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Management of stable coronary artery disease patients: Very efficient for a population but probably insufficient for every single patient. The Indyce survey

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Background: In studies and surveys involving stable coronary artery disease (CAD) patients, the global population often seems well managed; however, the question remains to know what is the proportion of patients who benefit from every simple medical intervention improving the prognosis or showing good quality of care.

Objective: To evaluate medical management of stable CAD outpatients in France by calculating a progressive quality index.

Methods and Results: The INDYCE survey was conducted in a sample of 343 cardiologists in France in 2008. Each physician had to include consecutively 10 stable CAD patients (absence of acute coronary syndrome or revascularisation in the 6 months preceding enrolment).

3119 patients (male: 80 %, 68 ± 11 years old, diabetes: 24.3 %, hypertension: 61.6 %) were enrolled.

Medical therapy was in keeping with Guidelines (antiplatelet agents (AA) : 88.4 % ; statins : 85.9 % ; ACE-I/ARBs : 78.8 %, beta-blockers (BB) : 74.6 %). Patients suffered from mild to moderate symptoms (angina : 19.2 %, NYHA class 0 or I : 43.5 %, NYHA class II : 46.9 %, NYHA class III : 9.3 % ; NYHA class IV : 0.3 %). Mean rest heart rate (HR) was of 64.2 ± 10.8 bpm, mean systolic and diastolic blood pressure (BP) of 131.8 ± 15.4 and 75.8 ± 8.4 mmHg respectively.

However, when calculating a progressive quality index:
(1) 44.69 % of the patients received an AA + a statin + an ACE-I/ARBs + a BB
(2) 29.79 % had (1) and a systolic BP < 140 mmHg + a diastolic BP < 90 mmHg
(3) 23.02 % had (1) + (2) and a resting heart rate < 70 bpm
(4) 12.6 % had (1) + (2) + (3) and had a regular physical activity
(5) 6.96 % had (1) + (2) + (3) + (4) and had performed an exercise test during the last 12 months
(6) 4.07 % had (1) + (2) + (3) + (4) + (5) and were asymptomatic (no angina and NYHA class 0 or I)

Conclusion: Stable CAD patients do not raise attention because they are often pauci-symptomatic. At a population level, they appear to be well managed. However, building a quality index allows us to show that very few of these patients benefit from every step of a simple medical management.

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Risk assessment for radiation-induced cancer after Interventional Cardiology procedures

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The increased use of interventional cardiology (IC) procedures, while providing important benefits to patients, also contributes to their radiation exposure. Radiation is a relatively weak carcinogen and demonstrating a radiation-induced cancer risk remains difficult. Only very crude results of lifetime risk assessment of cancer after IC procedures have been presented elsewhere, but the age distribution of population, technical procedures actually applied and target organs are also important to consider.

Based on a previous detailled description of clinical features and dosimetric data (absorbed organ doses: lung and bone marrow) of an adult French population undergoing IC procedure, and the latest radiation risk models (BEIR VII), a specific risk assessment for lung cancer and leukaemia mortalities was realized.

We considered patients having undergone either a coronary angiography or cumulating coronary angiography and angioplasty, at age 40-75 years, and followed until 85 years. Based on different scenarios of radiation exposure and delivered-doses, the number of deaths from lung cancer or leukaemia due to radiation per 1,000 general population spontaneous lung cancer or leukaemia deaths respectively, was estimated. Preliminary results show that the risk of specific radio-induced cancer in patients undergoing IC procedure exists even if it remains relatively limited. Moreover, depending on patients' age and type of IC procedure, additional procedures appeared to increase the lifetime risk estimates.

This study provides evidence of the potential radio-induced cancer risk in IC. The limitations of such calculations are due to the difficulty to take into account patients' possible shorter life prognosis than in general population, partly explained by comorbidities and coronary disease. Because of numerical evolution of IC procedures, interventions to promote delivered-doses optimization and "ALARA" requirements may prevent or limit this risk.

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Implementation time of a lipid lowering therapy in patients with dyslipidemia: results of Prysme study

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Despite the availability of specific guidelines, the management of dyslipidemia in practice is not optimal.

Objective and methodology: PRYSME, a non-interventional multicentre study carried out with 1226 general practitioners, aimed to describe the implementation time of a lipid lowering treatment according to cardiovascular risk level (primary objective) and to identify its determinants. Were eligible patients treated for a dyslipidemia diagnosed less than 2 years ago. Demographic and clinical characteristics and circumstances of diagnosis and treatment initiation were collected.

Results: 3268 patients were included (mean age: 57 years old, males: 64%). 26% were obese and 45% overweight.Only 12% had no cardiovascular risk factors (CRF) at the time of dyslipidemia diagnosis. The most frequent CRF were arterial hypertension (50%), smoking (43%), family history of premature coronary heart disease (28%), HDL-c <0.4g/l (20%) whereas 15% of the patients had a personal history of cardiovascular disease. Dietary programs were initially implemented for 98% of the patients. More than 90% were treated with a statin. The implementation time of the treatment (evaluated according to the biological confirmation of dyslipidemia), according to the initial number of CRF, was as following:

	0 CRF	1 CRF	2 CRF	≥ 3 CRF	Secondary prevention	Total
[-3;0] months	34.3%	28.6%	27.1%	29.3%	49.1%	33.1%
]0;3] months	23.1%	26.2%	26.4%	24.0%	21.9%	23.9%
> 3 months	42.6%	45.3%	46.5%	46.8%	29.0%	43.0%

Chi-2 test : P<0.001

The main determinant of an early implementation of a lipid lowering therapy (≤ 3 months) was secondary prevention (OR=1.8). The number of CRF had no significant impact.

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