There are problems too with the disparaging contrast of measures of prevalence with “the ‘hard’ data from the hospital admission for infarction.” Were routine strategies on hospital discharges as “hard” as all that, we in Dundee would not have had to commit as much time and effort as we have to their validation, with both Scottish and World Health Organisation MONICA studies, and we would not have been designated as a WHO Quality Control Centre and Collaborating Centre for estimates of cardiovascular epidemiology for training and methodology in this area. Equivalent validation work is also being done in the USA in the ARIC study.

The penultimate paragraph appears to be suggesting that we are accusing physicians of systematic misdiagnosis, and then goes on “It is irresponsible for epidemiologists to present incomplete and not fully developed observations and theories because publication of such ideas in a clinical journal implies that they should be incorporated into clinical practice.” Even out of context the statement is extraordinary if you analyse it. What are referees and editors responsible for? Where is the epidemiologist, or the clinician, who thinks that epidemiological survey methods are both necessary and sufficient for clinical diagnosis of surgical disease.

There is nothing incomplete or undeveloped about either the theoretical basis of the paper or the observations. The findings were presented to the International Epidemiological Association in Helsinki in 1987 and to the European Congress of Cardiology in Vienna in 1988, to critical acclaim, before submission to the British Heart Journal in 1989. The question to which we address ourselves is to ask what is the clinical relevance of well-conducted epidemiological and survey work. Variations in coronary heart disease mortality could correlate with morbidity (and therefore the need for clinical services) and with sudden cardiac death alone, largely inaccessible to clinicians. That mortality and morbidity do indeed correlate is of great importance to clinicians in areas of high coronary heart disease mortality. The resources are not commensurate. Clinicians frequently leap across from mortality rates to the need for clinical services. In this case an epidemiological study has provided essential stepping stones.

We apologise for inadvertent offence caused to the authors by the editorial. If an implication could have been drawn that the authors were attempting to apply epidemiological methods to clinical practice, we know this not to be the case.

Cardiac catheterisation with 5 French catheters

Sr,—I should like to comment on the article by O’Sullivan et al (British Heart Journal 1990;64:211–3). They cited a recent paper by Kohli et al in which the quality of coronary angiograms obtained with 5F and 7F catheters was compared in the same group of patients. 1 They concluded that “the conventional 7F coronary catheter appears to be superior to the 5F catheter in regard to diagnostic accuracy and image quality because of the higher flow rate possible with the former, allowing greater coronary filling. Also, while high flow may be possible in 5F catheters, thinner outer walls may compromise coronary flow.” However, at least two sets of large angiographic studies and the frequent incidence of non-diagnostic angiograms in patients using 5F catheters, angiographers must be aware that in some patients it may be necessary to up to larger catheters.

Brown and MacDonald reviewed 100 cases in which 5F catheters were used and encountered such a major problem of engagement and stability for the right coronary artery with the Judkins curve that they abandoned it after their first six cases and used a modified right coronary Amplatz catheter. 2 These workers, however, thought that the 5F catheters were easy to manipulate as bigger catheters. They also had difficulty in entering the left ventricle with a pigtail catheter until they changed their technique. With these modifications they thought the 5F catheters were satisfactory and have continued to use them as standard for day case catheterisation.

Molajo et al conducted a formal prospective randomised trial comparing 5F and conventional 8F catheters in 34 patients. 3 They concluded that “the 8F catheter is more manoeuvrable and thus reduces x-ray dose received by both patient and investigator. Furthermore, the superior torque (5F) catheter neither reduced the time to achieve haemostasis after catheterisation, nor the incidence of bruising. It produced poor quality left ventriculograms.”

As recently as June 1990, in a study of early ambulation after coronary arteriography, Kern et al used special large lumen 5F catheters to overcome these previously noted problems and obtained a significantly lower rate for coronary occlusion with a limited range of catheter shapes and seemingly without loss of angiographic quality. 4 They did not experience diminished torque control with their catheters.

In view of the differences of opinion in published reports we need a proper randomised study to compare the latest 5F catheters with traditional 7F catheters.

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A controlled trial of community based coronary rehabilitation

Sr,—We read with interest the excellent study of Bethell and Mullee (British Heart Journal 1990;64:370-5). In a large randomised controlled trial they showed both the safety and the benefits of a rehabilitation programme after infarction which included exercise training three times a week for three months.

As an index of physical fitness or of exercise capacity Bethell and Mullee use the peak oxygen uptake (V02 max) using the Astrand-Ryhming nomogram. Though the