BOOK REVIEWS

Cardiac Electrophysiology: a Textbook. Prepared in Honor of Brian F Hoffman.

Eds Michael R Rosen, Michiel J Janse, and Andrew L Wit. (Pp 1195; \$160.00.) Mount Kisco, NY: Futura Publishing Company, 1990. ISBN 0-87993-391-7.

We are all accustomed to seeing books that seem like the present volume but that consist of the proceedings of a meeting. There is a subtle and important difference here; while this book is a festschrift to Brian Hoffman, the contributions were collected beforehand and it has appeared within months of the gathering at which he was honoured. Hoffman had taught and indeed inspired many of the contributors and the central role of his unit at Columbia in diffusing the knowledge of cardiac electrophysiology is well recognised. It must give him considerable satisfaction to see how the basic concepts about which he and Paul Cranefield had written so helpfully more than 30 years ago in their *Electrophysiology of the Heart* have been explored in such considerable detail.

The editors are guilty of two acts of enthusiasm—in this excellent cause—that deserve a brief note. The subtitle “textbook” is not really appropriate for a collection of chapters of diverse origin which tend—helpfully—to overlap; and few students are likely to agree that it can be used as an introductory text to be read “cover-to-cover”: for all but those with some knowledge, that would be hard going.

These caveats should be set aside, and the book appraised for what it genuinely is, a superb collection of up to date expert contributions by most of the foremost figures in the field. It is an essential source book for basic scientists and cardiologists who seek well referenced material covering the knowledge that has been acquired over the last century, since Engelmann identified propagation of electrical excitation in cardiac muscle. Naturally, it focuses particularly on the understanding of normal and abnormal impulse generation and conduction made possible by the early microelectrode studies in nerve tissue performed by Hodgkin and Huxley just over 40 years ago. Chapters take you through new and old concepts and define terms that are now found in more general articles in current journals. Here you will find out all about reflection, as opposed to reentry; triggered afterdepolarisations, early and late, and their relevance to clinical events; parasytostole; ionic currents; neurohumoral factors; and much more. It is well indexed, the key topics are easy to find, and the explanations are there, though not always as easy to understand as the authors suggest. Perhaps the only redundant material is that on the clinical aspects of the management of arrhythmias, which is not to say that the relevant more basic sections elsewhere are unhelpful.

As one scans other publications that have the same coverage, it is difficult not to find them wanting in comparison with this book. Textbook or not, and introductory text certainly not, this is an unparalleled collection of important contributions that need to be published together. The developments in the field can now be drawn together: they may be hard

going for the clinical cardiologist, but looking at the progress achieved since Brian Hoffman and Paul Cranefield took us in the footsteps of the late Gordon Moe in 1960, we will find it helpful and indeed essential to use this book in order to keep aware of what is now accepted as well as of the directions in which knowledge is advancing.

DENNIS M KRIKLER

Lecture Notes on Cardiology. 3rd ed. Aubrey Leatham, Catherine Bull, and Mark V Braimbridge; with a chapter on electrocardiography by Derek J Rowlands and a section on echocardiography by Graham Leech. (Pp x + 342; £12.95.) Oxford: Blackwell Scientific Publications, 1991. ISBN 0-632-01944-1.

The third edition of this compact book, which was first published in 1967, has been extensively rewritten and provided with new illustrations.

By their nature, lecture notes have to be succinct and didactic. This requirement often makes for dull reading. This book continues with its original commitment to the application of physiological principles at the bedside or in the non-invasive cardiac department—each chapter starts with this approach and then moves on to consider the treatment, indications for surgical treatment, the surgery, and the results. This book thereby succeeds in making the reading interesting and educational. It gives sufficient information to allow an understanding of the various conditions discussed. It inevitably will disappoint the reader who is looking for help with a differential diagnosis or help with a management problem.

The text is liberally interspersed with excellent line drawing and illustrations of the relevant anatomy or investigations. It is a little disappointing that there are no examples of Doppler studies: the technique is discussed but there are no illustrations.

There are several excellent and comprehensive chapters. In particular, the chapters on electrocardiography, on congenital heart disease, and on disease of the thoracic aorta are very clear with good line drawings.

A major omission from this book is that of prevention of coronary artery disease. The first edition specifically excluded it because it was adequately considered in other books. The present interest in its role, the emerging good evidence of the possibility of reversing the disease process, and the huge advances made in the understanding of lipid metabolism and the role of platelets and the clotting factors should surely earn it a place in a book of this nature. The work “prevention” does not appear in the index.

My only other criticism is that it is perhaps sad that the United Kingdom Resuscitation Council guidelines were not mentioned in the chapter on cardiac emergencies. Some of the recommendations in this book are not entirely consistent with the guidelines.

Despite these criticisms, this book selling at £12.95, is very good value for money and will be very helpful to those looking for a succinct, soundly based, clinical approach to cardiology. It will be of particular use to those studying for their MB or at the membership level as well as to those physicians or general practitioners who need their knowledge refreshed.

D L H PATTERSON

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BRITISH CARDIAC SOCIETY NEWSLETTER

As avid readers of this newsletter will be aware the society recently established a Data Management Committee with John Parker as chairman. It has met on several occasions. Professor Peter Macfarlane has been an active member and has contributed much of the information that follows. One of the aims of the committee was to make suggestions for an agreed minimum cardiological data set that would facilitate audit, clinical control of contracts, and research. To this end, specific tasks have been allocated to members of the committee, who have undertaken to define data sets on cardiac care units, electrocardiography as applied to tracings recorded both at rest and during exercise, invasive cardiology, and cardiac surgery. Because the expertise of the committee cannot cover all areas of cardiology, other members of the society have been approached to help in the work. Assistance has been sought in matters relating to electrophysiology, echocardiography, and nuclear cardiology. Many more areas have yet to be discussed.

As with many new developments, other groups are active in the field even in relation to cardiology. We believe it is important to avoid unnecessary duplication of effort—so coordination with others, including a group under the aegis of the Royal College of Physicians of London, has become a high priority as specific objectives are defined. The committee has also sought liaison with others outside the specialty, and two invited speakers attended the most recent meeting in early July. These were Mr Gerry Gold, a consultant to the National Health Service Information Management Centre in Birmingham with responsibility for Common Basic Specification, and Dr James Read, director of the recently established National Health Service Centre for Coding and Classification.

The Information Management Centre and the National Health Service Centre for Coding and Classification are two of seven divisions of the Information Systems Directorate—the other five have responsibility for strategic planning, projects, implementation, statistics, and hospital information support systems (HISS). Rationalising and, where possible, standardising developments across the National Health Service (that have proceeded in a rushed and piecemeal fashion) is clearly a major task. Most members of the society who are not familiar with the new

information systems can be forgiven if they are confused by a plethora of terms that seem designed to hinder comprehension. But this is part of our new world, and it behoves us to attempt to understand it.

Dr Read was until very recently a full time general practitioner. His original ambition was to develop a set of diagnostic codes for use in general practice. But they were perceived to have a much wider application and they received such acclaim that he was encouraged to forsake general practice to become director of the Centre for Coding and Classification, which is based in Leicestershire. The Read code can be mapped on to the older systems such as ICD 9 and OPC 4 but the momentum behind the new method is such that it may well supersede these altogether in due course. It provides a dictionary that can already summarise clinical information in considerable detail: moreover, its structure lends itself to continuing development.

Each Read code has at present up to five characters. The code is hierarchical from left to right with each character offering progressively more detail. The first character defines the broad class, the second character the sub class, and so on. Each of the five characters may be a digit 0 to 9 or a letter a to z or A to Z. The letters i and o are excluded to avoid confusion with the digits 0 and 1. This still leaves over 650 million possible codes within the five character framework. An example illustrates the possibilities.

Level	Term	Read	ICD-9-CM
1	Circulatory system disease	G	390-459
2	Ischaemic heart disease	G3	410-414
3	Acute myocardial infarction	G30	410
4	Other acute myocardial infarction	G30y	410-8
5	Acute papillary muscle infarction	G30y1	410-8

Dr Read pointed out that the code was designed primarily to be useful for recording and retrieving clinical information and not specifically for grouping patients according to resource utilisation.

The Read approach allows coding of occupation, history and symptoms, examination and signs, diagnostic and laboratory procedures, and so on—as well as a wide range of diagnoses. In theory, most of the

medical record could be coded for ease of storage and retrieval, but the record itself will still be written in English by doctors. The reader will be relieved that we are not expected to face in the ward, catheter laboratory, operating theatre, or outpatient department a sheet composed of a long string of letters and numbers that have replaced ordinary language.

Thirty eight working groups are currently engaged in extending the Read codes. It seems clear that they will become a national standard. The Data Management Committee believe the British Cardiac Society should cooperate with the Centre for Coding and Classification to ensure that the Read classification and descriptive language benefit from the closest cooperation from the specialty. We hope that this objective can be achieved in association with others who have a legitimate interest. At some stage joint working groups may be needed to ratify proposals and to ensure that a wide consensus has been achieved.

We have more news of our plans to provide adequate identification cards for patients with valve replacements. The plan has now been approved by the Executive of the Cardiothoracic Surgeons of Great Britain and Ireland. The scheme will operate in cooperation with the valve registry kept by Professor Ken Taylor. A small committee has been set up with representation from cardiology as well as from cardiothoracic surgery, and cooperation is being sought from the valve manufacturers. We envisage that cards, probably similar to credit cards, will be given to every patient. These are likely to show the type and serial number of the valve, to identify the surgical centre, and to give the implantation date, as well as providing the usual demographic data. We hope this can be achieved without cost to the patient or additional expense for the centres.

Plans for the new registrar training programme are moving ahead slowly. Many of the regions have already adopted the lead given by the cardiologists and later by other specialties in making provision for three years' training at registrar level (we look forward to the abolition of the terms "registrar" and "senior registrar", because they are too closely associated with older concepts and thereby obscure the changes that must occur to meet modern needs). Manpower representatives of the major clinical specialties met, under the auspices of the Royal College of Physicians of London, with officers of three regional health authorities and discussed the way forward for the introduction of the new style posts, given the problems and constraints of the cuts in posts for career trainees imposed by the Joint

Planning Advisory Committee. We found great goodwill, and we were encouraged to believe that the problems associated with the changes can be overcome fairly quickly. More meetings will be arranged and more news will be forthcoming soon.

Finally, a reminder that the closing *postmark* date for abstracts for the American College of Cardiology (12 April to 16 April 1992, Dallas) is Friday 6 September 1991.

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NOTICES

1992

The Annual Meeting of the **British Cardiac Society** will take place at the Harrogate International Centre on 26 to 29 May. The closing date for receipt of abstracts is 3 January 1992.

The Arizona Heart Institute will hold its **International Congress V: Strategies in Endovascular Interventions** on 12 to 16 February in Scottsdale, Arizona. The deadline for submission of abstracts is 1 October 1991: Erika Scott, International Congress V, 2632 N 20th Street, Phoenix, AZ 85006 (Tel: 602 266 2200).

The **12th International Symposium on Intensive Care and Emergency Medicine** will be held at the Brussels Congress Centre on 23 to 27 March: Professor J L Vincent, Department of Intensive Care, Erasme University Hospital, Route de Lennik 808, B-1070 Bruxelles, Belgium (Tel: 32 2 526 33 80; Fax 32 2 526 45 55).

AAC '92 DALLAS TEXAS · APRIL 12-16

The **41st Annual Scientific Session and Exposition** will be held in Dallas, Texas on 12 to 16 April. The deadline for submission of abstracts is 6 September 1991: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20814-1699 (Tel: 800 253 4636-301 897 2693).