from being elucidated, whilst it is well demonstrated that the drug induces an intra-ventricular conduction disturbance. This is easily demonstrable by inducing recordable late potentials after injection of the drug, which confirms that flecainide induces major depolarization and not repolarization abnormalities.

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Variations in approach to the same disease

It was with great interest that I read the paper by Fox¹ on the causes of heart failure in a population-based coronary angiography study. Their major finding was that in patients monitored for admission to the hospital or through a rapid access heart failure clinic, the final aetiology of heart failure was coronary heart disease in 52% of cases.

This carefully performed study supports using coronary angiography in the great majority of cases who present for the first time with heart failure, at least if the patients are in a reasonable age range. This policy has not yet been adopted in all countries, whereas it is standard practice in most hospitals in our country. It is important to be aware of such differences in national approaches to the same disease. Despite international communication, such differences in routine patient management obviously exist. Among the reasons for this might be historical differences in clinical practice and teaching which might have been influenced by different ease of access to invasive techniques due to economic restraints.

Obviously, as shown by European morbidity and mortality statistics and the results of the EuroHeartSurvay Programme of the European Society of Cardiology, important differences in the number of diagnostic and interventional procedures performed in the various European countries exist. This was also shown in multicentre international trials. In the ATLAS trial, an international heart failure trial, important differences in patient characteristics and use of medications and coronary revascularization were evident. With respect to the large number of heart failure patients, different management strategies may finally contribute to the differences in the number of procedures.

In the 1995 Guidelines of the European Society of Cardiology on the diagnosis of heart failure, it was stated ‘Invasive investigation is generally not required to establish the presence of coronary heart failure but may be important in elucidating the cause. . . coronary angiography is required to exclude coronary disease when a diagnosis of dilated cardiomyopathy is being considered. In patients with heart failure and evidence of myocardial ischemia, coronary angiography will be required if revascularization is considered as treatment option’. Overall, this is quite a soft statement and had already raised comments when these Guidelines underwent review. Now, national differences in the way cases are managed have become apparent. The paper by Fox et al. clearly shows that the diagnosis of underlying coronary artery disease in heart failure patients can only be made with certainty by coronary angiography. It is now time to revise the proposal made in the 1995 Guidelines.

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