Tune in and turn off

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We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab… and beyond. In this column, he considers 'non-expert' opinion.

Driving home bleary eyed after coming in for the third infarct of the night, I am listening to the radio. The streets are deserted and glisten as the previous evening's rain reflects the glare of the city's seasonal illuminations. The route to and from work is all too familiar, so much so that I'm sure I could do it blindfolded. A late night phone-in programme emerges from the background drivel and gradually becomes more prominent until it reaches centre stage. Fatigue can play occasional tricks on the mind, and on the ears…

"Well, it's just gone 4am and you're listening to Danny Pointless on Yak-Yak Radio's 'It's A Long Night'. This is the show for all of you out there who have nothing better to do at this ludicrous hour but ring me with your views in the vain hope that someone else is listening (let alone, interested), other than you, me and the cat.

"Tonight we're discussing interventional cardiology: are we doing too much PCI, or perhaps not enough? Should patients with multivessel disease only be treated after full MDT discussion, what about left main stem lesions and with percutaneous valve replacement just around the corner, just what will our cardiac surgeons be doing in five years' time?

"With me in the studio I have an interventional cardiologist who, uniquely, would prefer not to be identified, so I will refer to him simply as Dr B. We are also joined by Professor Jason Newlove, lecturer in Medical Management, Journalism and Applied Media Studies at the Central Polytechnic of Nether-on-the-Wapping."

Time is muscle?

"And our first caller is Steve, from Clapham. Go ahead, Steve."

"Yeah. I just want to say that my mum had a heart attack, right? And instead of the ambulance goin' to her nearest hospital, she ended up being taken to another one five miles away to some big place for balloon treatment or something. I mean, that can't be right, can it? I thought you needed treatment really quick, so what's that about?"

"Dr B? Does Steve have a point?"

"Well, the evidence in favour of so-called primary angioplasty being superior to clot-busting drugs is very strong, and that being the case, it's better to be treated in a high volume centre that is doing this all the time."

"But doesn't that delay the process? After all, we're always being reminded that *time is muscle*. Jason?"

"Yaah. Too right, Danny, but primary PCI is still a cool idea because the time window for benefit is more forgiving than with thrombolytic strategies."

What was the point?

"Thanks for that, Steve. Gary, in Luton, you want to talk about the recent NICE appraisal covering the use of drug-eluting stents."

"Hallo, Danny. I'm a first time caller, so a bit nervous. I just wondered whether the latest NICE guidance actually changes anything."

"Gary, Doctor here. I think the only difference will be that industry will be obliged to bring down DES prices in order to make them a cost-effective alternative to bare metal stents. I suspect that was the point of the whole exercise all along."

"Yo, Gary! Jason here, mate. There's no doubt that we were all a bit anxious until the final decision was announced. The consequences of the original draft proposal would have been seriously bad news; many more patients would have had CABG unnecessarily and that wasn't factored in at all. We would have been in really deep sh…"

"…Thanks, Jason. Moving on, we've just got a text about this from Kevin in Grimsby. He says: *It's quite simple. To reduce the cost difference, industry should just bump up the price of their bare metal stents instead*. There's a novel idea."

It's a bit technical

"OK, we've got another caller on the line, and it's Dave from Llandudno. Go ahead, Dave."

"Hallo there! I had a PCI to an artery at the exact point where it branched, but they only put in one stent. Is that enough? It sounds like only half the job to me."

"Doctor?"

"I suspect this was what is called a bifurcation lesion. It's a bit technical but if the side branch itself is not actually involved, then it's better to leave it well alone and use just one stent placed in the main vessel across the branch origin. Do you know how they described it, Dave? Was it Medina classified with a zero as the third figure, such as one, one, zero? Dave? Dave…?"

"I think we've lost Dave."

Stick it to the man

"Now, we're getting in a lot of emails about acute infarct intervention, and particularly what to do with any residual, non-culprit disease. Do it at the same time, the same admission, not at all? Doc?"

"It's generally well accepted that you treat only the infarct vessel initially – that's if you can identify it. As long as there is nothing else critical, I would consider dealing with other disease on the basis either of later symptoms or stress testing of some sort."

"Prof?"

"OK. The crucial thing is that whatever you decide to do, you delay it beyond 30 days so that it then becomes classified as a second 'spell' of care. That way you should get a tariff for it as another procedure."

"Is that really true, Jason? You hear stories of such 'gaming' but does it actually work like that?"

"Probably not, Danny, but it sounds like a good wheeze. The rules are never quite what they appear; you think you've discovered a way around the system, and '*stick it to the man*' so to speak, and then they just change the rules."

Buddy support

"OK. Just before we go to the weather and a travel update, we have one more call and it's from Colin who is an interventional cardiologist himself and is ringing from Dundee. Yes, Colin?"

"It's a practical point really. Say you're working on a very tortuous (*crackle*), heavily calcified right coronary artery (*hiss, crackle*). You've got a support wire across and (*hiss, crackle*) you've pre-dilated with a two, and then a two-five balloon (*hiss*), and you still can't get a stent to the lesion (*crackle, fizz, crackle*). What then, Dr B?"

"Well, Colin. In that situation a buddy wire would be the best bet."

"Should that be another (*fizz, hum*) support wire or something more floppy?" (*Crackle, hiss, crackle*).

"Colin, Danny here. We're picking up a lot of interference on the line; have you got your radio on?"

(*Hiss, crackle*). "No. But it may be the signal (*hum, crackle*). I'm in the cath lab at the moment trying to do this bloody case."…

Diary

2008

14th–15th April	Ebstein's Anomaly: A Comprehensive Approach, Congenital Cardiac Unit, Southampton website: www.cfsevents.co.uk
17th–18th April	2nd joint Scientific Meeting of the Anticoagulation in Practice 2008, Birmingham website: www.anticoagulation.org.uk
26th–29th April	77th Congress of the European Atherosclerosis Society, Istanbul, Turkey website: www.kenes.com/eas2008
13th–16th May	EuroPCR 2008, Barcelona, Spain website: www.europa-organisation.com
18th–21st May	XVI World Congress of Cardiology, Buenos Aires, Argentina Website: www.worldcardiocongress.org
2nd–5th June	British Cardiovascular Society Annual Scientific Conference, Manchester Website: www.bcs.com
14th–17th June	Heart Failure 2008 Congress, Milan, Italy Tel: +33 (0) 4 92 94 7600 website: www.escardio.org
14th–19th June	Hypertension 2008. 18th Scientific Meeting of the European Society of Hypertension and the 22nd Scientific Meeting of the International Society of Hypertension, Berlin, Germany Website: www.hypertension2008.com
18th–21st June	CARDIOSTIM 2008, 16th World Congress, Nice Acropolis, France email: cardiostim@wanadoo.fr
19th–20th June	4th National Symposium on Adult Congenital Heart Disease, Bristol email: lrassociates@lycos.co.uk
25th–27th June	H.E.A.R.T UK 22nd Annual Conference, Hatfield, Hertfordshire website: www.heartuk.org.uk
10th–22nd August	41st Ten-Day International Teaching Seminar on Cardiovascular Disease Epidemiology and Prevention, Oxford email: kk101@medschl.cam.ac.uk