LETTERS TO THE EDITOR

The British Heart Journal welcomes letters commenting on papers that it has published within the past six months.

All letters must be typed with double spacing and signed by all authors.

No letter should be more than 600 words.

In general, no letter should contain more than six references (also typed with double spacing).


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DIRECT ACCESS ELECTROCARDIOGRAPHY: A NEW SERVICE THAT IMPROVES THE MANAGEMENT OF SUSPECTED ISCHEMIC HEART DISEASE IN THE COMMUNITY.

The paper by McClements et al on direct access electrocardiography (Br Heart J 1994; 71:531–5) is surely incorrectly titled. A new service that alters the management of suspected ischemic heart disease would be appropriate but to suggest that it improves the management I think not. As a result of the open access facility more than half of the patients with chest pain thought to be due to coronary artery disease and who had an abnormal exercise test were not referred for specialist examination and advice, thereby being deprived of access to two of the three available treatment options. Indeed, apparently the cost of these patients who received no treatment at all. In the current environment where quantity rather than quality of management seems to be the important factor perhaps I
am the one out of step, but I know how I would prefer my own chest pain to be managed.

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Sir,—We were interested to read the experience of McClements et al of a direct access exercise electrocardiography service for general practitioners.1 We have developed a fast track clinic for GP patients with recent onset (<48 h) chest pain or palpitation. GPs are asked to book the patients into the clinic by telephone and all patients are seen within 24 hours. A 12 lead electrocardiogram is performed, and the patient is reviewed by a cardiology registrar who decides upon appropriate management within previously defined guidelines. Those patients requiring further follow up are seen in a dedicated clinic by a consultant cardiologist after appropriate tests. Of the first 100 patients presenting to this fast track clinic, over a four month period, 60 had recent onset chest pain, 37 palpitation, and three murmurs or dyspnoea. This indicates that the referral pattern was appropriate. McClements et al also found that GP referrals largely followed their predefined guidelines. Thirty five patients were sent for exercise electrocardiography and 16 (47%) had positive tests, compared with only 34 of 192 (18%) in their unscreened population (x²=13.5; P<0.001). In an audit of our exercise testing service, which is available to all hospital physicians, 44% of the tests were positive (235 of 533 tests). Thus, far more patients had negative tests when they were not screened by a hospital doctor. Overall, 35% of the patients presenting to the fast track clinic with chest pain were found to have a final diagnosis of ischaemic heart disease. This did not differ significantly from an incidence of 33% in 100 patients seen in the routine cardiology outpatient service during the same period. The capital costs of setting up the service were low because it was based on an existing outpatient electrocardiography service for GPs.

Our experience shows that offering a rapid access cardiology outpatient service for GP patients with symptoms of recent onset identifies a population with a high incidence of ischaemic heart disease. We were also able to initiate treatment and advise GPs directly, without waiting for a further referral to the cardiology outpatient clinic. McClements et al provide no data to support their statement that an open access exercise electrocardiography service reduces outpatient referrals. We believe that restricting access to expensive cardiological investigations, such as exercise testing, by using a screening physician is more cost effective than open access.

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These letters were shown to the authors, who reply as follows.

Sir,—The aim of our study was to allow general practitioners direct access to exercise stress testing for patients with suspected ischaemic heart disease (IHD). We believe that this service avoided inappropriate specialist consultations and that patients received a prompt and efficient diagnostic service.

In response to Dr Layton: the incidence of IHD in this population was relatively low. Most had non–cardiac chest pain and 82% had no inducible myocardial ischaemia during exercise testing. Of the minority with inducible ischaemia, all those with strongly positive tests were appropriately referred for cardiac catheterisation. Decisions regarding management of the remainder were made by GPs on the basis of symptom status and level of exercise achieved on exercise testing. The four patients who did not require regular antianginal treatment had very infrequent angina or no recurrence of symptoms. These management decisions seemed to us to be appropriate and in line with practice in our outpatient clinic. There is no question of depriving patients of any treatment option. Specialist consultation is unlikely to have altered the management of any of these patients at this stage and was available at any time if circumstances changed.

We commend Dr O’Toole and Dr Channey on the fast track service they describe. However, this service is aimed at patients with recent onset (<48 h) chest pain—that is, a group with more acute disease. Our criteria excluded patients with pain thought likely to be unstable angina. Though there will be some overlap there is a difference in emphasis: their patients had usually been referred to the emergency department, whereas ours had been referred to the cardiology clinic. It is not surprising that the incidence of positive tests in the fast track system was higher, given that the populations are very different, particularly because a registrar selected patients for exercise testing, apparently on the basis of a high pre-test likelihood of IHD.

The diagnostic value, and therefore cost-effectiveness, of an exercise test is greatest when the pre-test likelihood of IHD is moderate. In our study the pre-test likelihood of IHD was assessed by the GP as low or moderate in 74% and the positive exercise test rate was relatively low at 18%. GPs see many patients with chest pain and because it is important to exclude IHD in this group the value of a negative test should not be underestimated. We believe our service is cost effective because it seems to avert many unnecessary hospital referrals. As there are at least four hospitals to which these patients could have been referred, it was not possible to assess directly the impact of the service on cardiology outpatient referral patterns. Therefore our evidence for this is the stated intentions of GPs (97% would have referred their patients to a hospital cardiology clinic had the service not been available compared with 10% after the exercise test). On the other hand, the true costs of the fast track system do not appear to have been acknowledged. The cost of a clinic staffed by a registrar is not insignificant. Some patients were also seen at a consultant’s clinic and many patients with chest pain were still referred for exercise testing. There are insufficient data to claim that one approach is more cost effective than another: both are attempts to improve the management of different groups of patients.

Contrary to what Dr. Layton suggests, we feel that the title of our paper is correct. Based on the results of our study we believe that a direct access exercise electrocardiography service enhances the quality of care for this group of patients and facilitates more efficient use of the limited specialist cardiology resources available in the United Kingdom.

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NOTICES

The 1995 Annual Meeting of the British Cardiac Society will take place at the Conference Centre, Harrogate, North Yorkshire from 23 to 25 May.

The Seventh European Symposium on Cardiac Pacing will be held in Istanbul, Turkey on 4–7 June, 1995. The congress will be the official meeting of the two working groups of the European Society of Cardiology (namely the Working Groups on Cardiac Pacing and Arrhythmia).
Direct access exercise electrocardiography: a new service that improves the management of suspected ischaemic heart disease in the community.

L. O'Toole and K. S. Channer

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http://heart.bmj.com/content/73/2/199.1.citation

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