Another cost effective treatment? n-3 Polyunsaturated fatty acids (n-3 PUFA) have a cost per life-year gained of about £15 000 based on the benefits shown in the GISSI Prevenzione trial. The authors conclude that this is comparable to simvastatin treatment and advocate the addition of n-3 PUFA therapy to treatments currently in use for secondary prevention after myocardial infarction.


PTCA or CABG? The ARTS trial: About 60% of patients treated by coronary angioplasty (PTCA) or bypass graft surgery (CABG) have multivessel disease which could feasibly be treated with either procedure. The ARTS (arterial revascularization therapies study) trial randomised 1205 such patients. The PTCA group has a high rate of stent (89%) use but glycoprotein IIb/IIIa inhibitors were used in less than 5% of cases. At one year, death and stroke rates were equivalent (91% event-free survival in both), but the PTCA group had more repeat procedures (16.8% v 3.5%). If death/myocardial infarction/stroke rates remain equivalent at later time points, would you rather be put on bypass once or on the “angio” table a number of times?

2 Serruys PW, Unger F, Sousa JE, Théroux P. Age-related differences in in-hospital mortality and the use of PTCA or CABG? The ARTS trial: About 60% of patients treated by coronary angioplasty (PTCA) or bypass graft surgery (CABG) have multivessel disease which could feasibly be treated with either procedure. The ARTS (arterial revascularization therapies study) trial randomised 1205 such patients. The PTCA group has a high rate of stent (89%) use but glycoprotein IIb/IIIa inhibitors were used in less than 5% of cases. At one year, death and stroke rates were equivalent (91% event-free survival in both), but the PTCA group had more repeat procedures (16.8% v 3.5%). If death/myocardial infarction/stroke rates remain equivalent at later time points, would you rather be put on bypass once or on the “angio” table a number of times?

Older people are still being denied thrombolysis, but would they benefit? Even in ideal candidates (that is, ECG ST elevation, no cerebrovascular disease absolute contraindications, and presentation within 12 hours of symptoms), those aged 75–84 years were three times less likely and those older than 84 years were 10 times less likely to receive thrombolysis compared to patients younger than 55 years. Does this matter? Older patients are usually excluded from clinical trials, so good quality evidence is lacking. US registry data suggest that patients aged 65–74 years receiving thrombolysis for myocardial infarction (MI) gained the benefits of thrombolytic therapy for acute myocardial infarction (AMI) with a survival advantage persisted after adjustment for social, demographic, and clinical factors and procedure utilisation (adjusted OR 0.68, p < 0.001). However, the non-fatal outcome advantages of hospitals with invasive facilities appeared to be explained by their teaching hospital status.


Alcohol intake is associated with some benefit in heart failure and heart attack: Moderate alcohol intake is associated with a reduction in the risk of first MI. Two studies show that it may also reduce the mortality after first MI and the risk of heart failure. The mechanism is not clear.


The advantages of admission to teaching hospitals: Although patients admitted to hospitals with invasive facilities were much more likely to undergo revascularisation (11.4% v 3.2% at other hospitals, p < 0.001), mortality rates were similar between the two institution types. In patients initially admitted to hospitals with invasive facilities the readmission was lower (71.3% v 80.4%, unadjusted odds ratio (OR) 0.65, p < 0.001). This advantage persisted after adjustment for social, demographic, and clinical factors and procedure utilisation (adjusted OR 0.68, p < 0.001). However, the non-fatal outcome advantages of hospitals with invasive facilities appeared to be explained by their teaching hospital status.


Low oestrogen pills do not predispose to MI except in heavy smokers: Non-smokers taking the low dose oestrogen pill are not at increased risk of MI compared to non-pill taking non-smokers. However, the risk was significantly increased in smokers (OR 12, 95% confidence interval (CI) 8.6 to 16) and was even higher in pill taking smokers (OR 32, 95% CI 12 to 81).


Patients with MI and left ventricular dysfunction should have β blockade: Most cardiologists are convinced of the benefits of β blockers post-MI and in stable heart failure. The CAPRICORN trial looked at high risk post-MI patients (30% had intravenous diuretics). Carvedilol 6.25 mg once daily was started 3–21 days post-MI, when the patient was stable, and slowly titrated up to 25 mg twice daily. All cause mortality was reduced by 22% (12% v 15%, p = 0.02). This relative risk reduction is in keeping with previous post-MI β blocker trials.


GENERAL CARDIOLOGY

Black patients with heart failure may not gain the benefits of ACE inhibitor treatment: In heart failure, angiotensin converting enzyme (ACE) inhibitors reduce all cause mortality by 16–20% at five years. ACE inhibitors are less effective in lowering blood pressure in black patients, a fact confirmed in a recent analysis of the SOLVD (studies of left ventricular dysfunction) trials. An average of 15 mg/day enalapril reduced blood pressure in a matched white cohort of patients by 5/3 mm Hg, but not in
the 800 black patients with heart failure. The black patients had a worse prognosis (death rate 12.2% vs 9.7/100 patient years) without treatment, and did not have the expected benefit on treatment despite similar compliance rates.


Prevent diabetes by weight loss: A western lifestyle begets diabetes, in part through weight increase and insulin resistance. A trial of 522 middle aged, overweight subjects (mean body mass index 31 kg/m²) with impaired glucose tolerance attempted to vigorously encourage weight loss. The mean amount of weight lost between baseline and the end of year 1 was 4.2 kg vs 0.8 kg in the control group, and 3.5 kg vs 0.8 kg at two years. The incidence of diabetes was reduced by 58% at four years (11% vs 23%). Weight loss should be recommended even more vigorously now.


Echocardiography is not very useful in diagnosing pulmonary embolism: If right ventricular (RV) dilatation, elevated tricuspid regurgitation velocity or RV systolic dysfunction are used to decide the presence of a pulmonary embolism, they are quite specific (90%) but miss 50% of cases. The unsurprising conclusion of this study is that echo plus clinical criteria are not good enough in excluding pulmonary embolism.


Spironolactone and ACE inhibitors—a warning: There is a risk associated with using two potassium sparing agents together. Of 25 cases of hyperkalaemia associated with these two medications, 17 needed haemodialysis, and two died. Older age (> 70 years) was the factor most commonly present in those with poor outcome. Care has to be exercised when adding spironolactone to ACE inhibitor, although in the original RALES (randomized Aldactone evaluation study) trial only 1–2% of cases got hyperkalaemia.


BASIC RESEARCH

Right ventricular cardiomyopathy—a single protein defect? Mutations of cytoskeletal proteins have previously been shown to be associated with cardiomyopathy, but how the gene links to the phenotype has been hard to elucidate. Mice lacking in Apl (a actinin-associated LIM protein) develop right ventricular cardiomyopathy. This protein has been shown to enhance directly the cross linking of actin filaments. Lack or dysfunction would clearly lead to cardiac dysfunction.


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