Acronym aggravation

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

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

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

A cronym stands for Clifton, or Clifton Island, or Clifton Hill. The authors of reference 1 referred to another article in which I finally found the derivation of the acronym. CARDIA is an approximate acronym for Coronary Artery Disease Risk Indicator.

The use of acronyms in medical articles is to be avoided, especially in the abstract. A list of acronyms should be provided in the body of the article. Acronyms are often necessary but may sometimes be quite frustrating if you do not know what they stand for. That is why I recently prepared a list of acronyms of major clinical trials (table), which is currently being updated. Acronyms can sometimes cause confusion, because several trials share the same acronyms—for example CATS, PACT, and TIPE.

The authors of this article used the acronym CARDIA without explaining it. Your Notice to Contributors clearly says that abbreviations should not be used in the text. The same rule should apply to acronyms. According to the International Committee of Medical Journal Editors, a full term for which an acronym stands should precede its first use in the text. Perhaps Savage and Saad justified not explaining the acronym CARDIA by referring to an earlier publication, their reference 20. Unfortunately there was no explanation of CARDIA in that reference either.

Acronyms of Major Cardiologic Trials

ACME (Angioplasty Compared to Medicine)
AFASAK (Atrial Fibrillation, Aspirin, Antikoagulation)
AFTR (Anistreplase Following Thrombolysis Effect on Reocclusion)
AILCA (Accidents Ischémiques Cérébraux liés à l'Atherosclérose)
AIMS (APSC Intervention Mortality Study)
AIRE (Acute Infarction Remipril Efficacy)
AITA (Aspirin in Transient Ischemic Attack)
AMIS (Aspirin in Myocardial Infarction)
AMPJ (APSC in Acute Myocardial Infarction Placebo-Controlled Investigation)
ANBP (Australian National Blood Pressure Trial)
APRICOT (Antithrombotics in Prevention of Reocclusion in Coronary Thrombosis)
APRICOT (Aspirin vs Cumarin Trial)
APSI (Acute Pulmonary Embolism Secondary Infarct Study)
APSIM (APSC in the Infarctus du Myocarde)
APSIS (Angina Prognosis Study with Isoprot and Seloken Trial)
ARIC (Atherosclerosis Risk in Communities Study)
ARIS (Anturane Reinfarction Trial)
ART (Anturane Reinfarction Trial)
ASK (Australian SK Trial in Stroke)
ASPECT (Anticoagulants in Secondary Prevention of Events in Coronary Thrombosis)
ASPS (Australian Swedish Pridolol Study)
ASSET (Anglo-Scandinavian Study of Early Thrombosis)
ATACAS (Antithrombotic Therapy in Acute Coronary Syndromes)
ATEST (Atenolol and Streptokinase Trial)
ATTAIS (Anturane Transient Ischemic Attack Italian Study)
BAATAP (Boston Area Anticoagulation Trial for Atrial Fibrillation)
BARI (Bypass Angioplasty Revascularization Investigation)
BEST (Beta-Blocker Stroke Trial)
BHAT (Beta-Blocker Heart Attack Trial)
BIRN (Belgian Interuniversity Research on Nutrition and Health)
BRHS (British Regional Heart Study)
BWIS (Baltimore Washington Infarct Study)
CABRI (Coronary Artery Bypass Revascularization Investigation)
CAFA (Canadian Atrial Fibrillation Anticoagulation Study)
CAMIAT (Canadian Amiodarone Myocardial Infarction Arrhythmia Trial)
CAPHY (Captopril Primary Prevention in Hypertension)
CAPRIE (Clopidogrel vs Aspirin in Patients at Risk of Ischemic Events)
CAPS (Cardiac Arrhythmia Pilot Study)
CARDIA (Coronary Artery Risk Development in Young Adults)
CARPORT (Coronary Artery Restenosis Prevention On Repeated Thrombolyse and Antagonism)
CASH (Cardiac Arrest Study Hamburg)
CASS (Canadian Amodipine Atenolol in Silent Ischemia Study)
CASS (Coronary Artery Surgery Study)
CAST (Cardiac Arrhythmia Suppression Trial)
CATS (Canadian American Ticlopidine Study)
CATS (Captopril and Thrombolyis in Myocardial Infarction Study)
CDP (Coronary Drug Project)
CECC (Confidential Enquiry into Cardiac Catheterization Complications)
CEDIM (Italian Study on 1-Carnitine and Digital Echocardiography in Myocardial Infarction)
CITO (Collaborative Italienne par la Thrombosi in Ortopedia)
CLAS (Cholesterol Lowering Atherosclerosis Study)
CLIP (Cholesterol Lowering Intervention Program)
CONSensus (Cooperative North Scandinavian Enalapril Survival Study)
CORIS (Coronary Risk Factor Study)
CRAFT (Catheterization Rescue Angioplasty Following Thrombolysis)
DART (Diet and Reinfarction Trial)
DAVIT (Danish Verapamil in Myocardial Infarction Trial)
DIMT (Dutch Iopamidone Multcenter Trial)
DLS (Diloxan Reinfarction Study)
DUCCS (Duke University Clinical Cardiology Studies)
Dutch IRS (Dutch Invasive Reperfusion Study)
DVT (Danish Verapamil Trial)
EARS (European Atherosclerosis Research Study)
EAST (Emory Angioplasty Surgery Trial)
ECCOMAC (European Coordinated CoCommunity Action Programmes)
ECAT (European Coordinated Action on Thrombosis and Disabilities)
ECATAP (ECAT Angina Pectoris Trial)
ECTIM (Etude Cas-Temoins sur l'Infarctus du Myocarde)
ECG (European Cooperative Study Group)
ECG (European Coronary Surgery Study)
ECG (European Carotid Surgery Trial)
EIS (European Ischemic Heart Disease Study)
ELCA Registry (Excimer Laser Coronary Angioplasty Registry)
EMERAS (Estudio Multicenter Estreptocinquinasa Republicas Americas Sud)
EMAT (European Myocardial Infarction Amiodarone Trial)
EIMP (European Myocardial Infarction Project)
EMPAR (Enoxaparine Maxima Prevention of Angioplasty Restenosis)
EMS (European Multicenter Study)
EPPI (Etude de Prescription Post Infarctus)
EPSIM (Encuesta de Prescripcion Secundaria de l'Infarctus del Myocarden)

We apologise for not following the recommended practice of spelling out all acronyms at the first mention in Savage and Saad’s editorial. Many of the articles that are submitted to the British Heart Journal for publication use acronyms without explanation. Like the authors of these articles and many speakers at meetings we share a tendency to drift away from best practice. We thank Dr Cheng for drawing attention to our lapse and for supplying overwhelming evidence (in his list reproduced with permission of the American Journal of Cardiology 1992;70:1512–4) why authors and speakers must spell out all acronyms at the first mention. —EDITOR
Monitoring myocardial damage in cardiac surgery by troponin T detection

Sir,—Perioperative myocardial injury remains the most common cause of death in cardiac surgery. The need for new diagnostic criteria to assess the comparative efficacy of different myocardial protection techniques prompted us to identify reliable markers of myocardial necrosis. Katus et al reported that the serum concentration troponin T, a cardiосpecific protein, reliably detects myocardial cell necrosis in patients undergoing myocardial revascularization.1 We assayed troponin T (ELISA, Troponin T, Boehringer Mannheim) in 40 different patients of whom 34 underwent coronary artery bypass grafting (CABG), four mitral valve replacement (MVR), and two aortic valve replacement (AVR). Myocardial protection was accomplished by antegrade-retrograde blood cardioplegia according to the method described by Buckberg.2 No perioperative deaths occurred. Using the same electrocardiographic (ECG) criteria for perioperative myocardial infarction described by Katus et al we found two cases among the CABG patients and one among the AVR patients Troponin T concentrations were lower than 0·1 μg/l in all preoperative samples and rose after surgery in the three patients with perioperative myocardial infarction to a peak value of 6.06 μg/l and 28·75 μg/l respectively. These results accord with those of Katus et al who reported a troponin T mean peak value of 11 μg/l (range 6·31 to 31 μg/l) in patients whom ECG signs of perioperative myocardial infarction developed after CABG. In patients with no evidence of myocardial infarction after surgery troponin T release was significantly lower (mean SD 0·96 (0·98) μg/l, median 0·68 μg/l, range 0·26–4·6 μg/l) than in patients with perioperative myocardial infarction. Surprisingly, these values were also lower than that reported by Katus et al in a similar subgroup (median 5 μg/l, range 1·3–11 μg/l) who were cardioprotected by a Bretschneider HTK cardioplegic solution.3 Because there were no apparent differences in the duration of cardiopulmonary bypass and aortic cross-clamping or the number of diseased and grafted coronary vessels we suggest that the reduced troponin T release seen in our patients was due to a different myocardial protection protocol. Therefore troponin T seems to be a highly specific and sensitive marker for myocardial cell necrosis, that is also useful for assessing the efficiency of myocardial protection techniques.

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BRITISH CARDIAC SOCIETY NEWSLETTER

The challenges that lie ahead in staffing cardiac units into the twenty first century, which were the subject of a meeting last November, require continuous debate. Both the Specialist Advisory Committee and the Manpower and Training Committee are developing strategies to improve our training programmes and ensure that staffing levels are appropriate.

The working party on cardiology in district general hospitals, chaired by Andrew McLeod, is contributing to this debate. All the indications are that nearly double the number of consultants will be required over the next decade and it remains to be seen how the funding will be provided. The formal government response to the Calman report after a period of consultation is awaited and will no doubt precipitate vigorous debate. Harmonising our training programmes with the rest of Europe is not going to be easy and cannot be achieved overnight.

The Specialist Advisory Committee is reviewing the content of training, which will become more structured with formal guidelines and a formal assessment of training of trainees being introduced.

Archives

Arthur Holman, who was appointed by Council, writes: “The main task of the archivist is the preservation and proper arrangement of the Society’s records. These will include: minutes of Council meetings; financial accounts; minutes of annual general meetings; records of the scientific meetings and programme books; membership records; minutes of Officers’ meetings; records and meetings of associated groups; and correspondence. Advice is being sought from a professional archivist on how these records should be kept and indexed, with special reference to computer management.

Our important need to have a complete set of the British Heart Journal from its foundation in 1939 has been met by a most welcome gift from Richard Emanuel. He has given us the bound volumes of the journal that belonged to his father, Professor J G Emanuel, and we are deeply grateful to him for his generosity. We now have to obtain a set of Cardiovascular Research.

In addition, I intend to establish a small library of books that will cover the development of cardiology from the mid-nineteenth century to the present day. If possible we would also like to have a small collection of historical instruments both diagnostic and therapeutic—for example, the Mackenzie polygraph and the mitral valve dilator.

If members have books, instruments, or other items of historical interest that they would like to donate to the Society I will be most grateful if they will get in touch with me either at the Society’s office or at my home: Seabank, Chick Hill, Pett, Hastings, East Sussex TN35 4EQ (tel: 0424 813228).”

Data Management Committee: progress on the Read Clinical Terms

Malcolm Tomlinson. The committee has created a list of diagnostic (clinical) terms in congenital heart disease and “adult” heart disease and terms for special investigations—such as electrocardiography, electrophysiology, and nuclear cardiology—have been completed. The list of terms for echocardiography is almost complete. The Centre for Coding and Classification now has the