

South African Heart Association Newsletter 2006

From the President's Desk by Len Steingo

The new year has so far been very busy. All the Exco and chairpersons of the sub-committees have been continuing to function at a fast pace. The *SA Heart Journal* under the guidance of Anton Doubell has been very successful and the most recent edition including heart failure guidelines has been very well received by all.

Publishing of guidelines covering various important and later less important topics will continue. These serve both our members and the medical funders who are able to refer to them. We believe the guidelines assist in best medical practice based on good scientific data and research. The guidelines are not meant to dictate but to assist and set standards for good medical practice.

In relation to the above we continue to receive letters of complaint from medical funders concerning colleagues' unusual or excessive charges. A recent complaint concerned the utilisation of an anaesthetist for all angiographic procedures. The anaesthetist is charging for all the procedures and for multi-organ dysfunction aftercare in the ICU. We are not in the situation of disciplining members but we need to respond to these types of questions and occasionally find it embarrassing trying to defend our colleagues.

We would appreciate more members participating in the cath lab registry as well as the script pad projects. Both these projects have great potential in collecting data, supplying practice information and a potential source of income for SA Heart.

The 2006 congress is well on track and being organised by the Bloemfontein branch.

The 2007 congress is going to be organised by SASCI and possibly in association with other special interest groups but this has not yet been confirmed. Professor Johan Brink, current chairman of the Cape Town branch has agreed on behalf of his members to organise the 2008 SA Heart congress. We thank him for this and wish him great success.

First All Africa Conference on heart disease, diabetes and stroke

Following the historic December 6, 2005 issue of *Circulation on Cardiovascular Disease in Africa*, the PAN AFRICAN SOCIETY OF CARDIOLOGY and the KENYA CARDIAC SOCIETY are convening the first multidisciplinary conference on heart disease, diabetes and stroke in Africa in Nairobi, Kenya, from 13-16 May 2007.

Please diarise the date and watch this space for more information. For further details please contact Erika Dau on: erika@saheart.org

Office Bearers of the Pan African Society of Cardiology:

President: Prof Albert Amoah, Ghana
Vice President-East: Prof Elijah Ogola, Kenya
Vice President-West: Prof Oluwole Adebo, Nigeria
Vice President-South: Dr Colin Schamroth, South Africa
Vice President-Central: Prof Pierre Kombila, Gabon
Vice President-North: Prof Salah Zaher, Egypt
Secretary General: Dr Sam Omokhodion, Nigeria
Treasurer: Prof Bongani Mayosi, South Africa
Immediate Past President: Prof Wali Muna, Cameroon

SASCI newsletter July 2006 - From the Chairman's Desk by Tom Mabin

SASCI continues to actively pursue all our objectives during 2006.

This newsletter reflects that the educational field receives a lot of attention but also please note the issues raised such as "Practice Cost and Tariffs" which could substantially impact on our ability to continue delivering quality patient care.

SA Heart Congress 2006: SASCI will host an Interventional Cardiology Satellite Session during the SA Heart Congress 2006. The session will include live cases by satellite link-up from Vergelegen Hospital. Cases will be performed by Dr McFadden (Ireland) with confirmation expected shortly from other noteworthy international opinion leaders.

SA Heart Congress 2006: As part of the exciting programme there will be a "**Tips and Tricks**" session. This will allow members and attendees the opportunity to present interesting and /or difficult interventional problems and to discuss or debate their potential solutions with the audience and a panel of guests. The cases for the "Tips and Tricks" session should focus on any area of interventional cardiology or endovascular disease and be 5 to 10 minutes in duration (with an additional 5 minute Q and A). We invite anyone with cases that we can all learn from, to submit them to the SASCI Organising Committee (Clive Corbett, Adie Horak and Mpiko Ntsekhe) via the SASCI Office. Submission closes on 28 July 2006.

As an affiliate of **EuroPCR**, SASCI will from 2007 have an educational session during the EuroPCR meeting in Barcelona. Please contact Farrel Hellig if you would like to contribute to next year's session.

The "**Boston Scientific RC Fraser International Fellowship in Interventional Cardiology**" recipient(s) for 2005 Dr Sanjay Maharaj and 2006 Dr Mbuyu Bushidi will be departing for Kings College (UK) in July and September respectively. Their time in the UK will be as part of Prof Martin Thomas's group. This exciting programme will once again be available for 2007 for South African Registrars being trained in the public sector in Interventional Cardiology during 2007.

The SASCI Wilderness Meeting (Cordis and Boehringer Ingelheim) took place from 3 to 5 March 2006 at the Protea Wilderness Hotel and was attended by 20 clinicians. The sessions, chaired by Dr Steve Spilkin, were well attended and focused on the following hot topics:
Biventricular pacing, 3D imaging, the use of cutting balloons, the use of drug eluting stents (indication specific) and stem cell therapies to mention but a few.

A number of opportunities exist for interventional cardiologists to follow **internationally developed training courses in South Africa** and gain the necessary experience through interactive learning at world class facilities. Below are short write-ups on two of these programmes (this is not necessarily an exhaustive list).

The **Institute for Therapy Advancement | South Africa** (Baroque Medical) will officially be opened by Prof Jean Marco on 26 July 2006. Courses will be offered for both vascular and peripheral intervention and training will be presented by international and local faculty members, approved by Prof Dr Jean Marco for coronary intervention courses and Dr Luc Stockx for peripheral vascular intervention.

Courses will consist of both theory and practical sessions utilising virtual reality simulators to enhance hands-on skills and knowledge.

Courses are internationally certified and in due course will be locally accredited.

CASES (Carotid Artery Stenting Education System) programme update (Cordis Johnson & Johnson): Carotid artery stenting has become a source of great interest to doctors from all interventional backgrounds. This was fuelled by the latest carotid stent data proving equivalence to carotid endarterectomy.

The CASES programme (supported by SASCI, VASSA and the Interventional Radiology Society of South Africa) aims to bring about better patient outcomes through training of all interventionalists to meet certain experience requirements. It has three phases, starting with online didactic (theory) followed by simulation and finally live cases proctorship. The programme has been operational for three months in South Africa, with 50 doctors enrolled on the online programme and five have been fully proctored and accredited to date.

The "**Controversies in Cardiology Weekend**" will be hosted by Sanofi-Aventis under the auspices of SASCI from 14-16 July 2006 at Mount Grace, Magaliesberg. The academic sessions will run for a full day on Saturday and until 11:00 on Sunday. A local faculty will support the international speaker Prof JP Bassand.

Focus will be on interventional cardiology with emphasis on anti-platelet and anti-thrombin controversies. Case presentations and open discussion will be encouraged, and 40 to 45 cardiologists are expected to participate. SASCI will hold an EGM to discuss ongoing issues.

Other activities for 2006

The **Cath Lab Registry** project has come a long way, and after much testing by cardiologists and suggestions for alterations to make it more user-friendly, it is in its final stage of the development cycle.

Tony Scott of Interprax is busy obtaining final signoff of all the modules from the members of the Cath Lab Registry Working Group, and we expect to be ready to roll out the latest version of the registry to SA Heart and SASCI members from 01 July 2006. Practitioners in Johannesburg will be the first to get a glimpse of the new registry in July, and cath labs in Cape Town and Durban will receive implementation of the registry from August onwards.

Elizabeth Schaafsma has been appointed by SA Heart as the Registry Data Manager. She will be on call to answer any enquiries about the registry, and will be in contact with practitioners to arrange implementation of the registry and training.

She will liaise with industry and doctors when new products are launched to ensure that they are available for entry within the registry, and will work with cath labs to ensure that the data entered into the registry is of good quality so that the registry can fulfil one of its purposes - providing local depersonalised data about cardiac procedures and interventions.

Please call Elizabeth on 083-603-7700 if you want any further information on the registry, or email her on elizabeth@vodamail.co.za

A postal survey from the Cath lab Registry subcommittee has had a very poor response from colleagues and SASCI will be addressing concerns expressed in that survey and attempt to encourage as much participation as possible to establish this database which will be considered essential by the Department of Health in the near future.

SASCI as a Special Interest Group within SA Heart participated in the structures created by SA Heart to address the issues of "**Practice Cost and Tariffs**". The cardiology submission to SAMA was based on data from only 15 cardiology practices and via SAMA submitted to Council for Medical Schemes for approval (www.medicalschemes.com, go to publications, go to NHRPL submissions).

The final outcome is expected by no later than the end of July 2006.

The process of acquiring data pertaining to practice costs and tariffs is ongoing; therefore it is an absolute imperative that SASCI members contact the SASCI Office to contribute to this programme which will impact substantially on our income and eventually patient care.

SASCI membership invoices for 2006 were distributed in April 2006 as part of the SA Heart's invoice. Thank you to the 50-odd members who have already settled their invoices. If you have not received an invoice please contact the SASCI Office or if you have not settled the invoice yet please do so as a matter of urgency. Also keep in mind that as a Special Interest Group within SA Heart, SASCI members must also be members of SA Heart.

I would also like to use this opportunity to address the **involvement of SASCI members**. In order for SASCI to act effectively in the market (with organisations such as medical aids and Government) we require that members demonstrate their support by becoming actively involved, the individual practitioner can not deal effectively with these organisations.

Lastly I would like to wish all members continued successful in 2006. Please contact myself or a regional representative if you have any suggestions or would like to become actively involved in SASCI.

SASCI Executive Committee for 2006-2007

T Mabin (Chairman), F Hellig (Vice-chairman and Secretary), C Corbett (Treasurer) with Regional Representatives G Cassel (Johannesburg), C Badenhorst (Pretoria), J Patel (Durban), A Horak (Cape Town), S Spilkin (Port Elizabeth), M Ntsekhe (Academic), R Kleinloog (Surgical) and J Harrisberg(Paediatric)

George Nel at the SASCI Office is available to assist you with any queries related to information contained in this newsletter.

Please feel free to contact him on 083-458-5954 cell phone, 086-675-0805 fax or george.nel@lantic.net

Da Various codes - a typical case study by Dr Ronnie Jardine

Dear 1500274,

Thank you for referring Discovery member number 8750205674 to me for evaluation. He is a 67-year-old man who presents with a 6-month history of R0.00 intermittently, lasting hours at a time, accompanied by R07.2 on occasions and always R06.0. On 8/4/2006 you performed a 1232 and found him to be in I48, so you admitted him to hospital number 1993/007540/06. I found him to have I10 and to be in mild I50.0 in NYHA II, sleeping on 3 pillows. A 3622 showed I42.0 and the EF was 0.35 on calculation from the 3621; 3625 showed functional I34 which on 3620 was mild. A 1235 showed no evidence of I25.1, but I performed 1252 nevertheless and it was normal.

Treatment was started with NAPPI numbers 735949 and 700710 but because of 8545, they had to be changed to 758272 and 868922 respectively. Unfortunately the latter caused a R05 so I motivated for 700710 once again. He was discharged after 5 days (12/4/2006).

Yours sincerely,

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Shoe size 7

Waist size 36

SADF number 68228907

Rifle number 107532

Any other irrelevant numbers will be supplied on request.

**Hypertension perspectives from the European Society of Hypertension (ESH) (Madrid 2006)
by Dr Adriaan Snyders**

The LIFE Study tells us about the reduction in stroke without reduction in myocardial infarction. Treating hypertension with losartan reduces the onset of new atrial fibrillation and diabetes mellitus. Losartan used as an antihypertensive can promote regression of LVH and improvement in microalbuminuria - **but** how would it compare with other ARBs? or with ACE inhibitors? - we'll have to wait for the OnTarget Trial. Will we get the same result with generic losartan - or other generic drugs? A combination of at least two drugs offers the best of two worlds. ACE inhibitors and CCBs have proven results.

The hyperuricaemic effects of hydrochlorothiazide is partly negated by the uricosuric effect of losartan - what about other ARBs or ACEs? Chlorthalidone quoted in all the diuretic studies is discontinued? Mortality reduction possible with BP reduction if even only 10-15/5-10 mmHg - even if not yet on target. ARBs are as effective as ACE-inhibitors - if used in the correct dose. What is the correct dose of losartan - 100 mg? and of valsartan - 320 mg? ARBs are surely indicated in DM II, microalbuminuria, LVH; ACE-cough but maybe also by preference.

A statin may even improve atherosclerosis and hypertension. An ACE inhibitor or ARB may improve the lipid profile. Control of diabetes can retard the progression of atherosclerosis. That leaves us with a poli-pill.

Is treating a cuff measurement in mmHg enough to protect the heart - reduce LVH and wall stress? LVH is present in 25% of all hypertensives (15/60 mil of hypertensives in the USA). LVH clearly correlates with morbidity and mortality. Oxygen demand during uncontrolled hypertension plays a major pathogenetic role.

Cardiac Risk Index takes into account LV Mass x LV Wall Stress x O₂ Demand. Hypertension promotes AF. AF is common and associated with hypertension, LVH and age. Beta-blocker based anti-hypertensive therapy is less effective to prevent AF compared with ACEI - no better with rate control, onset of new AF or the development of CVA due to AF with BB.

Benefit for ACEI therapy is not yet proven in patients without hypertension - but that probably depends on the definition of hypertension referred to - 120/80 or 130/80 mmHg? Diagnostic and prognostic importance of a large LA - should affect the aggression of therapy.

Protecting the kidney from hypertensive disease runs parallel to protecting the heart. Forty per cent of hypertensives develop nephropathy. Losartan 100 mg protects the kidney better than 50 mg does. UKPDS indicates that maybe lipid control is more important than BP control.

Is preventing CVA in hypertension only related to reducing the BP reading? How significant are the pleiotropic effects of ACEI and ARB? Is reducing oxidative stress, atherosclerosis, plaque rupture and thrombosis with ACEI/ARB as important?

Some evidence at least exists that ACEIs and ARBs do more than just lowering a reading in mmHg. It seems that CVA is not only related to the BP reading. Patients' therapy still needs to be individualised.

The ARB dose response curve is steeper for tissue ACE than plasma ACE. What is the place of CCB in CAD? ARB for CVA prevention but not to prevent MI? Beta-blocker only beneficial post MI for what, one year? two years? Does it matter which drug or which dose? or is treating to target all that matters? Should all patients over 50 be on an ACEI or AR? Some would think so! ALLHAT study is being criticised widely - but still referred to?

Newer drugs may play a larger role in the pathophysiology than older drugs.

Pro-Renin: Are beta-blockers not effective? A glucose infusion and dehydration activates RAS.

Waist circumference and waist/hip ratio is central to the diagnosis of metabolic syndrome. Fifty per cent of USA citizens are obese. Waist circumference of 88/102 cm in USA but 84 and 90 cm in a more ideal world.

As a risk is obesity more important in younger patients than older patients? What about a glitazone or metformin with ACEI/ARB combination? More than enough reasons exist to avoid beta-blockers and thiazides in metabolic syndrome.

Obesity certainly a marker of metabolic syndrome, but do we have evidence that weight reduction will prolong life? and by how much? Two months? Liposuction does nothing to intra-abdominal fat and prognosis, but omentectomy has benefit. Can a routine CT scan of the abdomen to assess intra-abdominal fat and risk be motivated? MI risk is increased 2-4 times with obesity. Obesity is present in 40% of MI patients. Exercise loses more visceral fat than diet alone.

Is PPAR-gamma just another talking point? Would managing PPAR gamma influence longevity? It certainly plays a significant role in insulin sensitisation.

AZD a new anti-platelet drug as effective as clopidogrel maybe? and reversible! Aspirin does not clinically reduce the ACEI benefit or worsen renal failure. Beware of aspirin if blood pressure is not controlled.

Symptoms, risk factors, target organ damage - all influence the drug treatment option. Guidelines are not prescriptive. Patient's need and risk should be individualised. A 10% risk may mean a 100% occurrence for 1/10 patients.

New drugs:

- Blocking the endocannabinoid system
- Combinations with statins of insulin sensitisers
- Combinations between different classes of antihypertensive drugs

Rimonabant acts on adipocytes and increases adiponectin; hepacytes and decrease FA synthesis; muscle and pancreas cells and decrease insulin resistance.

Medical aids will probably want mortality data.

Heart Failure Society of South Africa (HeFSSA) by Eric Klug, Karen Sliwa, Olaf Forster

Dear members

HeFSSA continues to develop into a formal operational organisation with the capabilities to deliver on our stated objectives.

It is our pleasure to announce that George Nel has joined the HeFSSA team as Executive Officer. George has extensive commercial experience and has been instrumental in establishing SASCI during the past three years. Please feel free to contact George regarding any HeFSSA related issues (083-458-5954 tel, 086-675-0805 fax and george.nel@lantic.net).

HeFSSA will be registered as a Section 21 company (non-profit) within the next eight weeks (with Price Waterhouse Coopers Inc as our auditors) and our HeFSSA website will go live in August 2006 (www.hefssa.org).

We would like to extend our gratitude to Abbott, Medtronic and Roche Diagnostic for their significant support during the launch phase of the new Society.

We encourage you to read the May edition of *SA Heart Journal*, covering various aspects of acute and chronic heart failure. The official HeFSSA logo features on the front cover.

With best wishes..