PROCEEDINGS OF THE CARDIAC SOCIETY OF GREAT BRITAIN AND IRELAND

The EIGHTH ANNUAL GENERAL MEETING of the Cardiac Society of Great Britain and Ireland was arranged to be held at University College Hospital Medical School, London, on Thursday, July 20, 1944, under the Chairmanship of Sir Thomas Lewis, F.R.S.

Early in July a majority of the Council decided reluctantly that this meeting should not be held.

PRIVATE BUSINESS

The following private business was conducted by postal vote with the written approval of 23 ordinary members, no members objecting.

1. The minutes of the last meeting were printed in the Journal (5, 238, 1943).
2. The accounts, held over for audit and approval, showed a balance of £40 7s. 5d. The Council had decided that no subscription should be collected for the year 1944/45.
3. The Secretary, on the recommendation of the Council, was re-appointed for another year and William Evans was again asked to act as Assistant Secretary.
4. Four Ordinary Members were elected as Extra-Ordinary Members.
   A. G. Gibson
   Donald Hall
   W. E. Hume
   H. J. Starling
5. The following new Members were elected:—
   Ordinary Members
   Janet Aitken
   Doris Baker
   Associate Members
   D. R. Cameron
   J. R. B. Hern

Six Associate Members were re-elected for another period of three years.

6. Subsequently, by postal vote, A. A. F. Peel, Glasgow, and B. T. Parsons-Smith, London, were elected members of the Council for the years 1944–48.

7. The Secretary reports the following events and decisions of the Council as he was unable to bring them before the Meeting.
   (a) He had written on behalf of the Society to the relatives of Frederick John Poynton, Honorary Member, whose obituary notice had been published in the Journal (6, 96, 1944).
   (b) In accordance with the decision of the last General Meeting, the Secretary had approached the British Pediatric Association, who had agreed that their Committee and the Committee of the Cardiac Society should meet together to try and draw up a combined report on The Care of Rheumatic Children. The draft report was produced later in the year and certain modifications were made in this by the Executive of the B.P.A. The Council of the Cardiac Society at its meeting on March 22, 1944, discussed this report and asked the Chairman, Sir Maurice Cassidy, and the Secretary, Maurice Campbell, to accept the invitation to attend the meeting of the Executive of the British Pediatric Association, with authority to propose and accept minor changes within certain limits discussed by the Council. The Chairman and Secretary attended this meeting on March 25, 1944, and agreement was reached to publish the document as a joint report by the Cardiac Society and the British Pediatric Association. British Heart Journal (1944), 6, 99.
   (c) The Royal College of Physicians had asked the Cardiac Society to appoint a member to serve on the Committee for the revision of the Nomenclature of Diseases and the Council had appointed Maurice Campbell. Subsequently the R.C.P. Committee asked the Cardiac Society to appoint two members to help with the revision of the
PROCEEDINGS OF THE CARDIAC SOCIETY OF
section on Diseases of the Circulatory System, and the Secretary with the approval of
the Chairman submitted the names of John Parkinson and Maurice Campbell.

(d) The Memorandum on Rehabilitation of Cardiac Patients was further considered by the
Council, and with further modifications was approved for publication at the Council
Meeting on March 22, 1944. The Secretary was instructed to send it for publication to the British Medical Journal (April 22, 1944) and to the Lancet. It is reprinted below.

PUBLIC BUSINESS
The proposed programme of Public Business was as follows:—

DISCUSSION
DISEASES OF THE PERICARDIUM
Opened by Terence East, Bruce Perry, John Parkinson, and Tudor Edwards

DEMONSTRATIONS
SPECIMENS OF NORMAL AND PATHOLOGICAL A-V CONDUCTION
Sir Thomas Lewis

A CASE OF AORTIC ANEURYSM, SUCCESSFULLY WIRED
Geoffrey Bourne

SHORT COMMUNICATIONS
A CASE OF TUBERCULOUS PERICARDITIS
Leslie Cole
(Published in full; p. 185)

THE ACTION OF INTRAVENOUS DIGOXIN
J. McMichael and E. V. Sharpey-Schafer

ELECTROCARDIOGRAMS OF A DYING HEART AFTER CORONARY THROMBOSIS
T. F. Cotton

CARDIAC ENLARGEMENT WITH BRADYCARDIA IN RECRUITS
Crighton Bramwell

CARDIAC ENLARGEMENT IN ANEMIA
Alastair Hunter

THE NATURE OF PAROXYSMAL TACHYCARDIA
William Evans
(Published in full; p. 221)

SURGICAL TREATMENT OF PATENT DUCTUS ARTERIOSUS
Rae Gilchrist
(To be published in full; 7, p. 1, 1945)

TWO CASES OF MALIGNANT HYPERTENSION TREATED BY UNILATERAL NEPHRECTOMY
C. Bruce Perry

NOMENCLATURE OF CARDIAC DISEASE
Maurice Campbell
REHABILITATION OF CARDIAC PATIENTS

Many patients, those with fractures, for example, derive great help from efficient rehabilitation. Without it they may be handicapped for long periods; with it most of them may be enabled to undertake full activities and to resume their normal work. The success achieved in this direction has led to the suggestion that similar methods should be used more widely, and the Council of the Cardiac Society felt the time was opportune for expressing their views and bringing forward some questions for wider discussion.

Patients with heart disease are in rather a special category as regards rehabilitation. In the first place any activity, including walking or other forms of physical effort, must automatically increase the work done by the heart. If the patient is going to recover completely, e.g. after some temporary infection, cardiac recovery will often proceed pari passu with recovery from the infection and no more than simple graduated exercises may be needed to ensure it; in fact he may need limiting rather than encouraging in his rate of progress. In other cases complete recovery may be impossible, and it may be most important that he should not return to his previous work and activity.

Further, the correct diagnosis of the condition of the heart and especially of the heart muscle, and the correct assessment of the cardiac reserve are of fundamental importance, and harm may be done by too much or by too little activity at any particular stage.

In our opinion there is only limited scope for rehabilitation, as the term is now being employed, for patients suffering from organic cardiovascular disease. Physiotherapy and graduated exercise are, of course, useful, but must be supervised by a doctor with special knowledge of heart disease. The main problem is the decision as to how much general activity should be allowed, and this depends more on the success of the doctor in charge in diagnosis and assessment of the patient’s cardiac reserve than on the availability of skilled assistants in physiotherapy or occupational therapy. The need for suitable convalescent homes is, of course, generally accepted.

There are, however, cases in which the heart is temporarily under suspicion, which fuller investigation proves to be unjustified, e.g. systolic murmurs which the inexperienced may hesitate to disregard but the experienced are able to label as “insignificant.” In many such cases all that is necessary is for an authoritative opinion that the heart is normal and that the patient is, therefore, capable of leading a full active life, but in others rehabilitation may be needed. There is also scope for rehabilitation in the case of effort syndrome, which is at least as common in civil life as under service conditions, though here it may appear diagnosed as “cardiac anxiety state,” “traumatic neurasthenia” or “post-influenzal tachycardia.” But we suggest that the rehabilitation of these patients, whether by graduated exercises or by simple psychotherapy, should not be carried out at cardiac clinics, once it has been decided that there is no organic disease.

We suggest, therefore, that there should be more well-staffed and well-equipped out-patient cardiac clinics at general hospitals, preferably under the care of an experienced cardiologist. Here a correct diagnosis could be made, and the patient could be advised about suitable employment and be kept under observation when engaged in such employment. The help of the Almoner’s department would often be useful. If necessary the patients could receive specialized treatment that experience has shown to be more satisfactory in cardiac clinics, such as the treatment of auricular fibrillation with digitalis or of congestive failure with mercurial diuretics, or the control of symptoms of early angina.

Special difficulties may arise in finding suitable work for patients with some permanent limitation as a result of heart disease, and this is a problem that should be discussed. Many such persons, especially the younger ones with rheumatic heart disease, are precluded from those occupations which are most appropriate to their condition, e.g. Civil Service, Banking, and Insurance. They are, therefore, forced to take less suitable work for which no medical examination is necessary and in which their health may break down. Alternatively, they are out of employment and the nation is losing citizens who might give valuable service for a considerable number of years.

We recommend that where a patient is fit for particular work his acceptance should not be impossible because he has valvular disease which precludes his joining an ordinary life assurance scheme; it should be possible to make special arrangements for accepting such patients in some branches of the Civil Service, Banking, etc.

Another difficulty is with the older patient who is beginning to be incapacitated by early signs of failure or angina or by such lesions as hypertension, arteriosclerosis, or myocardial disease which may lead to failure if his previous employment is no longer suitable. Such a patient would often be
better at work and would like to be at work, but cannot find anything because he is not fit for the heavy work that he did before.

We recommend that there should be some industrial advisory board or government department, through which arrangements could be made to ensure that these partially disabled patients could obtain suitable work, after, when necessary, appropriate special training. Often this would not be necessary and the patients’ previous employers might be able to carry out the medical recommendations, especially if they were safeguarded against claims against them under the Employers’ Liability Act,* in the event of a breakdown of an employee known to be suffering from heart disease.

The special care of rheumatic children is being dealt with elsewhere in a separate memorandum.

MAURICE CASSIDY,  
Chairman.

MAURICE CAMPBELL,  
Secretary.

Cardiac Society of Great Britain and Ireland.

* It has been pointed out that the Workman’s Compensation Act should be referred to here.