LETTERS TO
THE EDITOR

The British Heart Journal welcomes letters
commenting on papers that it has published
within the past six months.

All letters must be typed with double spacing
and signed by all authors.

No letter should be more than 600 words.

In general, no letter should contain more
than six references (also typed with double
spacing).

Answers to complex questions cannot
be derived from "simple" trials

SIR—Much can be learnt from the compari-
don drawn by Topol and Calif in between
mega-trials and mini-trials (British Heart
Journal 1992;68:548-51). The ideal mega-
trial should have the capacity to address
simple questions prospectively and univoc-
ally, as well as the ability to provide tenta-
tive answers to complex problems by
retrospective analysis. For instance, the
unequivocally beneficial effects on survival
emerging from the CONSENSUS trial1 ini-
tially obscured the fact that the dose regi-
mens employed could have adverse effects
on diuretic requirements. Almost by
default, this led to the belief that the co-
-prescription of angiotensin-converting
enzyme inhibitors generally resulted in an
increase in diuretic requirements,2 despite
evidence to the contrary emerging from at
least one "mini" study.3 It only emerged from
retrospective analysis that dose-dependent
hypotension was an important factor in
determining the renal response (and hence
the diuretic response) to co-prescrip-
tion of enalapril during the maintenance
phase of treatment.4 We now know that in
other states of fluid overload, such as cir-
rhosis with ascites, co-prescription of a
mean daily dose of 20-6 mg captopril has a
diuretic-sparing effect that is not evident at
higher doses.5 This paradoxical relation
between natriuresis and captopril dosages
does have been demonstrated in chronic
heart failure as well.6 These examples justify
the conclusion that, despite the increasing
popularity of the mega-trial, the mini-trial
(or even the mini-study) remains an "excel-
ient means of establishing drug dosing".

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1 CONSENSUS Trial Study Group. Effects of enalapril on mortality in severe
congestive heart failure: Results of the Co-operative North Scandinavian
2 Good I, Frost G, Oakley CM, et al. The renal effects of dopamine and dobutamine in
3 Drua VJ, Colucci WS, Williams GH, et al. Sustained effectiveness of converting
4 Ljungman S, Kiechhus J, Swedberg K, et al. Renal function in severe congestive heart
to furosemide and propranolol in patients with decompensated liver disease during
augmented by ultra-low-dose captopril in chronic heart failure. Circulation
7 Topol EJ, Calif RM. Answers to complex questions cannot be derived from "simple" trials.

Cardiac surgery: moving away from intensive care

SIR—The Oxford group have reported their efforts to minimise the costs of cardiac
surgery by reducing the need for postoperative intensive care (British Heart

Execlusive postoperative management of cardiac surgical patients in a
general recovery area as opposed to an intensive care unit has been mooted
and there is little doubt that certain patients do not require intensive care facilities.
On the basis of 245 patients treated over a four month period the Oxford group conclude
that "over 90% of patients undergoing cardiac surgery would recover safely and
be treated effectively in a more economical area than intensive care."1

This conclusion raises two important questions: (a) can it be extrapolated to all
cardiac surgical units in the UK and (b) should it be the basis of future planning
of postoperative care facilities for cardiac surgical patients? The answer to both questions
lies in the tacit understanding that the demographic features of the Oxford surgical
population are representative of those of the UK as a whole and that these features
are unlikely to change in the future. Is this valid?

To enable comparison between cardiac surgical populations Parsonnet and col-
leagues have described a simple method of
categorising patients into various risk groups that is highly predictive of operative mortality,
postoperative complications, and duration of hospital admission.2 Of particular
importance was the finding that patients greater than 70 years, ejection fraction lower
than 30%, redo operations, pulmonary artery pressure greater than 60 mm Hg
for mitral valve surgery, aortic gradient greater than 120 mm Hg for aortic valve
surgery, morbid obesity, diabetes, and hypertension.

Little of this information is present in the Oxford results, making comparison with
other units difficult. The fact that only 55% of the Oxford patients undergoing coronary
revascularisation received an internal mammary artery graft, compared with a UK
average of almost 70%, suggests that their practice is not identical.

There is an absence of British3 and American* evidence that with the success
of cardiac surgery and the growth of inva-
sive cardiological procedures an increasingly elderly population is being investigated
and referred for cardiac surgery. Apart from advanced years this population is more likely
to require emergency or redo surgery or both, to have poorer left ventricular function
and more severe medical disease and to have a greater prevalence of other dis-
eases.4 In addition to an increase in mor-
tality and morbidity there is a greater
demand for intensive care facilities includ-
ing prolonged ventilatory support in up to 16% of such patients.5

Though the Oxford group are to be con-
gratulated on their efforts to reduce the overall costs of cardiac surgery, clinical
safety must remain of paramount importance.

Walter Lewis

1 Aps C, Hutter JA, Williams BT. Anaesthetic management and postoperative care of cardiac
2 Parsonnet V, Dean D, Bernstein AD. A method of uniform stratification of risk for
evaluating the results of surgery in acquired aortic heart disease. Circulation
1989;79(suppl 1):3-12.
3 Livesey S, Caine N, Spiegelhalter DJ, English TA, Wallwork J. Cardiac surgery for patients aged 65 years and older: a long term survival analysis. Br Heart J
1990;64:480-4.
1988;78(suppl 1):179-84.
6 Salomon DM, Page S, Bigelow JC, Krause AH, Okes JE, Metzdorf MT. Coronary artery bypass grafting in elderly patients. Comparative results in a consecutive series of

NOTICE

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

BRITISH CARDIAC SOCIETY
NEWSLETTER

Cardiological technicians and NVQs

We hope that members of the Society will
read this section with care because it has
considerable relevance to the role and needs
of our departments. Cardiologists rely
increasingly on the expertise of technicians,
as diagnostic methods and treatments in
cardiology become ever more complex. The
Society of Cardiological Technicians has
played a leading part in training

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