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).

SIR,—While it is encouraging to note the advances that are being made in the non-invasive definition of the heart and great vessels, it is a cause of anxiety if this leads to surgical correction of trivial lesions that are less life-threatening and morbid than the treatment.

In their article Houston *et al* did not advocate closure of the silent ductus but they did raise the question.¹ To support this attitude they referred to papers published before antibiotics were available and when sepsis generally, and dental sepsis in particular, was rife. In 1991 the incidence of infective endocarditis on a ductus must have been low and similarly the morbidity of the condition—yet all clinically detectable ducts are closed.

From 1978 to 1987 about 500 cases per year were treated by "closed" surgery, and now others are treated percutaneously. Some will have other cardiac defects, some will be haemodynamically compromised but many will be symptom free with small shunts. For a long time, I have believed that treatment of patients in the latter group is unwarranted but the response has always been "Well if you don't do it, someone else will!"

Perhaps the time has come for a national survey to discover the risk to life and health of the untreated small ductus, if only, initially, from the history and presentation of those who survive the neonatal period.

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¹ Houston AB, Granapagassam JP, Lim MK, Daig WB, Coleman EN. Doppler ultrasound and the silent ductus arteriosus. *Br Heart J* 1991;65:97-99.

Doppler ultrasound and the silent ductus arteriosus

SIR,—Houston *et al* described 21 cases of "silent" patent ductus arteriosus (PDA) that were apparent only on echocardiogram by colour flow mapping and pulsed Doppler.¹ Two of the twenty one patients in their group had previously undergone surgical ligation of a PDA and residual ductal

flow was seen on colour flow mapping and pulsed Doppler studies. Houston *et al* raised the question, "do patients with a silent ductus arteriosus require prophylaxis against infective endocarditis?" They did not recommend endocarditis prophylaxis for the silent ductus. We offer further echocardiographic evidence against using endocarditis prophylaxis for the silent ductus.

We evaluated nine patients aged 3-21 years who had an echocardiogram for various unrelated indications, and were found incidentally to have clinically unsuspected PDAs. Six of the nine patients did not even have a murmur. We used echocardiography to determine whether or not there was a haemodynamic difference between the clinically unsuspected or "silent" PDA and the small, clinically appreciable PDA. We used eight age matched comparison patients with small PDAs. Our criteria for the "silent" PDA group were the same as the criteria used by Houston *et al*.

All patients with clinically unsuspected PDAs had normal M mode dimensions, with the PDA only being visualised by colour flow mapping and confirmed by pulsed Doppler, which demonstrated the characteristic Doppler signal showing continuous pulmonary flow with a relatively high velocity in diastole. No patient with a "silent" PDA had diastolic reversal in either the thoracic or descending abdominal aorta, unlike the patients with known clinically audible, small PDAs who also had normal M mode dimensions on the echocardiogram. In these patients, however, the PDA was visualized on cross sectional imaging, as well as by colour flow mapping and pulsed Doppler. All eight patients had diastolic flow reversal in the thoracic aorta, and 4/8 had diastolic flow reversal in the descending abdominal aorta. Our initial clinical experience indicates that diastolic flow reversal in the thoracic aorta distinguished a "silent" PDA from a clinically appreciable, small PDA.

The management of the "silent" PDA is a dilemma for the paediatric cardiologist. There is currently no published evidence that haemodynamically trivial, "silent" PDAs present a risk for endocarditis. In fact, our echocardiographic evidence supports the fact that there is a haemodynamic difference between the "silent" PDAs and clinically appreciable PDAs. We suspect that the amount of flow through the ductus is so small that often it not only does not give rise to a murmur but it also probably does not produce enough turbulence to form a jet lesion and thus does not place the patient at a risk for endocarditis.

We support the recommendation made by Houston *et al* that these patients with "silent" PDAs be placed in a registry and followed prospectively for the development of endocarditis.

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¹ Houston AB, Granapagassam JP, Lim MK, Daig WB, Coleman EN. Doppler ultrasound and the silent ductus arteriosus. *Br Heart J* 1991;65:97-99.

BRITISH CARDIAC SOCIETY NEWSLETTER

More on Senior Registrars and Registrars

The January newsletter gave stop press news that we have secured approval from the Joint Planning Advisory Committee (JPAC) for an increase in the number of senior registrars in adult cardiology and paediatric cardiology from 60 to 80.5 whole time equivalents. Paediatric cardiology is likely to require only one or two of these posts at the present time, but we must retain a degree of flexibility that will permit some adjustments between the two branches of the specialty. This is particularly important for paediatric cardiology because the overall numbers are small, and needs for trainees vary markedly from time to time depending on the number of retirements that are expected. In large specialties the variations from year to year are minor in relative terms.

We welcome this possibility for expansion of the senior registrar grade. We are entering a period when consultant posts would be difficult to fill if an expansion did not occur. But we must also recognise that we are also entering a period of uncertainty: sadly we may see the need for redeployment, and the Trusts may adopt policies that will confound the planners. We would be unwise if we were to implement at once all of the potential new expansion without continued careful monitoring and fine tuning. In any case it would be impossible to do so. Many difficult steps have to be taken between JPAC approval for an increase in numbers and filling new posts. First cardiac centres have to make a decision that new posts are desirable, then local approval and local funding must be obtained. In these difficult times funding may be a formidable hurdle. JPAC does not carry new money with its approval for expansion. Moreover, the specialty does not have full freedom to decide where new posts will be created. Except for small specialties, guidelines exist for the distribution between Regions of senior registrar posts: these must be followed unless good reasons can be shown for not adhering to them. Cardiologists from centres that could appropriately train an additional senior registrar—and would like to do so—should contact the Specialist Advisory Committee directly or through ourselves so that approaches can be planned and coordinated.

We are already facing major reductions in the number of career registrars. One welcome knock-on effect of an increase in senior registrar numbers will be a commensurate increase in the number of registrars. At present we have a serious bottle neck at this level because numbers have not been controlled effectively. We learn for example that a recent advertisement for a senior registrar appointment in Cambridge attracted applications from 39 registrars. Almost all seemed fully qualified for the post. Most of the applicants had considerable catheter experience; six already had an MD thesis;

10 others had submitted a thesis and expect to have one shortly. With such competition we fear that many registrars will find it difficult to progress until the new limits on numbers have taken effect. These tight limits may not be comfortable for those responsible for providing a service with resources that are already inadequate, but the time is overdue for recognising the primary purpose of the training grades.

Most readers should already know of a change in the regulations from the Joint Committee on Higher Medical Training (JCHMT) that could reduce the number of years in the training grades for at least a few of those who aspire to a career in hospital medicine. Until now a minimum of three years was required for general professional training before entering specialty training which currently extends for six years in cardiology. From 1 January 1993 the duration of general professional training may be shortened to a minimum of two years for those who acquire the MRCP (UK) or (Ireland) or equivalent during that period.

Contracts

Many colleagues will be experiencing the problems that are now arising between purchasers and provider units as contracts become completed little more than half way through the financial year. The difficulties are formidable. The purchasers themselves face severe financial constraints. Many contracts were negotiated on the basis of activity levels in 1989-1990 when some units were working below capacity in an attempt to 'balance the books' before the internal market came into existence. Moreover, many cardiac centres have over-performed in response to their block contracts partly because inadequate provision had been made for the needs of the community. On completion of the cardiological part of a block contract, provider units may offer to provide extra activity at cost, but the purchasers may be unable to accept even this offer because of lack of funds. Confusing and conflicting information is sometimes passed to the clinicians who have responsibility for clinical care. They may well share with patients the feeling of being caught in unpleasant cross fire. We have received reports of meetings between clinicians and purchasing authorities to discuss the consequences of inadequate estimates of service needs. Some but not all of these meetings have been very constructive, and potential problems are in the process of being resolved or averted: the workload for the remainder of the financial year may yet be renegotiated with flexibility on both sides. It seems that clinicians may be advised to interrupt their busy schedules to talk to their Purchasing Authorities: the time may be well spent. Sound data that show the projected need for cardiological services may perhaps be used successfully to renegotiate contracts for the next financial year.

More on Björk-Shiley valves

We discussed the risk of fractures in convexo-concave valves in March 1991, February 1992, and September 1992. Cardiologists and cardiac surgeons will have noted minor inconsistencies between our data and those published elsewhere. American data, Dutch data, and United Kingdom data have differed in matters of detail, and moreover estimates of risk have

been updated as new information becomes available. In general the results of the United Kingdom valve analysis are similar to the recently published worldwide data. The main risk factors for strut fractures that have been identified worldwide are large size (especially 31 and 33 mm), mitral position, and weld dates between 1 January 1981 and 30 June 1982. But for five individual weld dates the fracture rate in the United Kingdom has been higher than expected from other analyses. The figures may not be representative because numbers are small, but we believe they should be made known. There are approximately 130 patients in the United Kingdom who still have implanted valves welded on these dates and who may be potentially at higher than average risk. The worldwide total of valves welded on 25 June 1981 was 285 with a total of four failures; in the United Kingdom there were 31 implants and three have failed. For welds of 20 October, nine of 190 have failed worldwide but the United Kingdom total is three of eight. For welds of 3 December 1981, two of 284 have failed worldwide but the United Kingdom has had two of 22. For welds of 17 May 1982 six of 246 have failed worldwide but the United Kingdom has had five of 63. Finally for welds of 19 May 1982, three of 331 have failed worldwide but the United Kingdom has had three of 35. The interval between implantation and failure has ranged from one day to nearly 10 years. These data will be considered carefully in centres where the serial numbers of implanted valves are known. (Weld dates can be obtained from the company if serial numbers are available.)

News of our Societies

Our premises at 9 Fitzroy Square achieved near full occupancy in January. The Resuscitation Council of the United Kingdom took space in the rear room of the top floor and we also welcomed the Association of British Neurologists into the front of the top floor. By the time this newsletter appears we will have at the front of the building a plaque carrying the name and logo of the Society. The three magnificent fireplaces that were stolen from the building before we moved in have been replaced. We are planning to restore the interior of the building in a style appropriate to its period. This will be expensive, but we hope to obtain financial help and sponsorship. Plans are already under way.

The November teach-in arranged by Michael Davies on atherogenesis was very successful, and places were all taken a week or so before the event. Members should book now for the next in the series. Andrew Henderson is arranging a teach-in on "Endothelium for Cardiologists". This is to take place at the British Cardiac Society on 23 March—at 10 am to 4 pm as usual. It is another important hot topic. Book now if you want to avoid disappointment.

The next scientific meeting of the British Cardiovascular Intervention Society (BCIS) will be held at St Mary's Hospital, London on Friday 26 February. Further details are being sent to all members of BCIS. The British Society for Cardiovascular Research will be having its Spring meeting at Churchill College, Cambridge on 29 and 30 March. Peter Weissberg is the principal organiser. The topic of the meeting will be biology of the vascular wall. The British Cardiac Society lecturer will be Professor LT Williams from San Francisco; other

speakers will include Professor G Gabbiani from Geneva, Dr P Babij from University College London, Dr I Charles from the Wellcome Research Laboratories, Dr A P Davenport from the University of Cambridge, Dr G Evans from ICRF, Dr A Newby from Cardiff, and Dr NJ Samani from the University of Leicester. Members of the British Cardiac Society will be welcome.

News from Europe

Philip Poole-Wilson writes as follows. "The Congress of the European Society of Cardiology in 1994 will be in Berlin from Sunday 11 September to Wednesday 14 September. This is to be a joint congress between the International Society and Federation of Cardiology (ISFC) and the European Society of Cardiology (ESC). Because the meeting is also a world Congress it is expected that attendance will be large. Berlin has a magnificent modern congress centre with ample exhibition space. A large number of abstracts are anticipated from all over the world. Posters will be given considerable prominence. The timetable of the meeting will be slightly different from that which is normally used for ESC congresses. Registration is on the Saturday and the meeting itself occupies the period from the Sunday until the Wednesday inclusive. A Joint Management Committee has been formed together with a special Executive Scientific Committee to take account of the joint nature of the meeting. For this congress only (Berlin 1994) the last day for the receipt of abstracts will be 1 December 1993. The final date for the receipt of suggestions for symposia by the Executive Scientific Committee will be 1 June 1993. Suggestions for symposia are sought from national societies, working groups of the ESC, councils of the ISFC, and the many heart foundations that are members of the ISFC. I hope there will be many proposals from the British Cardiac Society that will take account of the international nature of the meeting."

News of colleagues

We have been informed of the following new appointments recommended by advisory committees. David Spriggs has been appointed as consultant physician with an interest in cardiology to Northampton General Hospital (to join John Birkhead). Andy Petros has been appointed as paediatric intensivist with special responsibilities in echocardiography at Alder Hey Children's Hospital. These are both new posts. No appointment was made to another important new post after two applicants had been interviewed. We presume it will be re-advertised. This is the third successive month in which we have given news of committees that have felt it impossible to make a recommendation. Some additional information from the Royal College of Physicians may also be of interest. In the quarter from 1 July to 30 September a total of seven posts were advertised of which five were new ones. The average number of applicants was 6.7 and the average number interviewed was 2.8. Of those appointed, four were not accredited; they had been in post as senior registrars for an average of 2.5 years. We are grateful to the registrar's department for giving us this information.

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