In this issue

In this issue we have some common themes. Four articles relate to the electrocardiogram (ECG) with the eminent Derek Rowlands and Philip Moore making a plea for formal ECG training for all doctors (see pages 47–8). Other articles cover Wolff-Parkinson-White syndrome (page 80), torsades de pointes (page 79) and Heather Wetherell continues her series on ECGs for the fainthearted highlighting whether we should trust our ECG machines (pages 62–3).

Another theme is coronary artery disease diagnosis with one article suggesting that following NICE guideline CG95 will reduce unnecessary computed tomography angiography (see page 78) whilst two other articles question whether the same guidance leads to too many invasive coronary angiograms (pages 75 and 77).

We also cover exercise for heart failure (page 76), atrial fibrillation screening (pages 64–8), radiation exposure (pages 72–4) and Raza Alikhan explains how to combat haemorrhage from ODIs (pages 69–71). ODIs stands for oral direct inhibitors, which most people now know as newer oral anticoagulants (NOACs). New or newer was always a mistake as eventually everything ages, including drug categories. Apparently those in power on the topic of nomenclature are currently debating what we call this group of drugs. One suggestion is ODIs, the other is that we stick with the acronym NOAC, but change the full name to non-VKA oral anticoagulation. That fudge gets my vote.

Last, but not least, we cover the launch of the much-awaited Joint British Guidelines version three, JBS3 (page 52). The first JBS guideline preceded the National Service Framework (NSF) and the then National Institute for Clinical Excellence (NICE). You might question the need for JBS following the establishment of formal Government approved bodies such as the NSF and NICE. The main difference is the JBS3 lifetime risk calculator, which is available at http://JBS3risk.com. JBS1 was published in 1998 and JBS2 in 2005. Those of you who are into simple arithmetic progression will have worked out that JBS4 is likely to appear in 2025. Or will it?

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Risk factor modification: 30 year follow-up

From Dr John Revill

In a single doctor's practice in a high-risk area of South Sheffield, aggressive measures were taken to prevent ischaemic heart disease (IHD) and non-haemorrhagic stroke (ST) since 1980. Four cardinal risk factors were detected: smoking, diabetes, hypertension and cholesterol. Smoking, diabetes and hypertension were treated critically using standard guidelines and applying the latest evidence available independent of cost from 1980 onwards. Mortality from IHD has been known for many years to be directly related to the level of serum cholesterol and more specifically to the low-density lipoprotein (LDL) cholesterol. It was assumed therefore that as levels of LDL cholesterol approached zero then IHD mortality would almost be abolished. Diet, fibrates and cholestyramine were used as lipid-lowering therapy until 1988 after which statins were introduced on an intensive scale for all standard high-risk patients. *This letter continues online...*

Assessing the clinical benefits of drugs for dyslipidaemia

From Dr Gilbert Wagener

A recent editorial in the *New England Journal of Medicine*[1] highlights several challenging issues in the development of new treatments for lipid disorders. There is now uncertainty regarding the regulatory approach of approving drugs on the basis of favourable lipid effects and evaluating clinical benefit after approval. *This letter continues online...*

Time for a re-assessment of EECP in the UK?

From Dr Robin Roberts

External enhanced counter pulsation (EECP) is a validated, safe, non-invasive treatment for angina and heart failure. To date, more than 300,000 people worldwide have been treated, with 15,000 involved in clinical trials. The 2013 European Society of Cardiology (ESC) Guidelines on the Management of Stable Coronary Artery Disease[1] give EECP a level 2a recommendation, meaning that the treatment should be considered for patients with refractory angina. The recommendation was made following a review of published data on the mechanisms of action and clinical benefits of EECP. *This letter continues online...*

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