LETTERS TO THE EDITOR

Scope

Heart welcomes letters commenting on papers published in the journal in the previous six months. Topics not related to papers published earlier in the journal may be introduced as a letter: letters reporting original data may be sent for peer review.

Presentation

Letters should be:

- not more than 600 words and six references in length
- typed in double spacing (fax copies and paper copy only)
- signed by all authors

They may contain short tables or a small figues. **Please send a copy of your letter on disk.** Full instructions to authors appear in the July 1997 issue of *Heart* (page 97).

Atrial fibrillation begets trouble

SIR,—We welcomed the excellent editorial by Waktare and Camm on the deleterious effects of atrial fibrillation and agree wholeheartedly with their conclusion that "the important principle is to investigate and treat appropriately from the outset".[1] There is little doubt that without proper investigation and treatment, atrial fibrillation begets trouble.

While it is well recognised that there are cardiovascular complications associated with atrial fibrillation such as heart failure, thromboembolism, and stroke, and that there are well validated treatment strategies to reduce the occurrence of stroke and thromboembolism by appropriate use of antithrombotic therapy, the message has failed to get through to many clinicians in hospital and general practitioners.

Much of the clinical epidemiology of atrial fibrillation in the United Kingdom has been criticised for being based on small and elderly populations that are unrepresentative. While there is need for more information on the prevalence of atrial fibrillation in Britain and the treatment and investigations of such patients, there have been some studies in this area. In a recent study on the use of anticoagulants among patients with atrial fibrillation in the community from Newcastle,[2] only 44% of patients with atrial fibrillation aged 65 to 74 years, and 11% of patients over 75 years were treated with warfarin. In the same study, only 33% of the subjects in the 65–74 year age group without contraindications to treatment were actually treated with warfarin, and 14% of the over 75 age group. Our survey of atrial fibrillation in two general practices in West Birmingham[3] broadly agrees with these findings. For example warfarin was prescribed to only 36% of the 111 patients with atrial fibrillation and of those not anticoagulated (n = 71), only 12 patients (17%) had significant contraindications to warfarin treatment. While aspirin is often considered as an alternative to warfarin, it was prescribed in only 19% of patients, primarily for established vascular disease. Similar low rates of antithrombotic treatment have been found among patients with atrial fibrillation in hospital,[4–6] but our general practice survey suggested that less than a third of the patients had ever been admitted to hospital.[3] Such information from hospital and general practice would have major implications for health care resources and service provision for this common problem.

The low use of anticoagulation in patients with atrial fibrillation may be related to the perceived absence of suitable guidelines; however, many such guidelines for the treatment of atrial fibrillation do exist.[7 8] Despite this there remains considerable variation among physicians in the management of patients with atrial fibrillation, especially between cardiologists and non-cardiologists, in the use of antithrombotic and antiarrhythmic therapy, and consideration for cardioversion.[9] The existence of many different guidelines would probably result in a very wide range on the actual rates of anticoagulation if applied to the same population of patients with atrial fibrillation.

If we improve screening, detection, and anticoagulation for atrial fibrillation, these have considerable implications especially with an aging population. A question often raised is who should be responsible for monitoring anticoagulant therapy? There is clear evidence that general practitioners can monitor anticoagulation intensity more efficiently than hospital anticoagulant clinics, however, many general practitioners are reluctant to undertake this role.[10] In our general practice survey, anticoagulation was monitored in hospital in the majority of cases (75%), by both general practitioner and in hospital in 17.5%, and by general practitioner alone in only 7.5%.[9 11] This issue requires further clarification and possible solutions, such as decision support for dosing and self-monitoring, need further evaluation.[12]

While many hospital clinicians and general practitioners are aware of atrial fibrillation, its associated problems, and the need for treatment, the message from many studies is that the management of atrial fibrillation remains suboptimal. Many of us would welcome any suggestions for implementation of proper investigations and treatment for patients with atrial fibrillation. Do we need more guidelines? Probably not; however, we do need a consensus plan involving our general practitioner and hospital physician colleagues in the detection and management of this common problem. We, as cardiologists, keep emphasising the need for managing this problem appropriately, but the evidence of much variation in management, even among cardiologists, suggests that much more work is needed before we can deliver appropriate care to all patients with atrial fibrillation.

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1 Waktare JEP, Camm AJ. Atrial fibrillation begets trouble [editorial]. *Heart* 1997;77:393–4.
2 Sudlow M, Rodgers H, Kenny RA, Thomson R. Population based study of use of anticoagulants among patients with atrial fibrillation in the community. *BMJ* 1997;**314**:1529–30.
3 Lip GYH, Golding DJ, Nazir M, Beevers DG, Child DL, Fletcher RI. A survey of atrial fibrillation in general practice: the West Birmingham Atrial Fibrillation Project. *Br J Gen Pract* 1997;**47**:285–9.
4 Lip GYH, Tean KN, Dunn FG. Treatment of atrial fibrillation in a district general hospital. *Br Heart J* 1994;**71**:92–5.
5 Zarifis J, Beevers DG, Lip GYH. Acute admissions with atrial fibrillation in a British multiracial hospital population. *Br J Clin Pract* 1997;**51**:91–6.
6 Bath P, Prasad A, Brown M, MacGregor G. Survey of use of anticoagulation in patients with atrial fibrillation. *BMJ* 1993;**307**:1045.
7 AHA Medical / Scientific Statement. Management of patients with atrial fibrillation. *Circulation* 1997;**93**:1262–77.
8 Lip GYH, Lowe GDO. Antithrombotic therapy for atrial fibrillation. *BMJ* 1996;**312**:45–9.
9 Lip GYH, Zarifis J, Watson RDS, Beevers DG. Physician variation in the management of patients with atrial fibrillation. *Heart* 1996;**75**: 200–5.
10 Taylor F, Ramsay M, Voke J, Cohen H. Anticoagulation in patients with atrial fibrillation: GPs not prepared for monitoring anticoagulation [letter]. *BMJ* 1993;**307**:1493.
11 Pell JP, McIver B, Stuart P, Malone DN, Alcock J. Comparison of anticoagulant control among patients attending general practice and a hospital anticoagulant clinic. *Br J Gen Prac* 1993;**43**: 152–4.
12 Fitzmaurice DA, Hobbs FDR, Murray JA. Monitoring oral anticoagulation in primary care. *BMJ* 1996;**312**:1431–2.

Increase in hospital admission rates for heart failure in the Netherlands, 1980–1993

SIR,—We were most interested to read the report by Reitsma *et al* on heart failure hospitalisations in the Netherlands.[1] While these authors found a trend in hospitalisations similar to our report from Scotland they point out that their absolute hospitalisation rates were lower.[2] There are at least three likely explanations for this.

First, Reitsma *et al* excluded a number of ICD codes for heart failure that we included in our report: ICD9 codes 425.4 (primary cardiomyopathy), 425.5 (alcoholic cardiomyopathy), and 425.9 (secondary cardiomyopathy, unspecified). These codes accounted for 4.4% of our total cases in 1990.

Second, and much more importantly, the prevalence of coronary artery disease, the major cause of heart failure, is much higher in Scotland than in the Netherlands. For example, the age adjusted mortality rate per 100 000 for men aged 35–74 in 1992 was 535 in Scotland and 248 in the Netherlands (ICD codes 410–414, standardised to England and Wales population 1972). The respective rates for women were 218 and 84.

Third, a considerably higher proportion of the Scottish population are elderly—the age groups with the highest incidence and prevalence of heart failure. The proportion of the population aged 75–79, 80–84, and 85+ in the Netherlands in 1993 was 1.96, 1.16, and 0.68%, respectively; in the UK these proportions were 2.37, 1.55, and 0.85%. For women in the Netherlands the proportions were 3.07, 2.29, and 1.86; in the UK they were 3.53, 2.86, and 2.49%.

In summary, when these differences are considered the findings of Reitsma *et al* are consistent with ours in the Scottish population.

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1 Reitsma JB, Mosterd A, de Craen AJM, Koster RW, van Capelle FJL, Grobbee DE, *et al*. Increase in hospital admission rates for heart

failure in the Netherlands, 1980–1993. *Heart* 1976;**76**:388–92.
2 McMurray J, McDonagh T, Morrison CE, Dargie HJ. Trends in hospitalisation for heart failure in Scotland 1980-1990. *Eur Heart J* 1993; **14**:1158–62.

This letter was shown to the authors, who replied as follows:

We highly appreciate the letter by McMurray and Morrison in which they mention several causes for the higher number of hospitalisations for heart failure in Scotland compared to the Netherlands. We endorse their viewpoints on these factors, especially their remark on the difference in prevalence of coronary artery disease between the two countries.

In addition to the explanations brought forward by McMurray and Morrison, other factors such as hospital admission policies and coding practice may influence the number of first listed discharge diagnosis, especially in a complex and chronic condition like heart failure. Differences in these factors are difficult to assess and need more attention in future research. For the sake of comparison the use of age specific discharge rates with smaller age intervals (5 or 10 years) or standardisation to a widely available standard (the European population standard) should be encouraged.[1]

1 McMurray J, McDonagh T, Morrison CE, Dargie HJ. Trends in hospitalization for heart failure in Scotland 1980-1990. *Eur Heart J* 1993;**14**:1158–62.

Coronary patients need cardiologists

SIR,—Dr Bethell makes the valid point that the care of patients with myocardial infarction in general is poor and ascribes much of the fault to general physicians. It is equally appropriate to assign blame to general practitioners who are in the most advantageous position if they should so wish to supervise and encourage a rehabilitation programme for their patients.

As someone who has been interested in this subject for many years and has encouraged the use of thrombolysis within his own practice within the community, I would take issue with Dr Bethell's comments that general practitioners are bound to follow protocols set by hospitals. It is such attitudes that have contributed to the problems in taking forward the appropriate acute care of patients with myocardial infarction as well as their rehabilitative care.

It is only through collaboration and discussion, not by diktat, that sensible programmes of cardiac rehabilitation can be established within the community. I would very much encourage such attitudes that might lead to improved patient care.

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1 Bethell HJN. Coronary patients need cardiologists [opinion]. *Heart* 1997;**77**:389.

This letter was shown to the author, who replied as follows:

Dr Grant is right to say that general practitioners are not bound to follow hospital examples of the management of patients with myocardial infarction. However, unless the general practitioner has a particular interest in heart disease, his or her management of coronary patients is likely to be influenced heavily by the approach of the hospital physician. In hospitals where infarct patients are admitted under the care of one of several on-duty consultants this approach is likely to lack consistency and be suboptimal. If all coronary patients were to have the benefit of a cardiologist's opinion, as is the case in some hospitals, a consistent management policy could be developed. This could then, as Dr Grant suggests, be discussed and put into practice by general agreement between hospital and community, an unlikely situation under current circumstances.

I did not "ascribe much of the fault to general physicians"; it was the system that I criticised. It is a paradox of the way we organise the care of the largest cause of death in the UK that heart attack patients may never see a doctor who is interested in their condition.

NOTICE

11th Congress of the Mediterranean Association of Cardiology and Cardiac Surgery will take place in the Convention Centre, Montpellier, France from 5–8 October 1998. For further information please contact: Congress Secretariat, Alliance Medicale et Scientifique, 1 rue Auguste Broussonnet—34000 Montpelier, France. (tel: 33 04 67 61 94 14; fax: 33 04 67 63 43 95).

CORRECTION

Flow associated or flow mediated dilatation? More than just semantics. K Bhagat, A Hingorani, P Vallance. Heart *1997;78:7–8.*

Under the section "Stimulus for dilatation", the second and third sentences should have read:

Leeson and colleagues measured flow and brachial artery diameter simultaneously and showed that there is a relation between the degree of increase in flow over the first 15 seconds and the percentage of flow mediated dilatation. Others have shown that following hand ischaemia, the increase in blood flow through the brachial artery is immediate and short lived, whereas the subsequent dilatation of the artery is slow in onset and progressive.

and not as published. The error is regretted.