the performance of a myocardial revascularisation procedure (percutaneous transluminal coronary angioplasty or coronary artery bypass grafting) indicates that advanced coronary atherosclerosis is present. Provision of exercise training for these patients in the 1990s includes identification of the specific needs of that individual patient for the prescriptive exercise training and education and counselling to help to remedy the disease. Referral conditions for rehabilitative care may include a structured supervised program, exercise at home or unsupervised exercise, counselling by physicians and/or other health professionals, or the use of contemporary technological aids such as videotapes to guide home exercise or computer-interactive educational programs to provide information and counselling.1 Exercise training as prescription rather than prescription is often the point of entry to rehabilitative care that facilitates adaptation of health-related behaviors.

Education and counselling involve not only the provision of information but also training in the skills needed to improve health-related behaviors, practising these skills, and reinforcement of successful changes in coronary status. Appropriate provision of cardiac (coronary) rehabilitation includes selection of the relevant components and the method of delivery for an individual patient, definition of the outcome to be achieved, and delineation of the time frame within which this outcome is expected to occur.

Exercise training, designed to decrease activity-induced symptoms and improve functional capacity, should be evaluated by this outcome measure, rather than by any effect of exercise on coronary risk reduction, psycho-social status, or neurological status, in later research. Although improved survival was a goal of exercise rehabilitation in the early 1970s, contemporary medical and surgical treatments have improved outcome so much that any added intervention is unlikely to improve survival further. The benefits of supervised and unsupervised exercise have not been compared in a randomised fashion, but for low-risk patients to whom supervised modern intensity exercise training may be more easily adhered to than the higher intensity supervised exercise regimen, which produce more musculoskeletal discomfort and are less convenient, this requires evaluation. As noted by Dr. Lipkin (British Heart Journal 1991;65:237-8) the availability of risk stratification procedures and the documented efficacy of low intensity exercise permits this physician-directed exercise rehabilitation outside a structured supervised program.

"Formal" exercise programmes (that is, individually prescribed exercise with instructions and training) are appropriate for most coronary patients. However, supervised and particularly electrocardiographically monitored exercise rehabilitation should be limited to selected patients.

Improved psychological function as an outcome of rehabilitative care should be assessed only among coronary patients who have identified psychosocial problems and for whom specific interventions are recommended. It should not be expected to come simply from participation in an exercise regimen.

Unfortunately, the "usual" supportive care may not include adequate multifaceted education and counselling, which often require considerable time and specialised knowledge—teaching dietary modification is a good example of this. However, the specific goals set for each educational component can provide a standard against which to evaluate outcome.

Perhaps analysis of the benefits of cardiac (coronary) rehabilitation are hampered less by the heterogeneity of the patients than by the heterogeneity of the questions asked.2 An optimal regimen (rather than an inflexible programme) of rehabilitative care should be defined by the patient's physician, in consultation with the patient (and perhaps a patient advocate if a structured supervised programme is chosen). If suitable rehabilitative services are selected and the desired mode of implementation and expected outcomes are defined for each component, the validity and efficacy of rehabilitative interventions can be assessed.

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This letters were shown to the authors, who reply as follows: 

Str,-I agree with Professor Tavazzi's comments. We do tend to concentrate on physical rehabilitation because changes in effort tolerance are easier to measure than the psychological and emotional responses to the treatment, which often improve with improvement in physical exercise capacity. Whether one wishes to call the post-hospital follow-up and treatment course of patients "rehabilitation or prognostic evaluation and long term care" is arguable. I agree that the supportive care many patients require includes "vocational and psychosocial counselling". An optimal regimen tailored to the patient's requirements would be ideal as I mentioned in my editorial, but as Douglas Chamberlain and his colleagues recently commented it is obvious that cardiological resources in the United Kingdom are so restricted that at present this ideal might not be met.1

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BOOK REVIEW


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**Tom Treasure**

Two of the editors of this book, Alain Carpentier and Juan-Carlos Chaquies, surgeons from Hôpital Broussais in Paris reported, in 1985, the first clinical use of latissimus dorsi muscle to augment the left ventricle. The third editor, bioengineer Pierre Grandjean, has made a major contribution to the pacing systems required to train and drive the transplanted and transformed skeletal muscle. Among the 50 contributors are the best known names in this field—such as the anatomist, Salmons; his surgical collaborator for many years, Larry Stephenson; and Pette who described changes in phenotype expression of muscle. The major clinical contributors to cardio-myoplasty are represented and include Magovern’s group from Allegheny, and Jatene and colleagues from Sao Paulo, Brazil who, with the Paris surgeons have provided the major part of the world’s clinical use of the technique. The monograph is authoritative, comprehensive, beautifully produced, and readily available. It is based on papers presented at a Paris meeting in June 1989 at which there were about fifty patients. Papers from another international meeting in October 1990, from the same principal authors, reviewing double the number of patients, had already appeared in April 1991 in Seminars in Thoracic and Cardiovascular Surgery, months before this hardback volume was released. This book may be seen as a landmark but it does illustrate the difficulties, acknowledged by Alain Carpentier in his insightful foreword, of publishing in a rapidly changing field.

The title reviewed here is available from the BMJ Bookshop, PO Box 295, London WC1H 9YE. Prices include postage in the UK and for members of the British Forces Overseas, but overseas customers should add 15% to the price of postage and packing. Payment can be made by cheque in sterling drawn on a UK bank, or by credit card (MasterCard, VISA, or American Express) stating card number, expiry date, and your full name.

**BRITISH CARDIAC SOCIETY NEWSLETTER**

The last newsletter gave the up to the minute news of completion of our purchase of our own property, Square. By now, this appears we should be well settled in the new house. It is a fine Georgian building ideally suited to the new and expanding activities of the society. The offices of the British Heart Foundation have been moved into the second floor. There are three premises—an ideal arrangement given our close working relationship. Our affiliated societies and groups have all expressed an interest in making use of the new facilities. We have rooms large enough not only for all the committees but also for our planned teach-ins, and for workshops if plans for these are approved. Kitchen facilities are available so that catering requirements can be met without complications. A new catering staff has been appointed. We hope that the house will become a well integrated headquarters for all major activities relating to the British Cardiac Society. To achieve this we will, of course, require additional staff. Mrs Elaine Brown (our administrator), and Mrs Jenny Lodge (our assistant administrator and bookkeeper) have coped so far with all the affairs of the society—with the help of Larry Ryden—our secretarial work and surveys. We have enrolled a new part-time secretary in London, and further changes may follow if the workload grows. If any members of the society find they need support we hope they will call in: it is only minutes from the Royal College of Physicians, and from Regents Park, Great Portland Street, Stourton Square and Warren Street Underground Stations.

The meeting organised by the society on the developing internal market in cardiology and cardiac surgery was held at the Royal College of Physicians on 4 December. It was well attended with over 200 delegates; 40% were cardiologists or cardiac surgeons, 30% were managers from provider units, and 30% came from purchaser health authorities. The speakers included a regional director of public health, a health economist, five clinicians (of whom one was American), and representatives of the NHS Management Executive and the Department of Health.

The initial presentations dealt with the future management of regional specialties and with modelling of treatment patterns of coronary artery disease—with economic evaluation of outcomes. The experience of three clinicians was reported, and the requirements were discussed for refining case mix and coding for effective setting of contracts. The difficulties ahead seem formidable, and the market seems likely to be managed centrally for some time to come. The meeting finished with a session looking at supragovernmental specialties and clinical research. Their future was linked to the research and development initiatives that are being developed by the NHS Management Executive. A full report is being prepared—and should be a valuable source of information in a difficult and new area. We will let you know later how this can be obtained.

A meeting of representatives of the affiliated groups was held at the British Cardiac Society on 29 November. Representatives from the British Cardiac Society (BCIS), the British Paediatric Cardiac Association (BPCA), the British Society of Echocardiography (BSE), the British Nuclear Cardiology Group (BNG), and the British Pacing and Electrophysiology Group (BPEG) all expressed an intention for the groups to be recognised as part of the British Cardiac Society, while retaining their autonomy within the individual organisations. This position has not previously been defined in any formal way, and the word “affiliation” had been open to varying shades of interpretation. The societies agreed to conflation of their positions after appropriate discussions, but in the meantime they were invited to submit a statement of the support they may wish to receive from the British Cardiac Society. This task has to be undertaken with some urgency, so that we can make the best use of it. Possible financial support, record keeping, secretarial assistance, data collections with other groups, representation of all societies, management of any subscriptions, and space for small meetings and arrangements for large ones, printing, and publications—all these considerations were considered. The special position of the British Nuclear Cardiology Group was recognised; most of its members are not cardiologists. This was not seen as an overriding difficulty: this group can be affiliated under the same arrangements as the other groups.

Arrangements for the Harrogate meeting are almost complete. Dr Eugene Braunwald has agreed to give the Sir Thomas Lewis lecture. The Queen will be the next United Kingdom (how else these days do we say “European”?) judge for the Young Research Workers Prize; and we are planning a partners programme. Simultaneously with the programme, we will have—as an experiment—a session designed for state-of-the-art presentations designed to suit the needs of district hospital cardiologists.

We hear that some district hospital cardiologists have felt that the society does not cater adequately for their needs. If the society has shown a bias towards matters of concern to cardiologists in the major centres, this is not intentional. We believe that the impression reflects an earlier pattern of activities that were entirely appropriate when district hospitals had few specialist physicians, and that this view is increasingly outdated. If we can do more for district cardiologists—who face so much of the burden of heart disease—then please make suggestions; they will be welcome.

The news that the British Cardiac Society in Harrogate, some have already been widely discussed: that council should include a representative from paediatric cardiology and that the chairperson of the cardiology committee of the Royal College of Physicians and the society’s own Postgraduate Cardiology Advisor should also be on council. A more recent suggestion that also seems to have merit relates to the officers: that in future the president should serve for two years rather than three, and that the president-elect is also in post for two years. Thus there will always be five officers. While future presidents will still have a total of four years in office, the load will be more evenly shared.

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