

## Coronary heart disease trends in England and Wales from 1984 to 2004: concealed levelling of mortality rates among young adults

**To the Editor:** O'Flaherty and colleagues<sup>1</sup> have identified a worrying change in the hitherto improving CHD mortality data in England and Wales, which has occurred despite record spending on coronary revascularisation. They correctly propose that the health intervention measures, as recommended by Wanless<sup>2</sup> and supported by the National Heart Forum<sup>3</sup> and NICE,<sup>4</sup> should be urgently implemented in an attempt to prevent premature death especially in young socially disadvantaged adults.

What O'Flaherty and colleagues fail to address is the funding issue.

As Wanless hints in his report, the most logical and theoretically least challenging way to fund the expansion of effective preventive interventions is to redeploy resources from wasteful and expensive practices that are unproven or whose cost/benefit balance cannot be justified.

PCT commissioners have a duty to optimise the effectiveness of NHS resources and should urgently review their blank-cheque approach to palliative percutaneous coronary intervention (PCI). The Courage trial<sup>5</sup> confirmed that PCI does not improve prognosis and is only marginally superior to optimal drug treatment in ameliorating symptoms in low-risk stable angina patients. Griffin *et al*<sup>6</sup> confirmed the suspicions first raised following the RITA-2 study<sup>7</sup> that the high cost of PCI cannot be justified. These data, coupled with concerns over late drug-eluting-stent (DES) thrombosis and the controversy around the inappropriate implantation of DES in unlicensed situations, have combined to change practice in the US, where manufacturers have recently reported a greater than 40% slump in DES sales.

When the QALY cost of preventive measures (£20-£400)<sup>4</sup> is compared with the cost of PCI (£47 000),<sup>6</sup> the case for redeploying resources becomes overwhelming, especially when the effectiveness of preventive measures takes account of their ability to

reduce the need for expensive revascularisation procedures.

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**The author's reply:** We agreed with Dr Chester in his argument supporting a redirecting of resources currently used in some revascularisation strategies to other uses, particularly preventive interventions. But, as we liberate resources, a battle for their "new" use will start.

These redirected resources will probably need to be shared between the primary and secondary prevention camps, not only because there are huge numbers of existing coronary heart disease patients requiring care but also because only about 40% of the decline in CHD mortality in the UK can be attributed to treatments, and about 60% to changes in risk factors.<sup>1</sup> Thus, it will be necessary to think on which secondary prevention strategies should be prioritised.

Our previous analysis<sup>2</sup> anticipates Dr Chester's comments in his letter;

revascularisation strategies play a limited role, while improving secondary prevention after myocardial infarction, or treating heart failure patients, potentially offers the greatest benefits.

And how can we distribute new resources aimed at increasing our levels of preventive strategies? The debate between a high-risk approach and a population-level approach has not been settled, but Emberson *et al*<sup>3</sup> demonstrate that, to obtain a significant reduction in CVD mortality, population-based initiatives (such as a smoking ban or food policy initiatives) may be more powerful than identifying and treating high-risk individuals.

Substantial debate is needed to implement these radical ideas. If it is difficult for the medical community to accept that a cherished cardiological treatment is probably not worth the money we are investing in it, what about redirecting resources from the NHS to other societal organisations better able to generate changes at the population level?

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### CORRECTION

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Chung H, Camejo RR, Barnett D. Alteplase for the treatment of acute ischaemic stroke: NICE technology appraisal guidance. *Heart* 2007;**93**:1616-18.

The second author of this paper, RR Camejo, should be listed as R Refoios Camejo.

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