LETTERS TO THE EDITOR

RITA trial protocol

Sir,—The merits of a well controlled clinical trial for the assessment of a new treatment in clinical medicine have been established. Statisticians and epidemiologists have increasingly laid low more stringent and exacting criteria for conducting these trials and this has led to more valid results and conclusions. Recently, however, there have been examples where the criteria necessary to fulfill the demands of the statistician have been such that the study population recruited no longer represents the intended population and consequently the relevant clinical questions have not been answered.

The randomised intervention treatment of angina (RITA) trial (1989;62:411-4) suffers from a major methodological error in that it imposes on one group of patients—the angio-plasty population—a treatment strategy that is not generally practised by the physician performing the procedure. The surgical strategies for revascularisation and the strategies for angioplasty are quite different and it is these strategies that should be compared rather than the likelihood that angioplasty will achieve exactly what the surgeon would wish to achieve.

Coronary artery bypass surgery aims to revascularise all important vessels with lesions that are haemodynamically significant at the time of the procedure or that are thought likely to become so in the future. The strategy of angioplasty varies between operators, centres, and individual patients, but it aims to make the patient symptom free with a pattern of disease that has a good prognosis. Lesions that are not haemodynamically significant are frequently not dilated because of the possibility of inducing a significant restenosis. With angioplasty the operator can postpone treating these lesions and treat them only if they become haemodynamically significant. The surgeon, because of the "cost" of surgery to the patient, does not have this option and therefore has to revascularise all vessels with potentially significant lesions at the time of the initial procedure. By forcing a treatment strategy on the physician performing the angioplasty that is not widely used and that favours the surgical arm of the trial, the result of the RITA trial, whatever the outcome, will have few implications for clinical practice. It is unfortunate that a large amount of effort and money is being spent on this trial that does not address the clinical problems relevant to coronary artery revascularisation and will not provide reliable information on which the future allocation of resources can be based.

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This letter was shown to Dr Henderson, who replies as follows:

Sir,—Several of the points raised by Dr Beatt were initially considered very carefully by the Protocol Committee of the RITA trial and his letter does not state the position correctly. Extensive surgical experience has shown the benefits of complete revascularisation and it was felt likely that the extent of revascularisation that would allow the surgeon to achieve safely, reliably, and feasible, and affordable, and diagnostic.

The debate will clearly continue as Mills suggested in his editorial in the British Heart Journal. The outcome may depend on the practice of cardiology in the United Kingdom.

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2 Mills P. Should coronary angiography be performed in district hospitals? Br Heart J 1990;63:73

Catheters or isotopes in the district general hospital?

Sir,—Stewart et al highlighted the potential problems of “routine” coronary arteriography performed without surgical cover (1990;63:74-7), and Mills has used their findings to fuel the debate about the safety of coronary arteriography in the district general hospital (1990;63:73). I believe that the debate is academic.

In patients with stable coronary artery disease diagnostic and therapeutic decisions can usually be made on the basis of the history, examination, electrocardiography, and non-invasive assessment of myocardial perfusion by thallium-201 or one of the newer technetium inomintielies. But cardiologists who are unaware of the high quality of modern emission tomography feel the need to resort to coronary arteriography to be on safe ground. Non-invasive tests alone, however, can be used to decide who is at high risk of future cardiac events and could presumably benefit from intervention and who may continue on medical treatment. Indeed, myocardial perfusion imaging is better than coronary arteriography for predicting future outcome. A knowledge of the coronary anatomy (as opposed to function) is needed only to guide the interventional cardiologist or the cardiac surgeon and should therefore be limited to the specialist centre. Here the decision to intervene has usually been made before referral and coronary arteriography cannot be avoided; but myocardial perfusion imaging remains important as an objective indicator of the site, extent, and depth of ischaemia.

Good quality nuclear cardiology is available only in a few district hospitals because many see it as a specialist technique that should be practised only in a specialist centre. The opposite is the case and the technique is most effective in aiding triage in hospitals without access to coronary arteriography. Most districts do have access to nuclear medicine equipment but a recent survey showed considerable underuse of nuclear cardiology in the United Kingdom. Only inertia and poor training in nuclear techniques can explain this.

Some cardiologists dismiss these views as those of an enthusiast. It is true that enthusiasm is an important part of providing a reliable nuclear cardiology service, but those
Major complications of coronary arteriography: the place of cardiac surgery

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