Britain: still the sick man of Europe?

The publication of the Healthwise Database in the *British Medical Journal* in June 2001[1] has shown again that in Britain we are poor at implementing well-established strategies which we know reduce the risk of coronary events in patients with ischaemic heart disease.

The Healthwise study, which was carried out over 18 months between 1997 and 1998, examined the records of 548 general practitioners (GPs) throughout mainland Britain. The records of 989 161 patients were examined and 24 431 patients with established coronary heart disease (CHD) were identified. The mean age of men was 67 years and women 72 years, and two thirds of the patients were over 70. The middle-aged man with angina has generally been regarded as the typical coronary disease patient. This is not true: it is my view that in the future we will be devoting much of our energies to heart disease in the elderly. The prevalence of CHD was 2.5% in this survey but it is known that the true prevalence is greater than this. There must be, then, a proportion of patients who are not considered by their general practitioner to have established coronary disease.

The Healthwise study addressed one main area: the measures that were being adopted by general practitioners to address risk factors and drug therapy for patients with established coronary heart disease.

Risk factors

First, regarding smoking, 23% of the patients continued to smoke. Among patients below the age of 50 years, more than half the patients continued to smoke. Stopping smoking is the most important intervention that can be made, reducing the risk of further events by 50%, more than any other drug or lifestyle therapy. But it is also the hardest to achieve and I know no easy way to help patients give up cigarettes.

Blood pressure was well controlled. Two thirds of the men and about half of the women had reasonably well-controlled blood pressures, a substantially better performance than the average British practice. (This reflects the bias of the Healthwise Database, which selected practices that had established computerised records by 1997 and that may have had more organised blood pressure services within each practice.)

Diabetics accounted for 11% of the population with coronary disease, and a high prevalence of diabetes would be expected among this population.

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Lipids were the least well managed risk factor. A third of the men, and more than half of the women, had never had a cholesterol measurement, although they had established disease. Of the patients who had a cholesterol measurement, almost half the men and 40% of the women had a total cholesterol >5 mmol/L. Thus while blood pressure is reasonably well managed, cholesterol is poorly controlled although guidelines published in 1997 by the Standing Medical Advisory Committee,[2] indicated that total cholesterol should be less than 5 mmol/L in patients with established coronary heart disease.

Drug therapy

Drug therapy was also examined in the Healthwise Database. About half the patients were recorded as receiving aspirin. Some patients will buy their own tablets but recording of this most valuable drug was haphazard. About 22% of the patients were on beta blockers. Disappointingly, this figure was not higher among the subgroup who had had a myocardial infarction, the group most likely to benefit from beta blockade. This represents a failing of hospital discharge policy because we know that at least two thirds of patients post-MI should receive beta blockers.

There was encouraging news about angiotensin converting enzyme (ACE) inhibitors. More than 50% of patients with

heart failure as a hospital discharge diagnosis were prescribed these drugs. Overall, 13% of the patients received ACE inhibitors; however, among diabetics, twice as many diabetics received ACE inhibitors as non-diabetics. This again represents good British general practice, implementing the evidence that ACE inhibitors are good for diabetics.

Statin therapy was the weakest area. Overall, only 16% of patients received statins although 75% of patients who had a cholesterol measurement had a high cholesterol value.

The Healthwise Database has several important messages, I believe. Smoking, the most difficult risk factor to approach, is poorly addressed in younger patients. Blood pressure, the next most difficult risk factor to address, is reasonably well managed in the majority of patients. Cholesterol, in my view the easiest risk factor of all, is very badly approached. Most of the patients had high cholesterol levels and the simple step of instituting a decent dose of a statin would reduce by about a third the risk of future events for this large population. There was encouraging news about management of diabetics; at least ACE inhibitors are being used a bit more among this exceptionally high-risk population.

So what should we do? Patients with a myocardial infarction (MI) should be discharged from hospital on the four drugs that prolong life: aspirin, beta blockers, ACE inhibitors and statins. It is the practice within Glasgow to commence all four therapies while the patient is in the Coronary Care Unit, so that at least he leaves hospital on these life-saving drugs. Within general practice the level of awareness of cholesterol should be brought to at least that of blood pressure control. Put simply, this means starting statin therapy for everybody with a cholesterol much above 5 mmol/L. Diet therapy alone is a waste of time for most patients: aggressive diet therapy will only lower cholesterol by about 10%, insufficient to achieve target levels. Moreover, an individual with a starting cholesterol of 5.5 mmol/L has a target of 3.9 mmol/L. This is a reduction of 30%, which is the stated target of the UK national guidelines and the recent NSF for coronary disease.[2,3]

The recent NICE report on ACE inhibitors[4] suggests that all patients with established coronary disease should receive these drugs. Whether it is a blood pressure-lowering effect or whether it is some other angiotensin-blocking effect does not seem to matter too much in population studies. Patients with a recent MI should be on a beta blocker; patients with an MI

Figure 1. CHD mortality compared to statin sales. August 1998 - August 1999
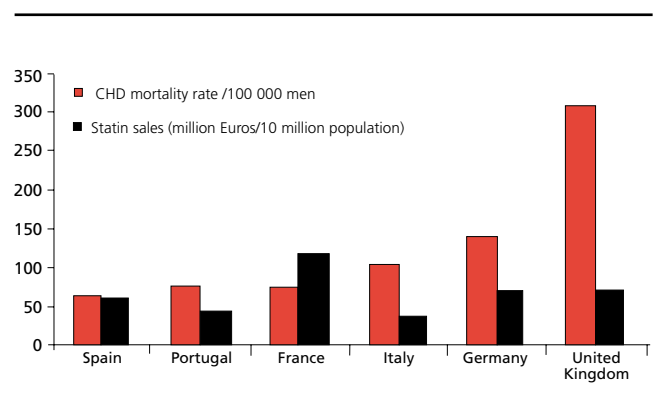
many years previously need not necessarily receive this therapy since the evidence for beta blockers post-MI is for the early months and years following the index event.

Where do we stand in Europe? Figure 1 shows statin sales compared to coronary heart disease mortality in some countries in Europe. Statin sales have been normalised for the population and the CHD mortality rates have been obtained from the MONICA database. France is an example to us all; Spain is also well sorted. The UK is an international laughing stock when we compare our CHD death rates with our modest level of intervention. Many of us have heard Americans describing Britain as an international control group – widespread disease with no intervention. It is up to us to change this.

References

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