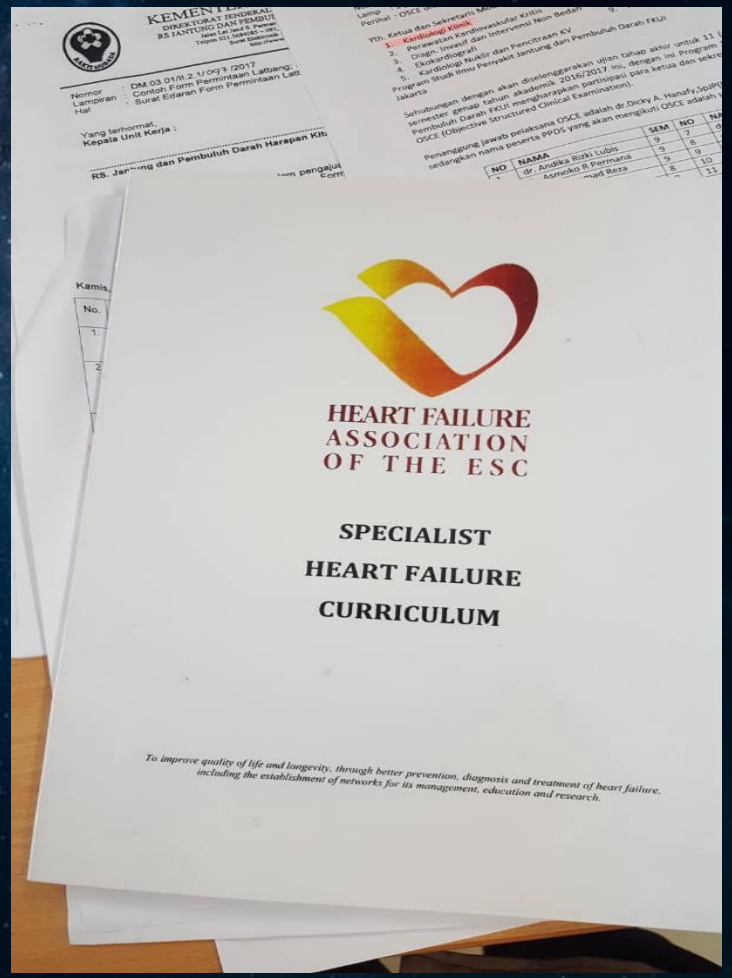
"It is A Journey that we should travel together"



BERSAMA KITA BISA

Be the first
Be the best
Be a winner

THANK YOU