A Napoleonic future for cardiology?

Many societies or association of physicians, whether generalist or specialist are struggling to come to terms with the professional and public demands for the accountability and continuing education of their members. In this issue the Italian Association of Hospital Cardiologists (AMNCO) have shown us one way in which such organisations can make a dramatic and rapid impact on the delivery of health care. 1

AMNCO mainly comprises the non-academic cardiologists in community rather than university hospitals; the latter form the bulk of the Italian Society of Cardiology, although there is some overlap and recent moves for more integration between the two.

Most national cardiac societies have concerned themselves with issuing guidelines or consensus statements, supplemented by seminars or teach-ins; but we have to admit that these strategies influence practice only slowly, if at all. The Italian strategy went much further than this in a stepwise and well planned fashion.

First they chose a condition—heart failure—which in all urbanised societies was an important and growing problem, and where there was new evidence from well conducted trials that treatment with β adrenergic blockade could add to the known benefit of angiotensin converting enzyme (ACE) inhibition. However, β adrenergic blockade was not easy to initiate, requiring careful titration and, moreover, many physicians feared that it could be harmful to such patients.

Next they conducted annual surveys of prescribing patterns among their members in 133 centres—in itself a valuable audit. These surveys showed that the use of β blockade was increasing, albeit slowly, from 7.5–18% over two years (1995–97). Through the Italian Network on Congestive Heart Failure (IN-CHF) they organised a series of regional meetings (260 centres) to examine the evidence for β blockade in heart failure, which involved all their local members.

Finally they carried out further surveys of prescribing. The result was an astonishing change of practice so that over a period of a few months the proportion of patients so treated had risen from the low teens to over half.

Importantly, I believe, they left to individuals the choice of which β blocker to use—bisoprolol, carvedilol, or metoprolol—and so neatly side stepped the confusion (and the resultant inertia) caused by rival commercial promotions. (The drugs were supplied free by the manufacturers.)

Ten experienced centres agreed to act as sources of advice for the other clinics. Finally, they involved 206 representative cardiac centres in a prospective study of over 3000 patients enrolled in one month early in 1998. About a quarter were already taking β blockers and a further quarter were started de novo. The patients will be followed for one year.

Importantly they chose a condition—heart failure—where most patients finally come to the attention of cardiologists, rather than a condition that is treated by a more diffuse group of physicians.

The GISSI group—an enormously important arm of AMNCO—have also helped the diffusion of evidence based medicine with their trials in myocardial infarction. Even in a quite localised area (Leicester) Ketley and Woods2 showed very nicely that the subsequent quite rapid uptake of thrombolytic treatment by individual hospitals was twice as rapid if that hospital had previously been involved in a trial, compared with hospitals not taking part.

Maggioni and Tavazzi admit that their study only embraces a part of the “heart failure world” but they clearly envisage greater diffusion of these strategies through the Italian medical system. 3 They are to be congratulated on this.

In my title I infer that this centrally organised and directed approach might owe something to Napoleon. Although Italy has only existed as a country since 1869 and although it has had problems with short lasting governments the “sottogoverno” of organisations like AMNCO, “owned” by the cardiologists, has produced lessons for all of us.

In conclusion, Maggioni and Tavazzi have outlined one way in which clinicians can act together under intelligent leadership to improve the treatment of a common and distressing condition. Their study raises questions of how we can best implement well proven treatments of—for example, hypertension, to prevent heart failure. Guidelines alone are clearly insufficient in this respect as many community surveys have shown that hypertension treatment is badly delivered and many patients are inadequately controlled.

Two recent important clinical trials in hypertension also have important messages. The HOT study3 showed that setting lower diastolic targets for treated blood pressure, 80, 85 or 90 mm Hg led to achieved pressure of <140/90 mm Hg for over 90% of patients, with no deleterious effects and no decrease in quality of life. If we set targets of 140/90 mm Hg it follows that about half our patients will have treated pressures above this.

The UK prospective diabetes study (UKPDS 38) has shown that tighter blood pressure control was more effective than tighter glucose control in reducing diabetic related end points such as myocardial infarction, stroke, and heart failure.

Both trials show that many patients will need two or three drugs to achieve this, and that this is feasible and tolerable. Can we use these Italian methods to achieve this? Perhaps we need a little Anglo-Saxon discipline!

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