trars who foresee difficulties in obtaining accreditation should contact Michael Webb-Peploe (chairman of the SAC in Cardiovascular Medicine) via the JCHMT office, Royal College of Physicians, 11 St Andrew's Place, Regents Park, London, NW1 4LE (tel: 071 935 1174).

**British Cardiovascular Intervention Society**

Martin Rothman writes: "The Winter Scientific Meeting of BCIS was held in Manchester and hosted by Bernard Clarke and his colleagues from the Manchester Royal Infirmary and Wythenshawe Hospital. As usual the meeting was well attended and apart from the time-honoured sessions for reviewing angiograms there were important presentations on intracoronary stenting and the results of the recent Benestent trial, the function of the Department of Health's new Devices Directorate, and an update on the advances made in our understanding of the function of the endothelium and the mechanisms underlying restenosis."

"The next BCIS meeting will be the international 2 day Angioplasty '94 Meeting, to be held in London on 20 and 21 January, 1994 for which generous sponsorship has been received from industry. The programme covers a wide range of topics, with presentations given by various speakers from the United Kingdom and elsewhere. Enquiries about this meeting should be made to Beverley Charters of BCOS Ltd, the course organiser (tel: 071 637 0016)."

"There will be a BCIS meeting at the British Cardiac Society Annual Meeting in Torquay on 18-20 May 1994 and the provisional date of the Winter Meeting, to be held in Cardiff, is Friday 30 September 1994."

"The final returns of data on interventional procedures undertaken in the United Kingdom in 1992 are being analysed and should appear in the *British Heart Journal* in the first half of 1994. A subcommittee of BCIS Council has been set up to look at the best ways of collecting data in the future and at how some additional information on risk stratification of cases can be included. It is likely that the collection of data will move to a more computer oriented system and away from the present paper forms; the feasibility and cost of such a system are being assessed. Unfortunately, for our contacts in interventional units, requests for the 1993 returns will be sent out early in the New Year. Prompt returns of complete data would be greatly appreciated."

"The membership of BCIS now stands at 275, with 180 medical, 15 radiological, 29 nursing and technicians, and 51 industry members."

"Finally, Peter Hubner and Alan Mackintosh will be standing down as council members of BCIS in February, having served on council since the inaugural meeting of BCIS in 1987, for much of this time as Honorary Secretary and Honorary Treasurer respectively. The present activity of BCIS owes a lot of their enthusiasm and hard work in the past, for which we owe them many thanks. Any BCIS member wishing to nominate their replacements should write to Huon Gray, Wessex Cardiac Unit, Southampton General Hospital, Southampton."

**European Society of Cardiology**

Philip Poole-Wilson writes: "At the Autumn meeting of the Board of the European Society of Cardiology the responses, both favourable and critical, to the Nice Congress were discussed. Many letters of appreciation had been received. One complaint concerned the fact that smoking took place on the Congress premises and a second pointed out how few women chaired sessions or were speakers during the Congress. I was surprised that there were so few adverse comments about the problem of transport in Nice. Perhaps that was because on balance any difficulties with travel arrangements were offset by the pleasant environment. Because of the large number of problems encountered with double projection the Board decided that in future double projection will not be available during the Congress, except in the largest auditorium which is usually reserved for plenary sessions. The Board was also concerned about the number of "no shows" for the oral and poster sessions, estimated to be 1%. In future firm action will be taken. Anyone who has an abstract accepted, either for oral presentation or for a poster, must ensure that it is presented."

**Other news**

Abstracts for the Torquay meeting have poured in and the total number received was 868—this is an increase of 22% on the number received last year. Abstracts have now been sent out for blind marking and the Programme Committee meets early in January to put together an exciting programme. In Torquay the St Cyres Lecture (the other formal lecture with the Thomas Lewis Lecture) will be given by Professor Gunter Breithardt. It is entitled "Management of patients with sustained ventricular tachycardia or previous cardiac arrest—the changing scenario in the 1990s.

It is sad to record the death of Leon Resnekov, a member of the Society since 1963. He spent 10 years in London at the Cardiothoracic Institute and National Heart Hospital before moving to the United States in 1967 where he followed a distinguished career in Chicago. He gave the St Cyres Lecture to the British Cardiac Society Annual Meeting in 1979.

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# CORRECTION

**Postoperative cardiac surgical care: an alternative approach** *A Jindani, C Alps, E Neville, B Sonmez, K Tung, B T Williams* (1993;**69**:59–64). We regret that the name K Tung, an author of this paper, was misspelt.

# CLINICAL GUIDELINES

## Mobile cardiac catheterisation laboratory: Recommendations of the Medical Practice Committee and Council of the British Cardiac Society

The increasing demand for diagnostic and therapeutic catheterisation has encouraged significant changes in service provision. One such development is catheterisation in district general hospitals, which was the subject of an earlier report from the British Cardiac Society (*Br Heart J* 1994;71: 110–2). Another linked development is the use of mobile catheter laboratories, which is the subject of these guidelines. Mobile catheter laboratories are a valuable addition to the currently available facilities.

Mobile catheter laboratories may be used in two different circumstances:

(*a*) In centres that also have fixed catheter laboratories, either to provide additional facilities or to substitute for the fixed laboratory in case of breakdown, methicillin-resistant *Staphylococcus aureus* contamination, etc (mainly regional centres).

(*b*) In centres that have no fixed catheter facilities, usually because the workload of that centre is not sufficient to justify the purchase of a fixed laboratory (mainly district general hospitals).

Mobile catheter laboratories can be used by host hospitals in various formats. They may require only the *x* ray facility (with medical, nursing and technical staff being provided by the host hospital) or, at the other extreme, they may require both the *x* ray facility and the staff to use it, including the cardiologist, in which case the host hospital needs only to organise the patients and monitor them after the procedure.

Because of this variety of practice all clinical and managerial responsibilities must be agreed before the laboratory becomes operational and responsibility for patient and staff indemnity must be clearly defined. All companies that own mobile laboratories should have their own procedure manuals to which the host hospital must agree before any procedures are carried out. The following items should be addressed in any such manual.

REQUIREMENTS FOR USE OF MOBILE CATHETERISATION LABORATORY

The mobile catheter laboratory should be sited on level ground in an accessible position—ideally, near to appropriate day care facilities. Before operating in the laboratory the cardiologist responsible for the procedures should agree:

(*a*) The stock and range of catheters, introducers, and other disposable equipment that are on the mobile laboratory

(*b*) The re-usable equipment, particularly for brachial arteriotomy

(*c*) The emergency drugs, contrast agents, and equipment (defibrillation, portable monitors, temporary pacing equipment)

(*d*) Who is to have access to the unit and under what circumstances?