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BRITISH CARDIAC SOCIETY NEWSLETTER

Changes within the Society

We are near the completion of the planned restructuring of the Society. In the past two years a system of committees was set up, a closer liaison was developed with the affiliated groups, a wider range of activities was adopted, and the new premises were purchased. We have now made an important new appointment. Patrick Fagan, CB, MBE will take up duties as executive officer of the Society from 1 September. Until recently, Patrick Fagan was Director General of Military Survey (as a Major General) with responsibilities to the Chiefs of the three armed services in relation to all forms of geographical information needed for maps, charts, and intelligence world wide. He directed a staff of 1500, of which 1000 were civilian. He is a London graduate (MSc) with diplomas in civil engineering, surveying, and photogrammetry. Patrick Fagan is a Fellow of the Royal Institution of Chartered Surveyors and a Fellow of the British Institute of Management. His wide interests are reflected in other activities. He is Vice President of the Royal Geographical Society, Chairman of the Mount Everest Foundation, and holds appointments relating to mountain sports and rugby. He has extensive international experience, and may be familiar to members because of frequent television appearances during the Gulf War. We welcome him to the Society and we are delighted with the new strengths that he will bring.

While we welcome one new colleague we are saddened to lose another. Elaine Brown, who has been our Administrator for five years, has decided to take the opportunity presented by the restructuring to seek new challenges. Elaine has contributed a great deal: her concerns for the Society and her loyalty to it have been a source of strength to us. With Jenny Lodge she has borne the heat of the day during the demanding organisational evolution and the physical moves of the Society. Her decision has therefore been a disappointment. We wish her well. We know that her interests in the well-being of the Society continue, and we hope that links will remain after she leaves at the end of July—several weeks before this newsletter appears.

Björk-Shiley valves

We mentioned the problem of strut fractures in some types of Björk-Shiley valves in our newsletters of March 1991 and February 1992. We regretted the anxiety for patients with valve replacements caused by the continuing publicity—though we accepted it was inevitable—and we discussed the MedicAlert proposals. Few then considered that elective replacement would be warranted. But the situation has continued to evolve as more information becomes available. The recent Dutch follow up study of 2303 patients published in February (*Lancet* 1992;**332**:257–61) raised the level of concern particularly for the 70°CC mitral valves that had a cumulative risk of outlet strut fracture of 17·4% over eight years. Younger patients were also at greater risk. Elective replacement was recommended by the authors for selected groups of patients with both 60° and 70° valves, but—mindful of the operative mortality—few units in the United Kingdom have adopted this policy so far. Confirmation (or otherwise) of the Dutch data became an urgent priority. Shiley have now released information that has been sent to all doctors in the United Kingdom based on re-analysis of their database with new definitions of risk groups particularly focusing on weld dates. The groups at highest risk (60°CC) show estimated annual fracture rates for size 33 mitral valves as follows: 2·52% for welds 1 July 1981 to 30 June 1982, 1·46% for welds 1 January to 30 June 1981, 1·08% for welds before 1 January 1980, and 1·08% for welds from 1 July 1982 to 31 March 1984. In addition, the size 31 mitral valves have an estimated fracture rate of 1·24% for welds from 1 July 1981 to 30 June 1982. The information, perhaps with slight update modifications, should be known to all cardiac surgeons and cardiologists well before this newsletter appears, and may also by then have been supplemented by data specific to the United Kingdom. Difficult decisions will have to be made. Two factors, however, should be borne in mind. First, the data are almost certainly an underestimate, since many patients with prosthetic valves die without recent expert review and without necropsy. Secondly, the often quoted average operative mortality figure for "re-do" mitral replacement of 10% is based upon series with severe complications such as endocarditis, valve dehiscence, and valve clot with complicating heart failure. We have no good data as yet for elective re-operation but mortality will be appreciably lower. We are aware from discussions with colleagues that many cardiac surgeons now accept the need for intervention in some patients. For those with the most vulnerable valves the risk of re-operation may be little or no greater than the risk of a fatal fracture within only two years. Cardiologists and surgeons will be keeping the matter under the closest review as more data, and more specific United Kingdom data, become available. (Early information suggests the failure rate in the United Kingdom may be lower than the overall figures, but the possibility of under-reporting is a concern.)

We have no available evidence that non-invasive tests can detect an early risk of valve failure, though there would be a great advantage to both patients and their professional advisers if one could be developed. Shiley has an active research programme in animals—and we know that progress is being made—based on sophisticated signal processing of relatively simple acoustic measurements and sophisticated radiographic techniques. Even if tests can be devised that have (alone or in combination) acceptable sensitivity and specificity we still face one major problem. Only one third of the CC valves inserted in the United Kingdom have been traced so far. Thus many patients may be unaware that they face potential risk. This problem is also being addressed vigorously through several different avenues of enquiry and the situation will doubtless improve.

Fenfluramine and primary pulmonary hypertension

Celia Oakley has written for the newsletter a follow up on this topic. "Events have moved on since the announcement at Harrogate of a survey of the possible association between fenfluramine and the development of primary pulmonary hypertension. I asked for retrospective information (rather like yellow card reporting) in order to get some idea of the likely numbers and would still like to have this information from colleagues. I am pleased to announce the establishment of an international prospective case control study on this matter. Cardiologists will be asked only to let me know by telephone of all newly diagnosed cases of primary pulmonary hypertension, whether or not there was any association with fenfluramine. They will then be asked to allow a visiting research registrar to examine the data, and to permit a trained interviewer to talk to the patient as well as to four control patients drawn from the patient's general practice. Permission will of course be sought from the general practitioner. This is an advance notice. Letters with further details will be sent to all members of the Society. The study has the blessing of the Committee on Safety of Medicines. The coordinating centre is at McGill University in Canada. In summary, all that is required of cardiologists is one telephone call to Celia Oakley on 081 740 3141."

Training programme

Arrangements for the new three-plus-three specialty trained programmes are progressing, and have started or been planned in detail in several Regions. We hope soon to report the results of discussions on the general medical component of the specialist programmes, but Brian Pentecost—as Medical Coordinator—has said that the Joint Committee on Higher Medical Training (JCHMT) is now prepared to look at all submitted training programmes in cardiovascular medicine for the first three year period. The individual limbs of a three year rotational programme cannot be viewed independently, but the JCHMT will make judgements on the complete three year programme. These will eventually be inspected together with the second (senior registrar) post within the same Region or cardiac centre. In the meantime, cardiologists who are planning for the new structure of training should submit details of agreed rotations to the JCHMT office. Many will have already done this when the new plans were first discussed, but no action will be taken by JCHMT unless up to date submissions are made.

Training log books

Members of the Society will have received in the last mailshot an application form for the British Cardiac Society Log Book for invasive and interventional procedures. These have been produced by the British Cardiovascular Intervention Society in association with the British Paediatric Cardiology Association and the British Pacing and Electrophysiology Group. Huon Gray has written for the newsletter: "It is directed mainly to those in training. The book allows brief details to be entered on all cases undergoing diagnostic cardiac catheterisation, interventional procedures, pacing, and electrophysiology. This should provide an excellent personal record for those training in the cardiac catheter laboratory, and trainees are encouraged to apply for their own copy. As many, if not the majority, of trainees who will require the log book will not yet be members of the Society, it would be helpful if the application forms were circulated within cardiac departments to all registrars who might be interested in obtaining one. The application forms

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are also available from the British Cardiac Society, which has funded the project."

Royal Medical Benevolent Fund
Members who attended the Harrogate meeting will have seen the display stand for the Royal Medical Benevolent Fund (24 King's Road, Wimbledon, London SW19 8QN. Tel: 081 540 9194). Perhaps few—other than senior members from St George's—will have recognised Mrs Judith Leatham who is a devoted member of the fund and who was on the stand for much of the time. There was also enthusiastic participation by the local guild of the Royal Medical Benevolent Fund. We have had a letter of thanks from the chairman, Dr JW Brooke Barnett. He wrote "Many doctors are unaware of the existence of the professions's leading charity which helps nearly 700 doctors and their dependants each year. It was, therefore, very fortunate that for the first time the British Cardiac Society at its annual meeting in Harrogate this year allowed the Royal Medical Benevolent Fund to be represented. The distribution of grants to doctors and their families in distress exceeds the income from the traditional means of collecting money for charities by covenants, subscriptions, and fund raising activities." A large number of members and guests requested information, and we hope they will continue to support a charity that is very much our own.

News from Europe
Philip Poole-Wilson is writing a series of short articles to increase our familiarity with the European Society of Cardiology. "To some members of the British Cardiac Society, the European Society of Cardiology may appear as a large, distant, and amorphous body. That image partly arises because of the size of the Annual Congress which is the major annual event organised by the Society, and partly because its activities may not be well known. A newsletter is being sent to all members of the European Society of Cardiology in an endeavour to improve communications and make members aware of developments in European cardiology. We hope that it will be sent twice each year. By now the first one has probably arrived.

The 1991 Congress in Amsterdam attracted 13 151 registered persons of whom 9308 were active participants from 76 countries. The numbers have increased steadily over the last few years. The size presents enormous difficulties to the organisers. Only a few places in Europe can provide sufficient lecture theatres, exhibition space, and hotels. The aim is to have the congress in the last two weeks of September. That has proved difficult, but the board is aware of problems with holidays and schooling. In 1996, the annual Congress will take place in Birmingham (August 25 to 29). If that is a success Birmingham may become a regular site for future meetings into the next century.

The European Society of Cardiology is made up of 32 national societies and 24 working groups. Anyone who is a member of the national societies is also a member of the European Society of Cardiology. A few additional persons are members of the European Society of Cardiology through the working groups. That arrangement particularly applies to non-medically qualified persons and scientists. The total membership is now more than 16 000. The population covered by the cardiologists who are members is in excess of half a billion. Although there is complete intermingling of functions amongst cardiologists, in broad terms the national societies represent the profession and the working groups represent cardiologists and scientists with an interest in a particular facet of cardiology. The working groups are: exercise physiology, epidemiology, pathophysiology, valvular heart disease, drug therapy, computers in cardiology, myocardial function, peripheral circulation, nuclear cardiology, anatomy and pathology, microcirculation, thrombosis, echocardiography, rehabilitation, arrhythmias, hypertension, cardiac pacing, myocardial and pericardial disease, coronary circulation, grown-up congenital heart disease, electrophysiology, atherosclerosis, pulmonary circulation, and cardiovascular nursing.

If you wish to become a member of these working groups (and you are encouraged to do so) please write to the appropriate chairman. The names and addresses can be found in the pink pages at the back of the *European Heart Journal*." More from Europe next month . . .

News of colleagues
Appointments recently (subject to the usual ratification) have included Thomas Marwick as senior lecturer and honorary consultant at St Mary's Hospital Medical School and John Morgan as consultant cardiologist at Southampton General Hospital. For the single quarter from January to March 1992 a total of nine appointments were made in cardiology in England and Wales—more than in any other medical specialty. 1992 was expected to be a bleak year for new consultant appointments, because only two retirements were planned. We hope that new posts will continue to be created, but there seems little prospect of avoiding a dearth of fully trained senior registrars over the next few years.

News of meetings
Steven Walton, chairman of the British Nuclear Cardiology Group, has asked us to give notice of a one day symposium on "The Assessment of Myocardial Viability that will be held on 18 September 1992 at St Thomas' Hospital. The programmed sections and speakers are as follows: biochemistry (Dr P Garlick, UMDS: electrocardiography (David Mulcahy, Royal Brompton); rest-stress echocardiography (John Chambers, UMDS); nuclear medicine (Professor J McKillop, Glasgow); MRI/CT (Dr D Pennell, Royal Brompton); and PET Scanning (Professor J Melin, Louvain). Further details may be obtained from Dr T Nunn, Department of Nuclear Medicine, St Thomas' Hospital, London SE1 7EH (tel: 071 928 9292, ext 2163)."

Huon Gray writes "The winter meeting of the British Cardiovascular Intervention Society (BCIS) will be held in Southampton on Thursday afternoon 24 September and all day Friday 25 September 1992. Further details regarding the meeting have been distributed to members of BCIS."

Members have first priority for the limited places at our teach-ins, but applications are open to non-members from two months before the event. Those members wishing to ensure reservations for "Emerging Concepts in Atherogenesis" arranged by Michael Davies for 10 November should telephone the office by the middle of September. The Workshop on Preventive Cardiology organised by David Wood is booked for 14 October.

DOUGLAS CHAMBERLAIN
President, British Cardiac Society,
DUNCAN DYMOND
Secretary, British Cardiac Society,
9 Fitzroy Square,
London W1P 5AH

NOTICE

The 1993 Annual Meeting of the **British Cardiac Society** will take place at the Wembley Conference Centre from 18 to 21 May.

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