LETTERS TO THE EDITOR

Scope
Heart welcomes letters commenting on papers published in the journal in the previous six months. Topics not related to papers published earlier in the journal may be introduced as a letter: letters reporting original data may be sent for peer review.

Presentation
Letters should be:
- not more than 600 words and six references in length
- typed in double spacing (fax copies and paper copy only)
- signed by all authors

They may contain short tables or a small figure. Please send a copy of your letter on disk. Full instructions to authors appear in the July 1997 issue of Heart (page 97).

Atrial fibrillation begets trouble
Sir,—We welcomed the excellent editorial by Waktare and Camm on the deleterious effects of atrial fibrillation and agreed wholeheartedly with their conclusion that “the important problem is to investigate and treat appropriately” 1 but our general practice survey suggested that less than a third of the patients had ever been admitted to hospital. 2 Such information from hospital and general practice would have major implications for healthcare resources and service provision for this common problem.

The low use of anticoagulation in patients with atrial fibrillation may be related to the perceived absence of suitable guidelines; however, many general practitioners are reluctant to undertake this role. 2 Despite this there remains considerable variation among physicians in the management of patients with atrial fibrillation, especially between cardiovascular and cardiologists, in the use of antithrombotic and antiarrhythmic therapy, and consideration for cardioversion. 3 The existence of many different guidelines would probably result in a very wide range on the actual rates of anticoagulation if applied to the same population of patients with atrial fibrillation.

If we improve screening, detection, and anticoagulation for atrial fibrillation, these have considerable implications especially with an aging population. A question often raised is who should be responsible for monitoring anticoagulant therapy? There is no clear evidence that general practitioners can monitor anticoagulation intensity more efficiently than hospital anticoagulant clinics, however, many general practitioners are reluctant to undertake this role. 2 In our general practice survey, anticoagulation was monitored in hospital in the majority of cases (75%), by both general practitioner and in hospital in 17.5%, and by general practitioner alone in only 7.5%. 2 The latter requires further clarification and possible solutions, such as decision support for dosing and self-monitoring, need further evaluation. 2

While many hospital clinicians and general practitioners are aware of atrial fibrillation, its associated problems, and the need for treatment, the message from many studies is that the management of atrial fibrillation remains suboptimal. Many of us would welcome any suggestions for implementation of proper investigations and treatment for patients with atrial fibrillation. Do we need more guidelines? Probably not; however, we do need a consensus plan involving our general practitioners and hospital physician colleagues in the detection and management of this common problem. We, as cardiologists, keep emphasising the need for managing this problem appropriately, but the evidence of much variation in management, even among cardiologists, suggests that much more work is needed before we can deliver appropriate care to all patients with atrial fibrillation.

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1 Waktare JEP, Camm AJ. Atrial fibrillation begets trouble [editorial]. Heart 1997;77:393–4.

Increase in hospital admission rates for heart failure in the Netherlands, 1980–1993
Sir,—We were most interested to read the report by Reitsma et al on heart failure hospitalisations in the Netherlands. 4 While these authors found a trend in hospitalisations similar to our report from Scotland they point out that their absolute hospitalisation rates were lower. 4 There are at least three likely explanations for this.

First, Reitsma et al excluded a number of ICD codes for heart failure that we included in our report: ICD9 codes 425.4 (primary cardiomyopathy), 425.5 (alcoholic cardiomyopathy), and 425.9 (secondary cardiomyopathy, unspecified). These codes accounted for 4.4% of our total cases in 1990.

Second, and much more importantly, the prevalence of coronary artery disease, the major cause of heart failure, is much higher in Scotland than in the Netherlands. For example, the age adjusted mortality rate per 100,000 for men aged 35–74 was 558 in Scotland and 248 in the Netherlands (ICD codes 410–414, standardised to England and Wales population 1972). The respective rates for women were 218 and 84.

Third, a considerably higher proportion of the Scottish population are elderly—the age groups with the highest incidence and prevalence of heart failure. The proportion of the population aged 75–79, 80–84, and 85+ in the Netherlands in 1993 was 1.86, 1.16, and 0.68%, respectively; in the UK these proportions were 2.37, 1.55, and 0.85%. For women in the Netherlands the proportions were 3.07, 2.29, and 1.86; in the UK they were 3.53, 2.86, and 2.49%.

In summary, when these differences are considered the findings of Reitsma et al are consistent with ours in the Scottish population.

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Coronary patients need cardiologists

Sr.—Dr Bethell makes the valid point that the care of patients with myocardial infarction in general is poor and ascribes much of the fault to general physicians. It is equally appropriate to assign blame to general practitioners who are in the most advantageous position if they should so wish to supervise and encourage a rehabilitation programme for their patients.

As someone who has been interested in this subject for many years and has encouraged the use of thrombolysis within his own practice with the community, I would take issue with Dr Bethell’s comments that general practitioners are bound to follow protocols set by hospitals. It is such attitudes that have contributed to the problems in taking forward the appropriate acute care of patients with myocardial infarction as well as their rehabilitative care.

It is only through collaboration and discussion, not by diktat, that sensible programmes of cardiac rehabilitation can be established within the community. I would very much encourage such attitudes that might lead to improved patient care.

JAMES A GRANT
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This letter was shown to the author, who replied as follows:

Dr Grant is right to say that general practitioners are not bound to follow hospital examples of the management of patients with myocardial infarction. However, unless the general practitioner has a particular interest in heart disease, his or her management of coronary patients is likely to be influenced heavily by the approach of the hospital physician. In hospitals where infarct patients are admitted under the care of one of several on-duty consultants this approach is likely to lack consistency and be suboptimal. If all coronary patients were to have the benefit of a cardiologist’s opinion, as is the case in some hospitals, a consistent management policy could be developed. This could then, as Dr Grant suggests, be discussed and put into practice by general agreement between hospital and community, an unlikely situation under current circumstances.

I did not “ascribe much of the fault to general physicians”; it was the system that I criticised. It is a paradox of the way we organise the care of the largest cause of death in the UK that heart attack patients may never see a doctor who is interested in their condition.
Atrial fibrillation begets trouble

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