Waiting for a bypass: a comment from primary care

The length of time that patients spend on the waiting list for coronary artery bypass surgery (CABG) is a matter of concern. In one study of 1,049 patients in the South East of the UK, the mean time to specialist consultation was 36 days (SD 43); the time waiting for coronary angiography was 85 days (SD 89); and the mean time on the surgical waiting list for CABG was 133 days (SD 134) – a mean time of 279 days (SD 209; range 1–1,579 days) from GP referral[1] to CABG.

This delay leaves everyone playing Russian roulette. Most deaths occur soon after patients are put on the waiting list – one third after two weeks and half within six to eight weeks. Older patients with left ventricular dysfunction, angina and left main vessel disease fare worst.[2]

The government is dedicated to providing more resources. In November 2001, £300 million was promised to reform cardiac services and provide more heart operations. The official Downing Street website predicted that this would mean that the maximum waiting time for heart surgery should fall from 19 months to 12 months by March 2002, well ahead of the targets set in the NHS Plan.[3]

This delay is still too long. The National Service Framework (NSF)[4] has recently proposed second stage maximum waiting times for patients with stable chest pain of one month from GP referral to specialist consultation; three months to angiography; and a further three to six months to CABG.

The waiting time is nevertheless a period during which concentration on coronary hygiene can pay dividends. Routine practice which will improve survival includes aspirin and other antiplatelet drugs; nitrates; beta blockers; statins; and angiotensin-converting enzyme (ACE) inhibitors where there is evidence of left ventricular impairment.[5-7] Rigorous control of blood pressure[8] and plasma glucose[9,10] has been shown to reduce both intra- and post-operative complications and mortality.

'Co-operative management is not simply a feature of maternity care. It could work for CABG patients too'

Peter Stott

It is a tragedy, therefore, that so few patients on waiting lists for CABG manage to achieve even the most basic targets.

In a paper published in this edition of the Journal (see pages 490–1), Charalambous *et al.* from Manchester Royal Infirmary[11] demonstrate the background statistics in their area. 15% of patients awaiting CABG continued to smoke. A majority did not achieve target levels for cholesterol. Over a third had raised blood pressure; and amongst the diabetic patients, 88% had an HbA_{1C} above 7%.

This is an area where primary care can play a valuable role. Cardiologists are poorly placed to prepare these patients. General practitioners not only have the holistic skills to optimise their metabolic control, they can also see them often enough to make a real difference. At this point in time, patients should be maximally motivated so long-term life-style modification has greatest potential.

If we are to achieve the targets in the NSF, then we will need to work together. Co-operative management is not simply a feature of maternity care. It could work for CABG patients too.

Peter Stott
General Practitioner
Tadworth Farm Surgery,
Troy Close, Tadworth,
Surrey, KT20 5JE.
(email: pstott@medicom.co.uk)

References

1. Chambers JB, Buckle R, Smeeton N. Coronary bypass grafting in South Thames: the correlation between clinical scores and waiting times. *Int J Clin Prac* 2002;**56**(1):11-4.
2. Morgan CD, Sykora K, Naylor CD. Analysis of deaths while waiting for cardiac surgery among 29,923 consecutive patients in Ontario, Canada. The Steering committee of the cardiac care network of Ontario. *Heart* 1998;**79**:345-9.
3. Downing Street Newsroom. http://www.number-10.gov.uk/news.dsp?newsID=3086
4. Department of Health. *National Service Framework for coronary heart disease: modern standards and service models.* London: Department of Health, 2000.

5. Shepherd J. Risk Factor modification extends the benefit of coronary artery revascularisation procedures. *Int J Clin Prac* 1999;**53**(5): 376-80.
6. Maynard SJ, Scott GO, Ridell JW, Adgey AAJ. Management of acute coronary syndromes. *BMJ* 2000;**321**:220-3.
7. Manhapra A, Borzak S. Treatment possibilities for unstable angina. *BMJ* 2000;**321**: 1269-75.
8. Muller M, Schindler E, Kwapisz M *et al*. Effect of intraoperative angiotensin-converting enzyme inhibition by quinaprilat on hypertension after coronary artery surgery. *Br J Anaesthes* 2000;**84**(3):396-8.
9. Zindrou D, Taylor KM, Bagger JP. Admission plasma glucose: an independent risk factor in on-diabetic women after coronary artery bypass grafting. *Diabetes Care* 2001;**24**(9): 1634-9.
10. Magee MJ, Dewey TM, Acuff T *et al*. Influence of diabetes on mortality and morbidity: off-pump coronary artery bypass grafting versus coronary artery bypass grafting with cardiopulmonary bypass. *Ann Thoracic Surg* 2001;**72**(3):776-80.
11. Charalambous C, Cleanthous S, Siddique I *et al*. Secondary prevention in patients awaiting CABG in the North West of England. *Br J Cardiol* 2002;**9**:490-1.