



Rhode Island Chapter of the American College of Cardiology

"THE MISSION OF THE RHODE ISLAND CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY IS TO BE AN ADVOCATE FOR ACCESSIBLE, HIGHEST QUALITY, COST EFFECTIVE CARDIOVASCULAR CARE FOR THE PEOPLE OF RHODE ISLAND AND TO ACTIVELY SUPPORT CARDIOLOGISTS IN THEIR EFFORTS TO ACHIEVE THESE GOALS."

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First ACC Honorary Chair Founded and Developed in RI

As a new state chapter, we encountered many challenges. Not only did we seek the widespread support of our membership, but also we strived to distinguish ourselves from other chapters in some unique way. One such accomplishment emerged quite unexpectedly. It seemed appropriate (but not entirely novel) that we should honor our first chapter governor by presenting him with an official chair — one of those black wooden models with official university logos, coveted by alumni and scholars at the Ivy League institutions throughout America. Confident of success, I volunteered to take charge of the “Chair” committee and eventually contacted the appropriate official at the ACC (Ron Mattocks), who agreed it was a terrific idea, but confessed that such an item did not exist (although the ACC was liquidating its clothing line and that a sweatshirt could be obtained at a special discount).

continued on page 5



*Immediate-Past-Governor Christian
with the result of the “Chair”
committee efforts*

INSIDE . . .

The President’s Quarterly Message	page 2
Protecting Patients	page 3
Clinical Briefs from <i>Journal Watch Cardiology</i>	page 6
ACC News Briefs	page 11

The President's Message

As I assume the role of President of the Rhode Island Chapter of the American College of Cardiology, I would like to thank Dr. Fredric Christian for his work on behalf of the Chapter over the past three years. As many of you know, Ric is responsible for obtaining official Chapter status from the ACC and served as our first Chapter President. His efforts and enthusiasm have established a lofty benchmark for future Chapter presidents. I hope all Chapter members will join me in congratulating Ric. Fortunately for all of us, Ric will remain active in the Chapter. He will sit on the Executive council as the Immediate past President and continue to serve on several sub committees.

Likewise, I would like to acknowledge and thank the members of the Executive Council who have been so instrumental in the early efforts of our Chapter. Al Parisi, Ken Korr, Pat Brannon, Lauralyn Cannistra, Bill Levin, Kirit Desai, Ed Thomas, Bob Schwengel, Howard Haronian, Steve Fera, Athena Poppas, Alan Katz, and Lloyd Feit have all spent considerable time and effort on many Chapter activities. I look forward to their continued participation.

As our Chapter matures, we are obligated, according to bylaws, to hold Council elections on a rotating basis. Elections will be held over the summer in several districts. Also, committee memberships are being revised in order to include participation from every Chapter member

who expressed an interest on the recent survey. Any other members who would like to be involved in Chapter activities can contact me directly. A list of the new Council and committee members will be published in the next newsletter and on our Website. I am pleased to report that Alice Kim, MD, a second year cardiology fellow at Rhode Island Hospital has agreed to participate in our council as a non voting representative of trainees in our state. She will also be a non voting member of the Education Committee.

The first Rhode Island Chapter survey was distributed to our members in January 2001. Thanks to all who took the time to respond. Our response rate was 31 out of 94 (33%).

The results of the survey will be used by the Council to shape this year's agenda and plan for future Chapter events, including the next annual meeting.

Based on the survey responses, the issues important to our members continue to be Education, Reimbursement, Advocacy, and Legislation. Our Chapter committees on Education, Third Party Relations,



George R. McKendall, MD, FACC

and State Government Relations will be important vehicles to address member concerns identified by the survey.

The next scheduled Chapter event will be the annual meeting in the fall. An October date is probable and will be communicated to all members as soon as it is confirmed. We are hoping that the overwhelming membership support shown by attendance at past meetings will continue.

Finally, as I begin my term as Chapter President, I would like to encourage any member with concerns or questions related to Chapter activities to feel free to contact me directly. I can be reached at 444-5891, 444-8158 (fax), or Gmckendall@lifespan.org.

Protecting Patients

—Fredric V. Christian, MD, FACC

My 14-year-old son recently asked me for a copy of the Hippocratic oath for a social studies project. I recalled that I had placed a copy in my medical school yearbook and took the opportunity to read and discuss with him the principles set forth in this timeless document. The third paragraph emphasizes the importance of always doing what is best for the patient and admonishes the physician never to be self-serving:

“I will adhere to the doctrine and prescribe treatment which my ability and judgment assure me are most beneficial to my patients. I will abstain from everything that may be harmful or dangerous to them. I will attempt no treatment that requires training or skills superior to mine.”

These principles are as relevant today as they were in ancient Greece and can be reflected upon in the context of 21st century cardiology

In the 23 years since I finished my cardiology fellowship, there has been an exponential increase in the therapeutic options available and evidence-based medicine that has demonstrated benefit both in terms of survival and quality of life. Cardiology has subspecialized as the knowledge and skills required to practice each discipline has increased. There are now interventionalists, electrophysiologists, nuclear cardiologists, and echocardiographers, each of which

has its subspecialty boards to set standards of training and competence.

The American College of Cardiology (ACC), a 24,000-member professional organization whose mission is to foster optimal cardiovascular care and disease prevention through professional education, has produced clinical guidelines in collaboration with the American Heart Association that are widely used as the most authoritative standards of cardiovascular care by generalists as well as cardiovascular specialists. These guidelines, which range in topics from ablation for cardiac arrhythmias to preventive cardiology for women, are accessible on-line through the ACC website, www.acc.org.

The ACC has recognized the importance of patient advocacy and has been a leader in the Patient Access Coalition, which emphasizes patient choice and access, health plan accountability and information disclosure to patients. Although it has not yet been possible to pass a federal patient bill of rights, the ACC will continue to advocate for the same in the next session of Congress.

Despite the lack of Federal legislation, we are fortunate in Rhode Island to have legislation that partially fulfills the major principles of the proposed patient bill of rights. This legislation:

1. gives patients the right to appeal decisions for denial of care or denial of payment decisions by insurers,

The ACC has recognized the importance of patient advocacy and has been a leader in the Patient Access Coalition.

2. bans “gag rules” and guarantees both patients and physicians the right to speak freely about health plan products and services, and
3. provides health plan accountability that says that physicians cannot be held liable because of health plan management of utilization review decisions.

Legislation which allows patients timely and adequate access to specialty care treatment and services at a reasonable cost is still needed.

continued next page



Our members want us to be more aggressive at the local and national level, help chapters address their concerns, and reach out to the public.

In Rhode Island, as in the rest of the nation, the shortage of nurses threatens the quality of care and patient outcomes. Having an adequate number of well-trained and dedicated nurses in all practice settings is crucial to delivery of high quality care and good patient outcomes.

In Rhode Island, we have recently witnessed the threat to patient access and quality care by the union action at Rhode Island Hospital in

late June. Despite the resolution of this crisis, there continues to be a shortage of skilled nurses, especially cardiovascular surgical nurses, which has caused both delays and cancellations in urgent and elective cardiovascular surgery. This shortage threatens both the availability and quality of tertiary cardiovascular services in this state.

ACC President, George A. Beller, MD, has recently written an article challenging the cardiovascular community, in concert with

hospital administrators and educators, to participate in discussions concerning how to solve the nursing shortage. There is clearly an opportunity in Rhode Island to develop a task force to define the “local problem” and to set forth a plan to deal with this problem. This effort must be preceded by the acknowledgment that to increase the number of nurses, working conditions and salaries must be commensurate

with available opportunities in the nonmedical job market. There is little time to waste as it takes many years to educate and train a qualified cardiovascular nurse. This need has taken on an even greater importance since adequate numbers of well-trained nurses are an integral component in improving patient safety as a response to the recent Institute of Medicine Report on Health System Errors.

The practice of medicine and cardiology in particular has been increasingly burdensome to physicians as a result of managed care and Medicare. The prestigious Mayo Foundation has estimated that the number of pages of Federal regulations and related paperwork that doctors and hospitals must comply with in order to treat Medicare/Medicaid patients totals more than 132,000 pages — almost 111,000 of which governs Medicare alone. This is roughly 6 times the size of the impossibly complex IRS code and its Federal tax regulations.

The public has also been led to believe that the Medicare program is

continued next page

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riddled with fraud when in reality, complexity is the root of the problem. This has contributed to the continuing erosion in public confidence in our health care system. We must all have zero tolerance for real fraud but differences in interpretation and honest mistakes are not fraud. Unfortunately, the medical record has become a billing record rather than a record that reflects medical decision making and cognitive function. Solutions must be sought which simplify this process yet satisfy an appropriate level of documentation.

Despite all the technical advances of the 20th century, the physician-patient relationship remains a sacrosanct bond, which is the foundation of trust and consent. It is based upon honesty and sincerity. HCFA's recent attempt to weaken this relationship by enlisting Medicare recipients to be "fraud watchdogs" is a reprehensible action which should be soundly rejected. I am beginning to wonder who is really guilty of fraud and abuse. Physicians, and especially cardiologists, must remain informed regarding these issues and participate in the process for change by both word and deed through the legislative process.

Despite these major problems, I, along with my fellow cardiologists, remain optimistic as we begin each day caring for patients. The most

important message that physicians communicate to their patients is "hope" in the physician's ability to diagnose and treat their condition and bring them to wellness. There has never been a moment in medical history when the cardiovascular physician has had so much to offer his/her patients to improve their quality of life and its duration.

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Fredric V. Christian, MD, FACC, is the ACC Immediate Past-Governor for Rhode Island. He is a Clinical Professor of Medicine, Brown Medical School, and practices with the University Cardiology Foundation.

References:

Beller, George A. President's Page: High quality cardiovascular care threatened by shortage of nurses and allied health professionals. *JACC* Vol. 36, No 5, 2000 pp. 1722-1724.

Nevertheless, he provided his support in this endeavor and encouraged me to procure this item on my own, authorizing the use of the official ACC logo. After multiple phone calls, Steve Ostroff at Standard Chair of Gardner (tel. 978-632-1301) accepted the task of engraving the first ACC chair in its history! This solid maple hardwood captain's chair is personalized with Dr. Fredric V. Christian's name below the ACC logo indicating his dates of service. I assured Mr. Ostroff that there would be great interest in this chair and that our national organization would surely contact him soon with tremendous interest and many orders to follow. Most importantly, we are pleased to provide Dr. Christian with The First ACC Honorary Chair and remain forever grateful for his dedication and tireless effort in establishing RIACC as an official state chapter.

—Steven R. Fera, MD, FACC

THE RHODE ISLAND CHAPTER OF THE
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Clinical Briefs from *Journal Watch Cardiology*

Journal Watch Cardiology has graciously allowed us to reproduce selected articles from their publication that we feel are of special interest.

Radiation to Prevent Restenosis

Restenosis rates after successful balloon angioplasty are 30% to 40%. Stent implantation reduces rates to 20% to 30%, primarily by eliminating vascular recoil with no effect on neointimal proliferation. In 2 multicenter, randomized trials, investigators used local radiation therapy as an adjunct to percutaneous coronary intervention to inhibit neointimal proliferation and, thereby, reduce restenosis.

In a European study, investigators (2 of whom invented the tested system) randomized 181 patients undergoing balloon angioplasty to 9, 12, 15, or 18 Gy of beta-radiation (range of mean duration, 1.8 to 3.2 minutes). Radiation was delivered automatically to the coronary artery using a flexible coil of yttrium-90 and a centering balloon. Fifty-one patients (28%) required stents.

Six-month follow-up angiography in 168 patients (93%) revealed mean losses in luminal diameter of 0.31, 0.12, and 0.09 mm in the 9-, 12-, and 15-Gy groups, respectively, and a mean increase of 0.04 mm in the 18-Gy group. Among patients who did not receive stents, restenosis rates were 28%, 17%, 16%, and 4%, respectively. Vessel occlusion occurred in more stented (14%) than angioplasty-alone (3%) patients, and only in patients who no longer were receiving ticlopidine.

In a U.S. study, supported by the radiation-system manufacturer, 252 pa-

tients with in-stent restenosis were randomized to angioplasty either with intracoronary gamma-radiation using an iridium-192 ribbon or with no radiation using a placebo ribbon. Treatment times were calculated to deliver 8 Gy to the target farthest from the source and, at most, 30 Gy to the closest target (mean delivery at 2 mm, 13.5 Gy).

Incidence of the primary composite endpoint (death, MI, or target-vessel revascularization within 9 months) was 44% in placebo recipients and 28% in radiation-treated patients. The 6-month rate of in-lesion restenosis was significantly lower in radiation recipients (32% vs. 55% in placebo recipients), due to in-lesion luminal diameter losses of 0.64 mm and 0.83 mm, respectively. Late thrombosis occurred more often with radiotherapy (5.3% vs. 0.8% with placebo), and it occurred only in patients who had discontinued antiplatelet therapy for at least 1 month and in radiation subjects who had received new stents.

Comment: These results reinforce prior findings that brachytherapy can reduce neointimal hyperplasia after angioplasty and stenting. However, as the editorialists note, only a few hundred patients have been studied with this promising new therapy, and 1-year follow-up data are available for even fewer. In addition, concerns about late thrombosis prompted the FDA to recommend antiplatelet treatment for up to 1 year after brachytherapy. Thus, although 2 radiation systems are being marketed, questions about indications, ideal dose, type of radiation, long-term effects, and risk remain.

—HC Herrmann

Verin V et al. for the Dose-Finding Study Group. *Endoluminal beta-ra-*

diation therapy for the prevention of coronary restenosis after balloon angioplasty. N Engl J Med 2001 Jan 25; 344:243-9.

Leon MB et al. *Localized intracoronary gamma-radiation therapy to inhibit the recurrence of restenosis after stenting.* N Engl J Med 2001 Jan 25; 344:250-6.

Sheppard R and Eisenberg MJ. *Intracoronary radiotherapy for restenosis.* N Engl J Med 2001 Jan 25; 344:295-6.

Sapirstein W et al. *FDA approval of coronary artery brachytherapy.* N Engl J Med 2001 Jan 25; 344:297-8.

Benefit of Low-Dose Aspirin in Primary Prevention

Although clinical trial results have shown that aspirin has some primary-preventive cardiovascular effects, whether general practitioners should recommend it is less clear. In an open-label trial with a 2x2 design, investigators from Italy randomized 4495 patients (mean age, 64; 58% female) to low-dose, enteric-coated aspirin (100 mg/day), synthetic gamma tocopherol vitamin E (300 mg/day), both, or neither. Patients, recruited mainly from general-practice sites between 1994 and 1998, each had at least 1 major cardiovascular risk factor. Among the few exclusion criteria were treatment with antiplatelet drugs and chronic use of anti-inflammatory drugs or anticoagulants. Baseline cardiovascular drug use was well balanced across groups.

The trial was stopped prematurely (mean patient follow-up, 3.6 years) because results from 2 other primary-prevention trials were found to be consistent with interim analysis results of this trial (e.g., see JWC Aug

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1998, p. 67, and *Lancet* 1998; 351:1755). Compared with no aspirin, aspirin was associated with significantly lower rates of cardiovascular mortality (0.8% vs. 1.4%) and adverse cardiovascular events (6.3% vs. 8.2%), but a significantly higher rate of severe (mainly gastrointestinal) bleeding (1.1% vs. 0.3%). Adherence to study regimen was excellent overall. Side effects caused discontinuation of aspirin in 7.9% of recipients; 7.2% of those not assigned to aspirin were taking it at the end of the trial. Vitamin E had no noteworthy effects.

Comment: In this study of mostly general-practice patients, low-dose aspirin (along with typical risk-factor interventions) significantly prevented adverse cardiovascular events, with an acceptable rate of nonfatal bleeding complications. Given this new evidence, an editorialist notes that physicians now should be confident in recommending low-dose aspirin for primary prevention in patients with at least 1 major cardiovascular risk factor. —BJ Meyer

Collaborative Group of the Primary Prevention Project (PPP). Low-dose aspirin and vitamin E in people at cardiovascular risk: A randomized trial in general practice. Lancet 2001 Jan 13; 357:89-95.

Rosser WW. Aspirin for primary prevention of cardiovascular events. Lancet 2001 Jan 13; 357:84-5.

Cardiac Resynchronization for CHF Patients with Intraventricular Conduction Delay

Cardiac-resynchronization therapy delivered via atrial-synchronous biventricular pacing is a promising new therapy for patients with congestive heart failure (CHF) and intraventricular conduction delay. Previous studies of this therapy have demon-

strated improvements in quality of life and exercise capacity but have been limited by uncontrolled or poorly controlled designs.

The MUSTIC study, supported in part by 2 manufacturers of atrial-synchronous biventricular pacemakers, was a European, multicenter, single-blind, randomized, controlled crossover trial of cardiac resynchronization therapy in patients with NYHA class III left ventricular systolic heart failure, normal sinus rhythm, and QRS durations of more than 150 ms. MUSTIC patients were randomized to 3 months of either cardiac resynchronization (atrial-synchronous biventricular pacing) or no cardiac resynchronization (ventricular inhibited pacing) and then were switched to the alternative mode for 3 more months.

Of 67 initial enrollees, 9 withdrew before randomization, and 10 failed to complete both study phases. Among the remaining 48 subjects, mean 6-minute walking distance was 23% farther, mean quality-of-life score was 32% better, and mean peak oxygen uptake was 8% higher with cardiac resynchronization than without it — all differences were significant.

In addition, CHF hospitalizations during the first phase (before crossover) were significantly less common with resynchronization.

Comment: Though limited by a small number of subjects and the single-blind nature of the crossover phase, the MUSTIC trial adds to a growing body of evidence supporting the use of cardiac-resynchronization therapy in CHF patients with intraventricular conduction delay. Results from large-scale, double-blind trials of this therapy in CHF patients are forthcoming. Data are yet to be published from another arm of MUSTIC, in which the

researchers evaluated biventricular pacing (without atrial synchrony) in CHF patients with intraventricular conduction delay and atrial fibrillation. —WT Abraham

Cazeau S et al. for the Multisite Stimulation in Cardiomyopathies (MUSTIC) Study Investigators. Effects of multisite biventricular pacing in patients with heart failure and intraventricular conduction delay. N Engl J Med 2001 Mar 22; 344:873-80.

Are Beta-Blockers Effective for Neurally Mediated Syncope?

Neurally mediated syncope (NMS), or vasovagal syncope, is by far the most common type of syncope, but remarkably few data about appropriate therapy exist. To evaluate the efficacy of the beta-blocker atenolol for NMS, investigators from Spain prospectively studied 50 consecutive patients who were diagnosed with recurrent NMS on the basis of clinical history and the exclusion of other diagnoses. Positive tilt-test results were not required for enrollment (though all patients were tested).

Twenty patients (40%) had positive tilt-test results; 18 underwent repeat testing 3 hours later to assess the efficacy of intravenous atenolol (5 to 10 mg), which normalized tilt responses in 5 patients. Regardless of tilt-test response, patients were randomized subsequently to oral atenolol (50 mg/day) or placebo and followed for 1 year. Time to recurrence did not differ significantly between groups, nor did frequency of recurrence (atenolol, 62%; placebo, 46%) or median number of recurrent episodes (2 vs. 0, respectively).

Comment: These results challenge the widely held belief that beta-blockers

continued next page

are effective treatment for NMS. The low NMS recurrence rate among placebo recipients in this study is particularly striking. However, as the authors and an editorialist note, study patients were not selected on the basis of positive tilt-test response. This contrasts with patient selection in the only other randomized clinical trial of oral beta-blocker therapy for NMS, in which atenolol was found to be effective (see *Am Heart J* 1995; 130:1250). Furthermore, the present study lacked information about adjunctive treatments, such as increased salt and fluid intake. As we await results of several ongoing, prospective, multicenter trials of beta-blocker therapy for NMS, clinicians should heed the basic principles of NMS treatment, including patient education and advice about increased salt and fluid intake. For most patients, these simple, inexpensive therapies will prove effective.

—H Calkins

Madrid AH et al. Lack of efficacy of atenolol for the prevention of neurally mediated syncope in a highly symptomatic population: A prospective, double-blind, randomized and placebo-controlled study. J Am Coll Cardiol 2001 Feb; 37:554-9.

Sra JS. Can we assess the efficacy of therapy in neurocardiogenic syncope? J Am Coll Cardiol 2001 Feb; 37:560-1.

CABG vs. Stenting for Multivessel Disease

Coronary stenting has led to improved outcomes for patients who undergo percutaneous transluminal coronary angioplasty (PTCA). In this new treatment era, controversy remains about whether the best revascularization approach for patients with multi-vessel disease is PTCA plus stenting or coronary artery bypass grafting (CABG).

In a study supported by a stent manufacturer, these investigators randomized 1205 patients (mean age, 61; 76% male) with multivessel disease to CABG or to PTCA plus stenting. All were considered suitable candidates for either strategy and had not undergone previous revascularization procedures. Patients with ejection fractions of 30% or overt congestive heart failure were excluded.

Nonsignificant 1-year differences between the 2 groups were found in rates of death (2.5%, stenting; 2.8%, CABG), stroke (1.5% vs. 2.0%, respectively), and MI (5.3% vs. 4.0%). By 1 year, repeat revascularization was significantly more common among stented patients (16.8% vs. 3.5%), and significantly fewer stented patients were free of angina (78.9% vs. 89.5%).

Quality-of-life scores, however, were virtually identical in the 2 groups.

Total direct medical costs were significantly lower for stented patients (\$10,665 vs. \$13,638).

Comment: In this study, patients with multivessel disease experienced similar clinical outcomes with CABG versus PTCA plus stenting. However, stenting was significantly less expensive, despite a larger number of required repeat procedures among stented patients. Longer-term follow-up data, including assessment of change in cognitive function, would be useful. Depending on the nature of the long-term data, cost may end up being the most noteworthy difference.

— HM Krumholz

Serruys PW et al. for the Arterial Revascularization Therapies Study Group. Comparison of coronary-artery bypass surgery and stenting for the treatment of multivessel disease. N Engl J Med 2001 Apr 12; 344:1117-24.

Beta-Blockers for Congestive Heart Failure

An Updated Meta-Analysis One-year survival rates for congestive heart failure (CHF) approach 50%. Clinical trials of beta-blockers have pointed to substantial survival benefits for CHF patients (see *JWC* May 2000, p. 39, and *JAMA* 2000; 283:1295), but use still is not widespread, perhaps because of lingering concerns about short-term negative inotropic effects. Previous meta-analyses have not included the largest randomized trials of beta-blockers for CHF, so these investigators conducted an updated meta-analysis (of 22 trials from 1966 to July 2000) and used a sophisticated statistical model to account for between-studies variation. Follow-up for the trials ranged from 3 to 23 months. All 10,135 enrolled patients were clinically stable for at least 2 to 3 weeks.

Deaths numbered 624 among 4862 placebo recipients (12.8%) and 444 among 5273 beta-blocker recipients (8.4%); hospitalization for CHF occurred in 15.5% (754) and 10.2% (540) of patients, respectively. The probability that beta-blocker therapy reduced total mortality and hospitalization for CHF was almost 100%. Beta-blockers saved an estimated 3.8 lives and prevented an estimated 4.0 hospitalizations per 100 patients treated.

Positive clinical benefits were seen for both selective (e.g., bisoprolol and metoprolol) and nonselective (e.g., carvedilol) agents.

Comment: These results confirm that beta-blockers, along with ACE inhibitors and diuretics, should be part of first-line treatment for CHF. Clinicians must overcome their reluctance to use

continued next page

beta-blockers for CHF, except when true contraindications exist, if patients are to derive the impressive clinical benefits they can confer. — JM Gore

Brophy JM et al. Beta-blockers in congestive heart failure: A Bayesian meta-analysis. Ann Intern Med 2001 Apr 3; 134:550-60.

Special Note, Dear Readers:

An important aspect of *Journal Watch Cardiology's* mission is to provide you with information to use in your clinical practice. The editors are presenting a new feature called **Clinical Practice Guideline Watch**. From time to time, they will review those published guidelines that they consider of the greatest importance for clinicians. **Guidelines** do not replace clinical judgment, but by synthesizing current knowledge and distilling best practice, they provide valuable assistance in defining approaches to patient care. They hope that you find the new feature useful.

Guidelines for Percutaneous Coronary Intervention Sponsoring Organizations:

This revision of the 1993 guidelines for percutaneous transluminal coronary angioplasty (PTCA) was developed jointly by the American College of Cardiology and the American Heart Association and is endorsed by the Society for Cardiac Angiography and Interventions.

Background and Purpose: Since 1993, the definition of PCI has broadened beyond PTCA, PCIs are performed more frequently (an estimated >1 million procedures annually worldwide), and advances have been made in the use of adjunctive technology and medicine. Furthermore, the landscape of device use in interventional cardiology has changed considerably: PTCA alone is now used in <30% of procedures; frequency of stent use is >70%. These guidelines are intended

to help clinicians address these new realities as they make decisions involving PCI.

Key Points:

1. Stents reduce the incidence of acute complications of balloon angioplasty.
2. Strong evidence (i.e., from multiple randomized clinical trials) shows that stenting reduces restenosis in selected patients undergoing single-vessel PCI. However, effective stent use is expanding to a wider patient domain.
3. In patients who have undergone coronary artery bypass grafting (CABG), PCI increasingly is recognized as a palliative procedure (in both native coronary arteries and bypass grafts) with the potential to delay repeat CABG.
4. Evidence from nonrandomized studies shows that PCI should be performed by high-volume operators (>75 procedures/year) at high-volume institutions (>400 procedures/year).
5. In general, PCI should be performed in facilities with on-site cardiac surgery. However, limited evidence shows that sites without surgery also may have success with PCI, if they have proven plans for rapid access and transfer to surgical facilities.
6. Patients with class 1 indications for PCI (i.e., for whom evidence shows that PCI is useful and effective) include asymptomatic, nondiabetic patients with a large risk area; patients with moderate or severe symptoms and ischemia; and acute-MI patients (as an alternative to thrombolysis) if PCI is performed within 90 minutes by high-volume operators, or later when there are objective signs of

ischemia. Other class I indications are listed in section V of the guidelines.

7. Although strong evidence and general expert agreement still are lacking, the report acknowledges the usefulness of intravascular ultrasound for optimal stent placement and of intracoronary physiologic measurements for assessment of intermediate lesions.
8. In certain clinical subsets of patients, PCI results may be improved with adjunctive pharmacotherapy. Among the class I indications are aspirin for all patients, clopidogrel for all patients in conjunction with stenting, and glycoprotein IIb/IIIa blockade for patients with unstable angina and for MI patients after thrombolysis.

Comment: These carefully written, comprehensive, extensively referenced guidelines expand the indications for PCI, primarily based on evidence for the safety and efficacy of intracoronary stents. The guidelines are available free of charge on the Web at <http://www.acc.org/clinical/guidelines/percutaneous/dirIndex.htm> — HC Herrmann

Smith SC et al. ACC/AHA guidelines for percutaneous coronary intervention: A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1993 Guidelines for Percutaneous Transluminal Coronary Angioplasty). J Am Coll Cardiol 2001 Jun 15; 37:2239i-2239lxvi.

NCEP Guidelines for Cholesterol Management

Sponsoring Organization: This executive summary of the 1993 guidelines

continued next page

revision was authored by the National Heart, Lung, and Blood Institute's (NHLBI's) National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol. Purpose: The NHLBI has developed these new cholesterol guidelines to help clinicians integrate current findings into clinical practice, with new emphasis on assessing patients' underlying risk for coronary heart disease (CHD).

Key Points:

1. Elevated LDL cholesterol is a major cause of CHD. Evaluation of LDL levels should be a key component of an overall risk-assessment strategy.
2. In people 20 or older, a fasting lipoprotein profile (total, LDL, and HDL cholesterol levels, plus triglyceride level) should constitute initial screening for hypercholesterolemia and should be obtained every 5 years. Follow-up profiles should be obtained if total cholesterol is ≥ 200 mg/dL or HDL cholesterol is < 40 mg/dL.

3. For people without clinically manifest CHD, 10-year CHD risk should be assessed with the newly modified Framingham Risk Prediction Score. Ten-year CHD risk calculations should be used with other risk-factor data and cholesterol-screening results to guide management, including consideration of lifestyle changes and drug therapy. See table 5 of the executive summary for calibration details.
4. Regardless of CHD status, all diabetics should have their LDL levels treated to the target of < 100 mg/dL. With the new emphasis on underlying risk, diabetics no longer should be considered candidates for just primary prevention.
5. More intensive "therapeutic lifestyle changes" are recommended as first-line therapy. These include weight reduction, increased physical activity, and diets with < 200 mg/day of cholesterol and $< 7\%$ of calories from saturated fat.
6. The guidelines identify the metabolic syndrome as a secondary target of therapy. Management of this disorder should be directed at underlying causes, such as obesity and inactivity, and at related nonlipid and lipid risk factors.
7. The guidelines recommend treating borderline high triglyceride levels (newly defined as 150 mg/dL to 190 mg/dL) with weight control, physical activity, and medication (if necessary).
8. Cholesterol lowering with statins has been shown to reduce the incidence of adverse cardiovascular events in women with and without CHD. Hormone replacement

therapy is not recommended as an alternative to cholesterol-lowering drugs in postmenopausal women with CHD.

Comment: These guidelines expand the indications for aggressive lipid lowering to new patient subsets. A key change is modification of the Framingham Risk Prediction Score to estimate CHD risk. Also noteworthy is the expert panel's inclusion of recommendations to ensure guideline implementation and adherence to therapy. The complete guidelines are available on the Web at <http://www.nhlbi.nih.gov> — **JM Foody**

Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). JAMA 2001 May 16; 285:2486-97. Lauer MS and Fontanarosa PB. Updated guidelines for cholesterol management. JAMA 2001 May 16; 285:2508-9.

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Newsletter of the RI Chapter of the ACC

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As early as Thursday, July 26, the patients' bill of rights

is expected to be brought to the House floor for consideration. The debate in the House centers on two bills: one sponsored by Reps. Ernest Fletcher, R-KY, Nancy Johnson, R-CT, and Collin Peterson, D-MT, (H.R. 2315), and a bill sponsored by Reps. Greg Ganske, R-IA, and John Dingell, D-MI (H.R. 526). The likely floor strategy will be that House members will be given an opportunity to vote on both bills. The sponsors of both bills are aggressively seeking support from their colleagues for their respective bills. The votes are expected to be close and whichever bill passes last will prevail. After very careful review, the American College of Cardiology (ACC) issued its support for both bills on the grounds that they both contain strong patient protection provisions long-supported by the ACC.

Contrary to some reports, the Fletcher bill is identical to the Ganske/Dingell bill in nearly every aspect. The principal differences lie in the health plan liability provisions. What the debate really boils down to is what bill has the best opportunity of being signed into law by President Bush. President Bush has said repeatedly that he will veto the Ganske-Dingell bill. The ACC is encouraging members of Congress to pass a meaningful bill that can be enacted into law this year and is engaging in targeted grassroots. If you have any questions, please contact Camille Sorosiak in the

ACC's Legislative Affairs Department at (800) 435-9203 or csorosia@acc.org.

The ACC has formally joined a coalition initiated by the American Heart Association to advocate for Medicare coverage of cholesterol screening. The Ad Hoc Coalition for Medicare Coverage of Cholesterol Screening held its first plenary meeting July 19 and has begun meeting with members of Congress to pursue a legislative proposal.

In Ohio, legislation that would require health plans to pay or deny claims in 30 to 45 days was sent to the governor for his signature. According to an Ohio Hospital Association report, the legislation also prohibits insurers from developing contracts that include payment time-frames that are longer than those required in the legislation. Penalties for insurers that violate the law would include tacking on 18 percent interest to the payment claims. The bill would take effect one year from passage into law.

Thanks in large part to ACC feedback, effective June 30, 2001, Medicare carriers have been instructed to delete processing edits that deny claims or identify for manual review preoperative evaluations obtained outside of the global surgical period. The instruction affects the use of ICD 9 codes V72.81 through V72.84. Code V72.81 is a preoperative cardiovascular examination and is reported by cardiologists as the reason for their services. Denials for payment of preoperative screening

were highlighted by the ACC in a report to HCFA on "physician hassles" compiled by the AMA. It will now be easier for cardiologists to get paid as long as the preoperative exam is medically necessary and meets documentation requirements. The Medicare Carriers Manual Transmittal 1707 describing the change is available on the HCFA web site: www.hcfa.gov/pubforms/transmit/r1707b3.pdf

The ACC has endorsed the "Teaching Children to Save Lives Act," which would provide federal grants to states to be divided up among school districts and localities for CPR training. The legislation was introduced in the House by Rep. Lois Capps, R-CA, and in the Senate by Sens. Susan Collins, R-ME, and Russ Feingold, D-WI. In letters of support sent to the sponsors, ACC President Douglas P. Zipes, MD, applauded their efforts to increase the number of people with CPR training. Teaching CPR as part of school curriculums, Dr. Zipes said, will help to ensure that "the pool of bystanders trained to administer CPR will greatly increase and lead to speedier CPR interventions."

Reimbursement for stress echocardiography, code 93350, will increase approximately \$9 million per year starting in 2002. According to the proposed rule published in the June 8 Federal Register. HCFA has agreed to increase the work RVU for stress

continued on next page

ACC NEWS BRIEFS

continued from page 11

echo from .78 to 1.48, or about \$26. The ACC conducted a survey on stress echo last year. Alan Pearlman, MD, and James Maloney, MD, presented the ACC's survey data on stress echo to the HCFA Relative Value Update Committee. Over 900 codes were evaluated in the five-year review process. The five-year review changes involve a redistribution of Medicare spending that will exceed \$200 million. Cardiology as a whole loses about 1 percent due to budget neutrality adjustments. Cardiac surgery will increase by about 6 percent because of significant increases for some bypass and valve procedures.

Save This Date:

3rd Annual Meeting of the RI Chapter of the ACC

Tuesday,

October 23, 2001

Metacomet Country Club

Keynote Speaker:

Douglas P. Zipes, MD, FACC

President, ACC

Look for your invitation in the mail!!

SUBMISSIONS, SUGGESTIONS OR COMMENTS REGARDING THE RIACC CHAPTER NEWSLETTER SHOULD BE E-MAILED TO ROBERT H. SCHWENDEL, MD FACC AT RSCHWENDEL@HEARTRI.COM

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