EACPR

6 May 2010

Cardiovascular prevention and rehabilitation, a lifelong challenge

After the success story: what are challenges for the future?

Ian M Graham

Chairman of the 4th Joint Task Force on the Prevention of CVD in Clinical Practice and of the EACPR Prevention Implementation Committee

Er, thank you for asking me to think of challenges, not solutions

It is better to be healthy than ill or dead.
That is the beginning and end of the only real argument for preventive medicine.

It is sufficient."

Geoffrey Rose

Nanos gigantium humeris insidentis

Isaac Newton 1676: "If I have seen further it is by standing on the shoulders of giants" (letter to Robert Hooke)

John of Salisbury, 1159

Bernard of Chartres, d.1124: "We are like dwarfs standing upon the shoulders of giants, and so able to see farther than the ancients"

"Let us now praise famous men and our fathers that begat us" (Ecclesiasticus 44:1)

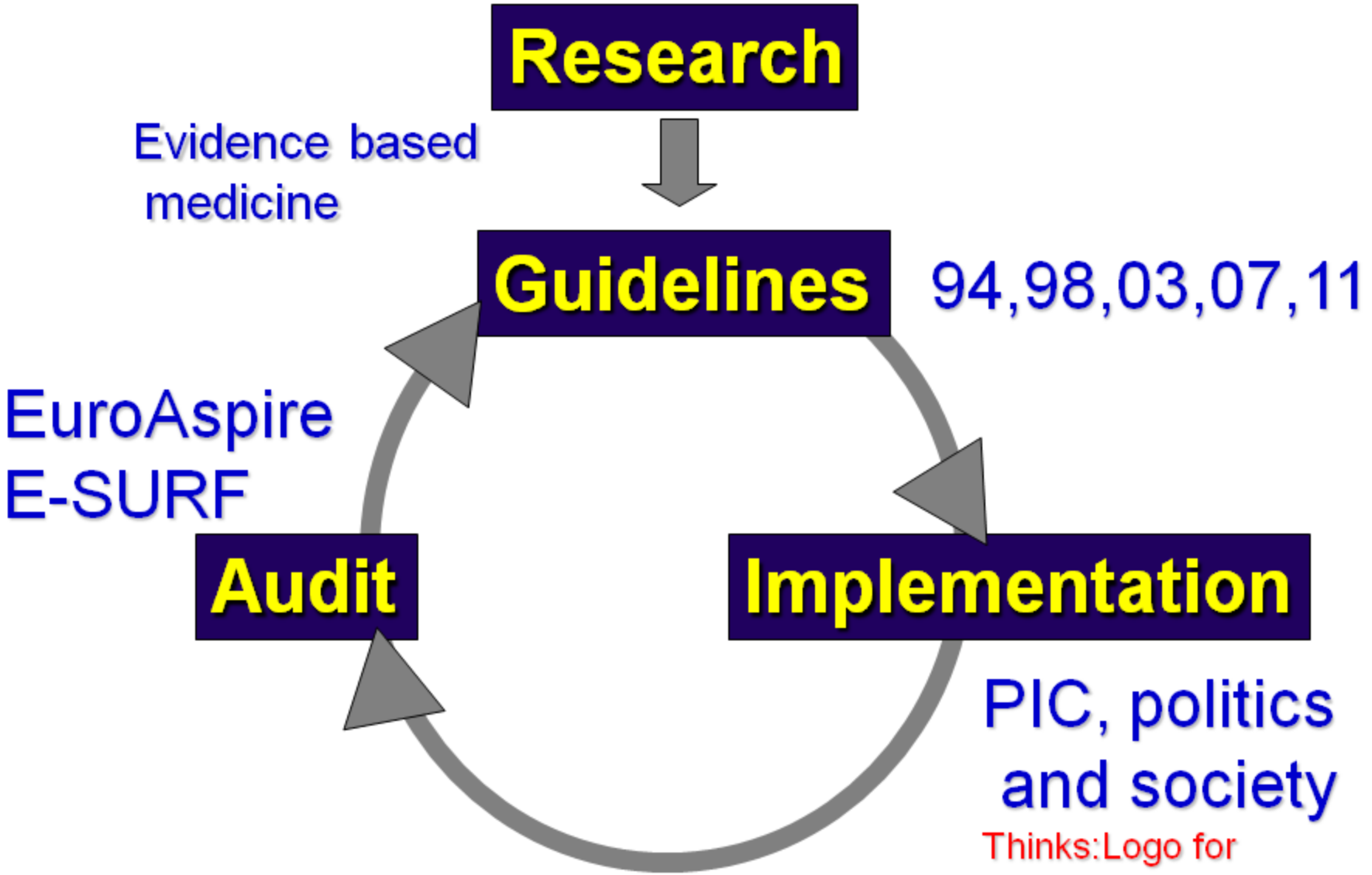
Some giants

- Ancel Keys
- Jeremiah Stamler
- Geoffrey Rose
- Henry Blackburn
- Archie Cochrane
- Kalevi Pyorala

A few of the hundreds from whom I have learned

- Luke O'Donnell
- Robert Clarke
- Pat O'Callaghan
- Marie-Therese Cooney
- Alexandra Dudina
- Emer Shelley
- Ronan Conroy
- Kalevi Pyorala
- Guy de Backer
- David Wood
- Lars Ryden
- Susana Sans
- Joep Perk
- Dirk de Bacquer
- Tony Fitzgerald

CVD Prevention-The future



CVD prevention: Challenges for the future

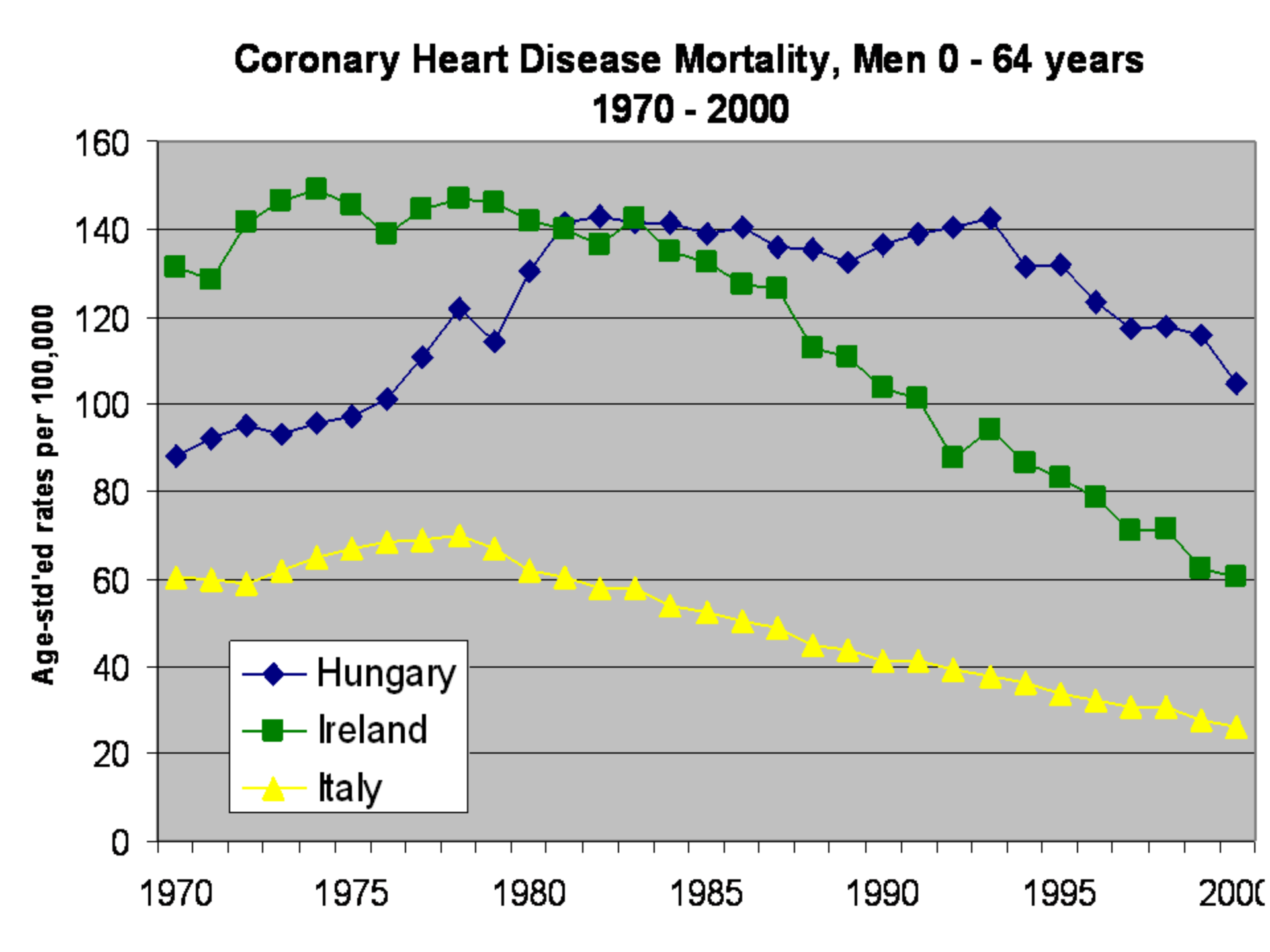
OUTLINE

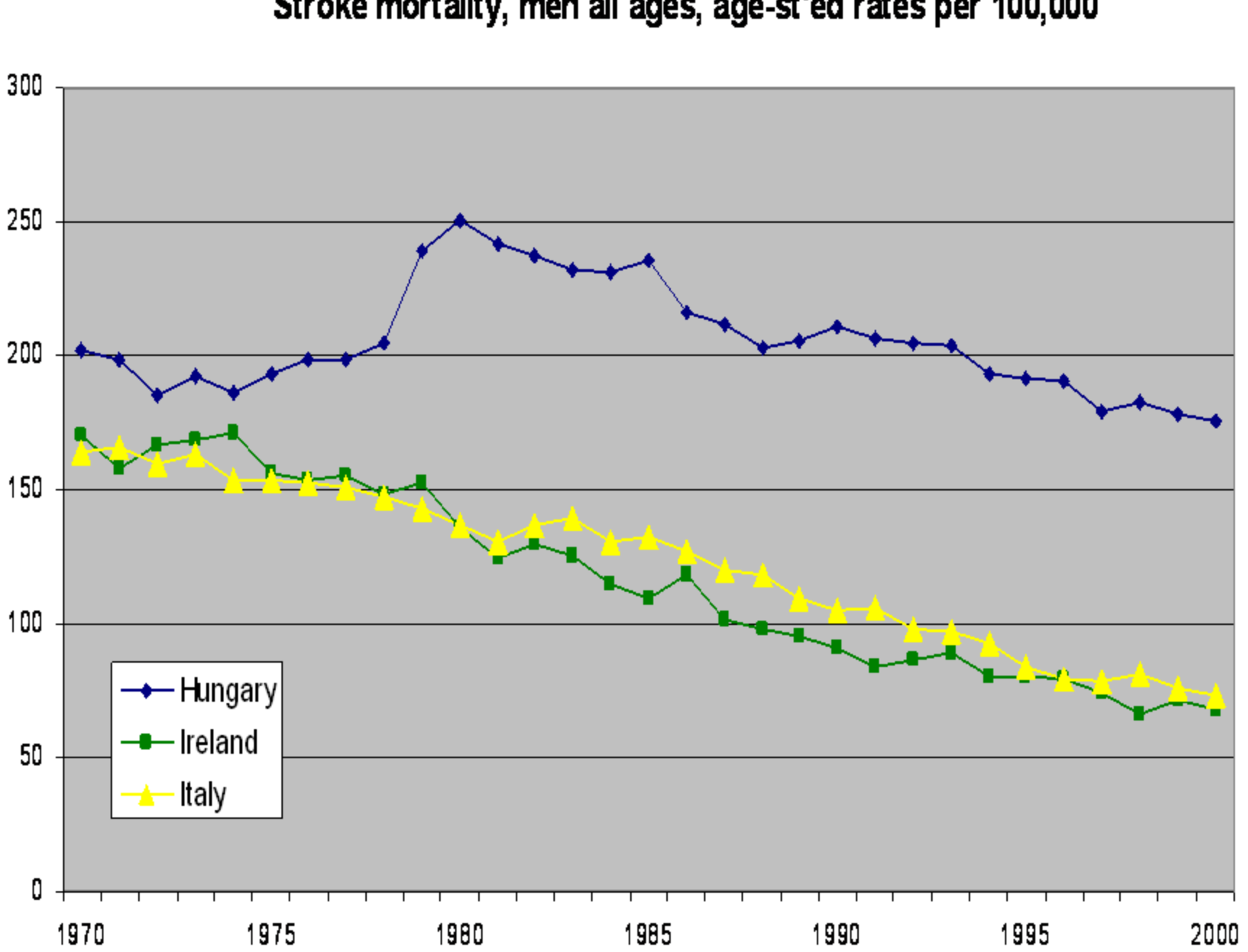
1. Background
2. Research
3. Evidence based medicine: the link between research and-
4. Guidelines
5. Implementation
6. Audit
7. Society and prevention

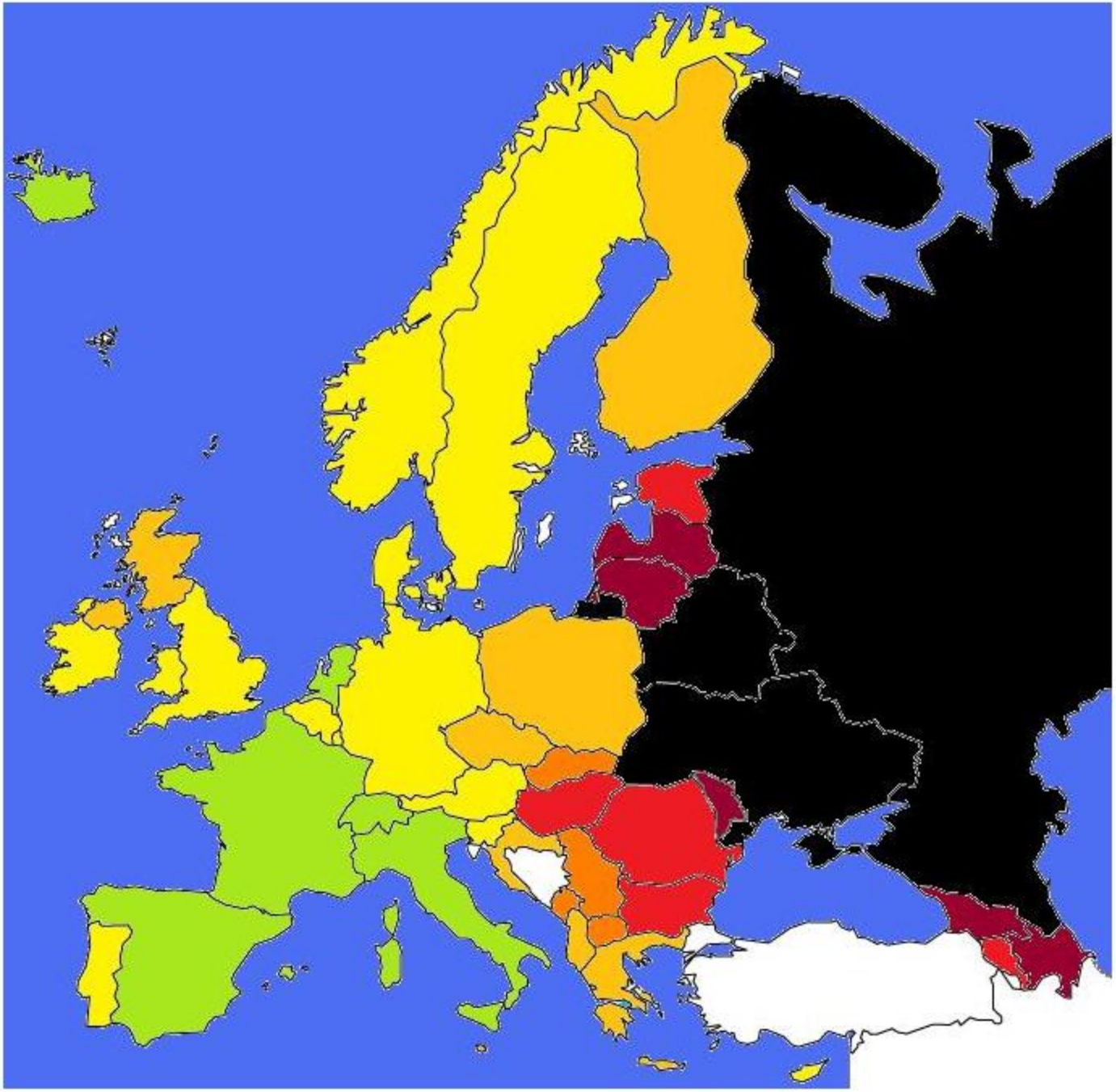
CVD prevention: Challenges for the future

1. Background :

The size of the problem: secular and geographic trends

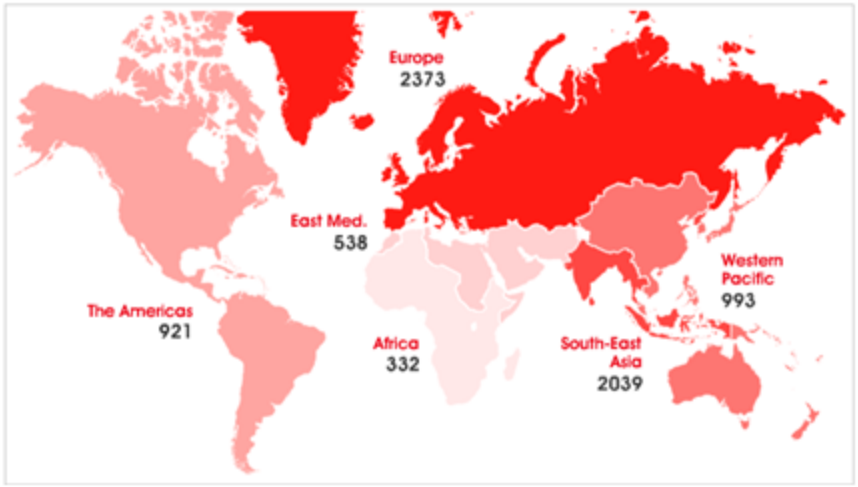

Coronary Heart Disease Mortality, Men 0 - 64 years
1970 - 2000
Age-std'ed rates per 100,000
160
140
120
100
80
60
40
20
0
1970
1975
1980
1985
1990
1995
2000
Hungary
Ireland
Italy


Stroke mortality, men all ages, age-st'ed rates per 100,000
300
250
200
150
100
50
0
1970
1975
1980
1985
1990
1995
2000
Hungary
Ireland
Italy



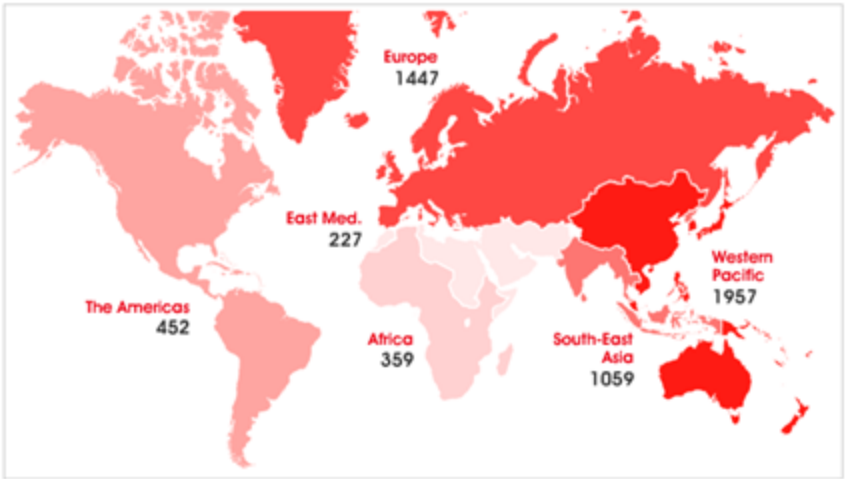
Age standardised CHD mortality rates (under 65) in men & women

Cardiovascular Disease - The Scope of the Problem



Ischaemic Heart Disease

Cerebro vascular Disease



World Heart Organisation, World Health Report, 2004

Changing Asia

The impact of the CVD epidemic in the Asia Pacific region

- 50% of world's population- 1.3bn China, >1bn India
- CHD in China increased from 6% in 1950s to 39% in 1990s, while rheumatic heart disease declined from 50% to 10%
- McDonalds increased from 1in 1990 to 1000 in 2006
- High salt intake (16G/d), high prevalence of hypertension and stroke
- Rising weight (with a high body fat)
- Those with metabolic syndrome may be more salt sensitive
- 42,000,000 diabetics
- Rising cholesterol
- Rising proportion of smokers

The Asian Pacific Studies Collaboration (APCS)

Woodward M et al. Int J Epid 2006;35(6)1412-6

Eu J Cardiovasc Prev & Rehab 2005;12(5):484-91

- 46 studies, n=659,000
- 35 studies from Asia (16 Chinese), n=513,000
- 16.7 million deaths worldwide from CVD in 2000
- ½ the world's CVD burden now arises in the Asian-Pacific region- and rising
- Hypertension, stroke and diabetes are major problems in China
- "Unless immediate steps are taken to implement preventive programmes, the number of Asians who are disabled by heart disease will be far greater than ever seen in the West". Prof Stephen MacMahon, George Institute, Univ of Sydney

1 June 2007-
World no tobacco day

312 million Chinese men smoke

CVD prevention: Challenges for the future

1. **Background :**

   The size of the problem: secular and geographic trends

- Huge shift in problem from West to East.
- If we are to help, we need to understand the reasons and the reactions of different cultures
- Shift in interest among Asians from US to Europe? Do we wish to be world leaders?
- Encourage and develop ESC-Asian Pacific collaborations

CVD prevention: Challenges for the future

1. Background
2. **Research:**

CVD prevention in future
2. Research 1

- Nobody has a monopoly on knowledge. Many fine epidemiologists have started as basic scientists
- Basic science needs epidemiology (Bias, sample size, confounders, association and causality, interaction etc.)
- Will the promise of genetics finally be realised??- The individual portfolio of candidate and variability genes and polymorphisms....

CVD prevention in future
2. Research 2

- The American vision (NIH) or the American curse ? (is there a profit in it? You're as good as your last grant. What me, conflicted?)- hence the financial pecking order may become based on greed, not need-
- Molecular medicine and genetics>other basic science>clinical research>epidemiology>humanities
- Need for European NIH/NHLBI? ESC/EACPR to promote?
- In public health terms, **we know enough** to promote major applied research into effective implementation strategies- including research into promoting national and EU involvement

CVD prevention in future
2. Applied Research- Risk estimation

- All risk estimation systems currently available are crude and make assumptions of doubtful validity, yet work adequately well.
- Re-calibration of U.S and European systems may work adequately in other countries, but ongoing cohort studies still needed
- A massive enough cohort study to render risk estimates unnecessary would be ideal
- Even a large but simple data set such as SCORE has allowed further explorations of, for example age effects (B-coefficients are not constant), HDL-cholesterol (independent at all ages and at all levels of risk) and body weight (not independent because it works through effects on lipids and BP)
- Ongoing thanks for the generosity of the SCORE, FINRISK, CUORE and CONOR investigators.

Risk estimation- be careful about age when estimating risk...

"35 is a very attractive age: London society is full of women who, of their own free choice, remained 35 for years"

Oscar Wilde

Talking about age...

Senescence begins
and middle age ends
the day your descendants
outnumber your friends

Ogden Nash, 1902-74

CVD prevention: Challenges for the future

1. Background
2. Research
3. Evidence based medicine- the link between research and guidelines: problems with the current ESC approach and suggestions

ESC classes of recommendations

Class I: Evidence/general agreement that treatment is beneficial, useful and effective

Class II: Conflicting evidence-

- IIa: Weight of evidence in favour
- IIb: Usefulness/efficacy less well established

Class III: Not useful/effective or may be harmful

ESC levels of evidence

A: Multiple randomised clinical trials or meta-analyses

B: Single randomised clinical trial or large large, non-randomised studies

C: Consensus of experts and/or small studies, retrospective studies, registries

3. Grading the evidence

- The ESC system is problematic. Smoking cessation may reduce mortality by 40% and statins by 30%. Yet statins will be 1A and smoking cessation at most 1B because it is not amenable to a RCT. Trials of exercise and nutrition cannot be blinded.
- The process is not necessarilly transparent- is a numerical grade truly evidence based, or just an opinion that has been given a number?
- Differing types of evidence are needed when considering, for example, lifestyle measures, causality, screening and diagnostic techniques as opposed to therapeutic interventions; the ESC system only relates to interventions

3. Grading the evidence: Suggestions

- The Guidelines Committee to convene a group to consider and perhaps revise the present grading system, examining the approaches used by SIGN, NICE and WHO GRADE. The EACPR has the skills to justify major input
- Important to liaise with WHO and AHA/ACC to work towards an agreed system
- The key question is whether the proposed intervention does more good than harm and the recommendation becomes “Do it/ don’t do it” or “probably do it/probably don’t do it”
- The ESC or EACPR to organize workshops/teaching courses on how to do a systematic review and grade evidence
- Acceptance as a guideline author might require attendance at such a course
- Guideline authors to be prepared to outline clearly how a grade was assigned and on what evidence

3. Grading the evidence:
Suggestion No 2

"If the facts don't suit your prejudice, it's time to change your prejudice"

John Maynard Keynes

3. Evidence: The principles of EBM are becoming universally accessible:

- BAD SCIENCE
  Ben Goldacre. Fourth Estate 2009

- TRICK OR TREATMENT
  Simon Singh & Edzard Ernst. Corgi 2009

- THE TIGER THAT ISN'T
  Michael Blastland & Andrew Dilnot. Profile Books 2008

CVD prevention: Challenges for the future

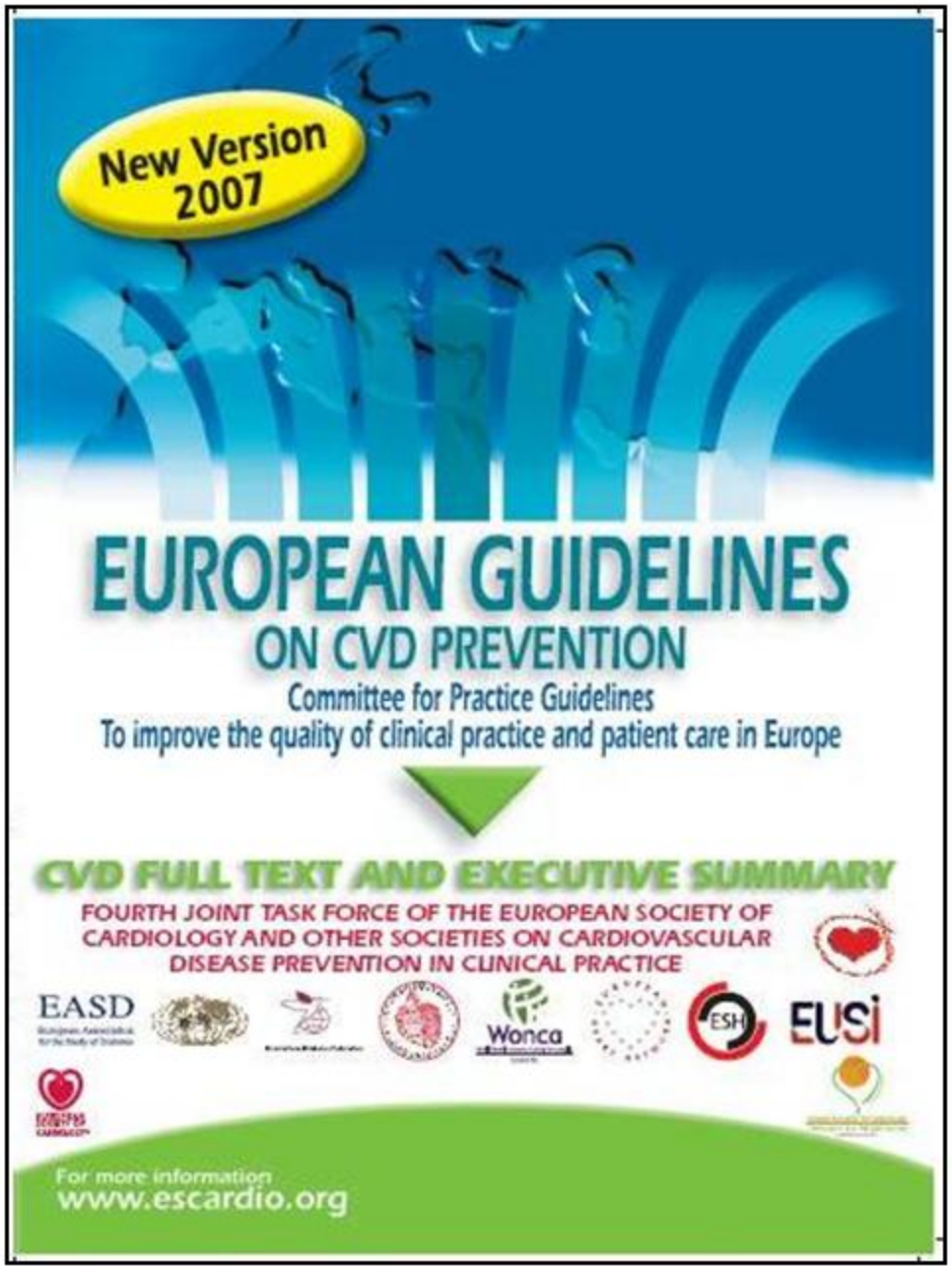
OUTLINE

1. Background
2. Research
3. Evidence based medicine: the link between research and-
4. **Guidelines**

European Guidelines on CVD Prevention

Fourth Joint European Societies' Task Force on cardiovascular disease prevention in clinical practice

Ian M Graham
Chairman JTF4


New Version
2007
EUROPEAN GUIDELINES
ON CVD PREVENTION
Committee for Practice Guidelines
To improve the quality of clinical practice and patient care in Europe
CVD FULL TEXT AND EXECUTIVE SUMMARY
FOURTH JOINT TASK FORCE OF THE EUROPEAN SOCIETY OF CARDIOLOGY AND OTHER SOCIETIES ON CARDIOVASCULAR DISEASE PREVENTION IN CLINICAL PRACTICE
EASD
Wonca
ESH
EUSI
For more information
www.escardio.org

European Society of Cardiology (ESC)

European Association for Cardiovascular Prevention & Rehabilitation (EACPR)

European Society of Hypertension (ESH)

International Society of Behavioural Medicine (ISBM)

European Heart Network (EHN)

European Association for the Study of Diabetes (EASD)

European Atherosclerosis Society (EAS)

International Diabetes Federation Europe (IDF-Europe)

European Society of General Practice/Family Medicine (ESGP/FM)/Wonca

European Stroke Initiative (EUSI)

JTF 4 & 5 on Prevention of CVD

PHILOSOPHY

- Prior to 1994, there was a plethora of similar but confusingly different guidelines. The JTF partnership wishes to address this by finding common ground
- Each partner must perceive an advantage in giving to and learning from this process, and that the needs of their organization will be served and strengthened. This implies high level, interactive participation, not just observer status
- The production of individual partner's more detailed guidelines is encouraged, specifically as an amplification of the agreed Joint Guidelines

BUT

Compatibility with the Joint Guidelines is regarded as critically important

Desirable attributes of clinical guidelines

1. **Validity**: Predicted health benefits/costs achieved?
2. **Reproducibility**: Same evidence and method produces same recommendations?
3. **Reliability**: Same interpretation in similar clinical circumstances?
4. **Representative development**: Key groups affected involved?
5. **Clinical applicability**: Useful for real-life patients?
6. **Flexibility**: Exceptions and patient preferences permitted?
7. **Clarity**: Unambiguous and user friendly?
8. **Meticulous documentation**: Who? What assumptions? What evidence was collected and how? How graded?
9. **Scheduled review**: When and how

JTF4 Guidelines on CVD Prevention Suggestions for JTF5

- Philosophy- still appropriate
- Evidence base- Not explicit enough, partly because grading system inappropriate. Debate with ESC Guidelines Committee
- Priorities and targets- Still appropriate?
- Full text- far too long!- treat as a resource document. Summary boxes from the pocket guidelines to make navigation easier
- Pocket guidelines- better, more accessible
- Single page- summarizes the key points
- The challenge- to keep the key points in the health professional's mind- and on his/her desk

JTF5: are the PRIORITIES for prevention in clinical practice still appropriate?

1. Patients with established atherosclerotic CVD

2. Asymptomatic individuals who are at increased risk of CVD because of
   - 2.1 Multiple risk factors resulting in raised total CVD risk (≥5% SCORE 10-year risk of CVD death)
   - 2.2 Diabetes type 2 and type 1 with microalbuminuria
   - 2.3 Markedly increased single risk factors especially if associated with end-organ damage

3 Close relatives of subjects with premature atherosclerotic CVD or of those at particularly high risk

JTF5: Are the TARGETS still appropriate?

People who stay healthy tend to have certain characteristics:

0	No tobacco
3	Walk 3 km daily, or 30 mins any moderate activity
5	Portions of fruit and vegetables a day
140	Blood pressure less than 140 mm Hg systolic
5	Total blood cholesterol <5mmol/l
3	LDL cholesterol < 3 mmol/l
0	Avoidance of overweight and diabetes

0 3 5 140 5 3 0

People who stay healthy tend to have certain characteristics:

0	No tobacco	
3	Walk 3 km daily, or 30 mins any moderate activity	
5	Portions of fruit and vegetables a day	
140	Blood pressure less than 140 mm Hg systolic	130
5	Total blood cholesterol <5mmol/l	4.5, 4
3	LDL cholesterol < 3 mmol/l	2.5, 2
0	Avoidance of overweight and diabetes	

CVD prevention: Challenges for the future

OUTLINE

1. Background
2. Research
3. Evidence based medicine: the link between research and-
4. Guidelines
5. **Implementation**

Utility of Guidelines

- Guidelines alone are good for the vanity of the authors and bad for rain forests; they are a waste of time without a defined implementation strategy
- Hence the Prevention Implementation Committee and other implementation efforts

“Said is not heard,
heard is not understood,
understood is not agreed upon,
agreed is not applied,
applied is not at all maintained.”

Konrad Lorenz, 1903-1969
[Thank you, Ulrich Keil]

European Prevention implementation is complex- many players are involved

1. The EU- vital but no legislative framework
2. Individual countries and their Departments of Health- like their independence
3. ESC/EACPR
4. JPG partner European Specialist groups
5. National Cardiac and other specialist and GP societies
6. Nurses and allied health professional, European and National
7. Educators- 1st 2nd & 3rd level
8. Industry- Pharma, Food, Exercise, Neutral

It's like herding cats!

The European Heart Health Charter and the Joint European Guidelines on cardiovascular disease prevention

- The European Heart Health Charter advocates the development and implementation of comprehensive health strategies, measures and policies at European, national, regional, and local level that promote cardiovascular health and prevent CVD
- The CVD prevention guidelines aim to assist physicians and other health professionals to fulfil their role in this endeavour, particularly with regard to achieving effective preventive measures in day-to-day clinical practice
- They reflect the consensus arising from a multi-disciplinary partnership between the major European professional bodies represented

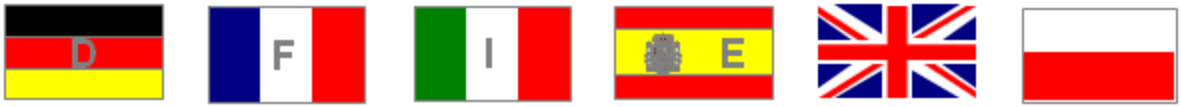
Factors impeding the implementation of cardiovascular prevention guidelines: findings from a survey conducted by the European Society of Cardiology

Graham IM, Stewart M & Hertog M for the Cardiovascular Round Table Task Force .
EJCPR 2006:13; 839-45

- Market research survey
- In-depth interviews with 66 cardiologists & 154 primary care physicians (N=220)
- 6 focus groups involving 49 physicians
- D,F,I,E,UK,P

Factors Impeding the Practical Implementation of Cardiovascular Prevention

An international market research project in 6 countries:
Germany, France, Italy, Spain, the United Kingdom and Poland



- PRESENTATION CHARTS -

This study was commissioned by
European Society of Cardiology (ESC)
Cardiovascular Round Table (CRT)
Task Force 4

Technical staff at Psyma International:
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e-mail: info@psyma-international.com
website: www.psyma-international.com

Study No: 41057021
December 2002

Barriers to implementation

REACT study, Hobbs FDR, Erhardt L, Family Practice 2002
ESC CRT Market research survey, Graham I, EJCPR 2006

- Lack of patient compliance
- Lack of time
- Lack of budget
- Lack of clarity (complicated, confusing, too much information)
- Guidelines too general (do not fit my patient)
- Unhelpful government health policies (assistance, remuneration, patient education)

SUMMARY:
Key factors to increase usage of guidelines

- Simple, clear, credible national guidelines
- Sufficient time
- Facilitatory government policy:

  -Defined prevention strategy

  -Reimbursement for health professionals

  -public awareness and education from school on
- Multidisciplinary implementation strategy- with teeth

Implementation strategies: European level

1. Publication of Guidelines in relevant journals
2. The Prevention Toolkit, comprising the Guidelines (paper and electronic), a slidekit and HeartScore stand alone
3. A defined dissemination strategy
4. Presentations at international conferences of the participating societies
5. Directly influencing EU health policy- for example through the Luxembourg Declaration and the European Health Charter- the product of a partnership between the EU, WHO, ESC and EHN

Implementation Strategies: National Level

- The ESC asks National Cardiac Societies to nominate a **National Co-ordinator** to develop and lead a **multidisciplinary implementation group** which will develop-
- National guidelines adapted to local needs
- Partnerships between politicians, health professionals, educators and business
- A defined communication strategy
- An evaluation strategy
- BUT it must have teeth. This requires high level political representation if it is not to be a talking-shop. Indeed...
- This process has been variably successful. It is now proposed that there should be two national co-ordinators- one a cardiologist and one from the Department of Health/ Health Service Executive

Guideline Learning Tool-
a new, electronic, interactive learning tool based on JTF4 & 5

GLT-AIMS

- To outline the important issues in the epidemiology of cardiovascular disease

- To make practical prevention easier through practical examples

The Guideline Learning Tool

- **The Guideline Learning Tool is intended for both group teaching and as a personal learning tool. It has four parts-**

1. An introduction dealing with policy, epidemiology and the need for Guidelines
2. Interactive cased based examples
3. How well are we doing in prevention? Audit
4. Why is the implementation of guidelines so difficult?

- Thus the learning tool is interactive in two ways- to encourage interaction with the an audience, and electronic interaction when used by an individual
- The intention is to have it recognised for CME

Implementation of prevention

"To regain my youth I would do anything in the world, except take up exercise, get up early, or become respectable"

Oscar Wilde

CVD prevention: Challenges for the future

OUTLINE

1. Background
2. Research
3. Evidence based medicine: the link between research and-
4. Guidelines
5. Implementation
6. **Audit**

How big is the gap between recommendations and practice?

Has there been an improvement over time?

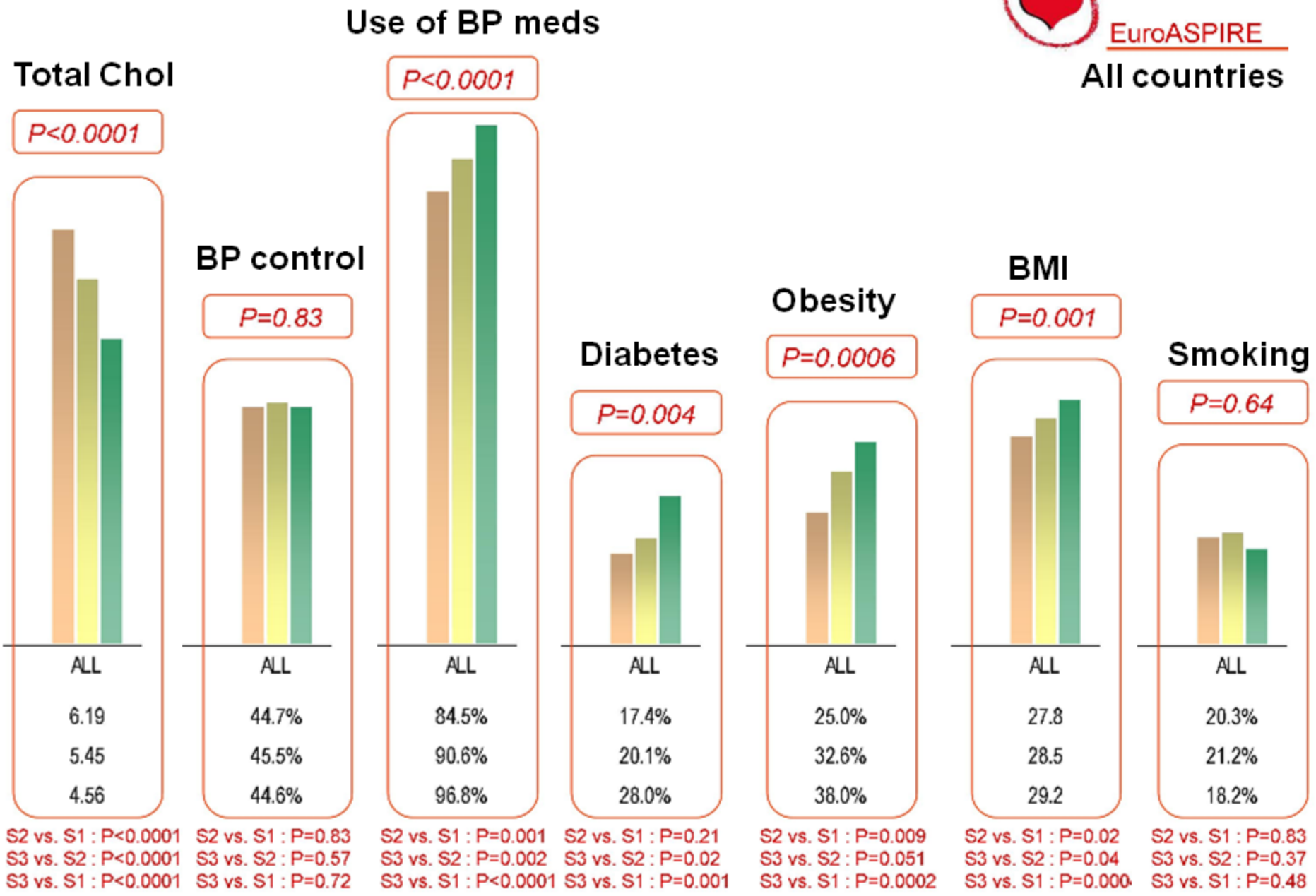
EUROASPIRE- Surveys of patients with proven CHD

- EASP I: 1995-1996. 9 countries
- EASP II: 1999-2000. 15 countries
- EASP III: 2005-2007. 22 countries

- 6 months after first CABG, PCI, or ACS without prior CABG or PCI. Now extended to primary care and stroke
- Considerable potential to improve risk factor control:

EuroASPIRE

All countries



E-SURF

The European SUrvey of Risk Factor Management

E-SURF: The Proposal

- **To construct a system for auditing risk factor control in subjects with established CVD that is sufficiently simple, quick and easy to use that-**
- It can be conducted within 60- 90 seconds at routine clinic attendances to minimise selection and participation bias
- Piloting in Ireland (40 centres, 30 responses so far), Belgium and Croatia. Then assess if suitable for European usage
- Would be easy enough to use to allow annual or bi-annual repeat surveys to audit secular changes in risk factor control
- Aim to complement the much more sophisticated EuroAspire

E-SURF-IE Data Collection Sheet

Demographics					
Initials:				Hospital:	
Date of birth:				MRN:	
Gender:	☐ Male	☐ Female		Date of examination:	
CHD Category:	☐ CABG	☐ PCI	☐ Acute coronary syndrome	☐ Stable AP	☐ Public patient ☐ Private patient
Was the patient admitted to hospital in the last year with for a CHD related reason?				☐ Yes	☐ No

Risk factor history			Most recent risk factor measurements	
Smoking history	☐ Current smoker ☐ Ex smoker ☐ Never smoked		Systolic BP	mmHg
			Diastolic BP	mmHg
			Heart rate	bpm
Physical activity	☐ Less than below ☐ Moderate (walking or equivalent) 30 mins 3 to 5 times per week ☐ More than this		Waist circumference	cm
			Height	m
			Weight	kg
			Fasting bloods within 1 year?	☐ Yes ☐ No
			If yes, date of fasting bloods:	
Known history of (Patient was told of diagnosis previously)	Yes	No	Fasting total chol	mmol/l
	☐	☐ Hypertension	Fasting LDL chol	mmol/l
	☐	☐ Dyslipidaemia	Fasting HDL chol	mmol/l
	☐	☐ Diabetes type 2	Fasting triglycerides	mmol/l
	☐	☐ Diabetes type 1	Fasting glucose	mmol/l
Did the patient ever participate in cardiac rehab?	☐ Yes, fully or in part ☐ No		HbA1C (if diabetic)	%

Medications			
☐ Any anti-platelet	☐ Any beta-blocker	☐ Any ACE inhibitor	☐ Any nitrate
☐ Any statin	☐ Any Ca antagonist	☐ Any diuretic	☐ Any insulin
☐ Any other lipid lowering agent	☐ Any other anti-hypertensive	☐ Any ARB	☐ Any oral hypoglycaemic agent

CVD prevention: Challenges for the future

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1. Background
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7. **Society and prevention**

WHO report on the Prevention of CHD (and hence CVD) defined three components to preventive strategy:

1. Population
2. High risk
3. Secondary prevention

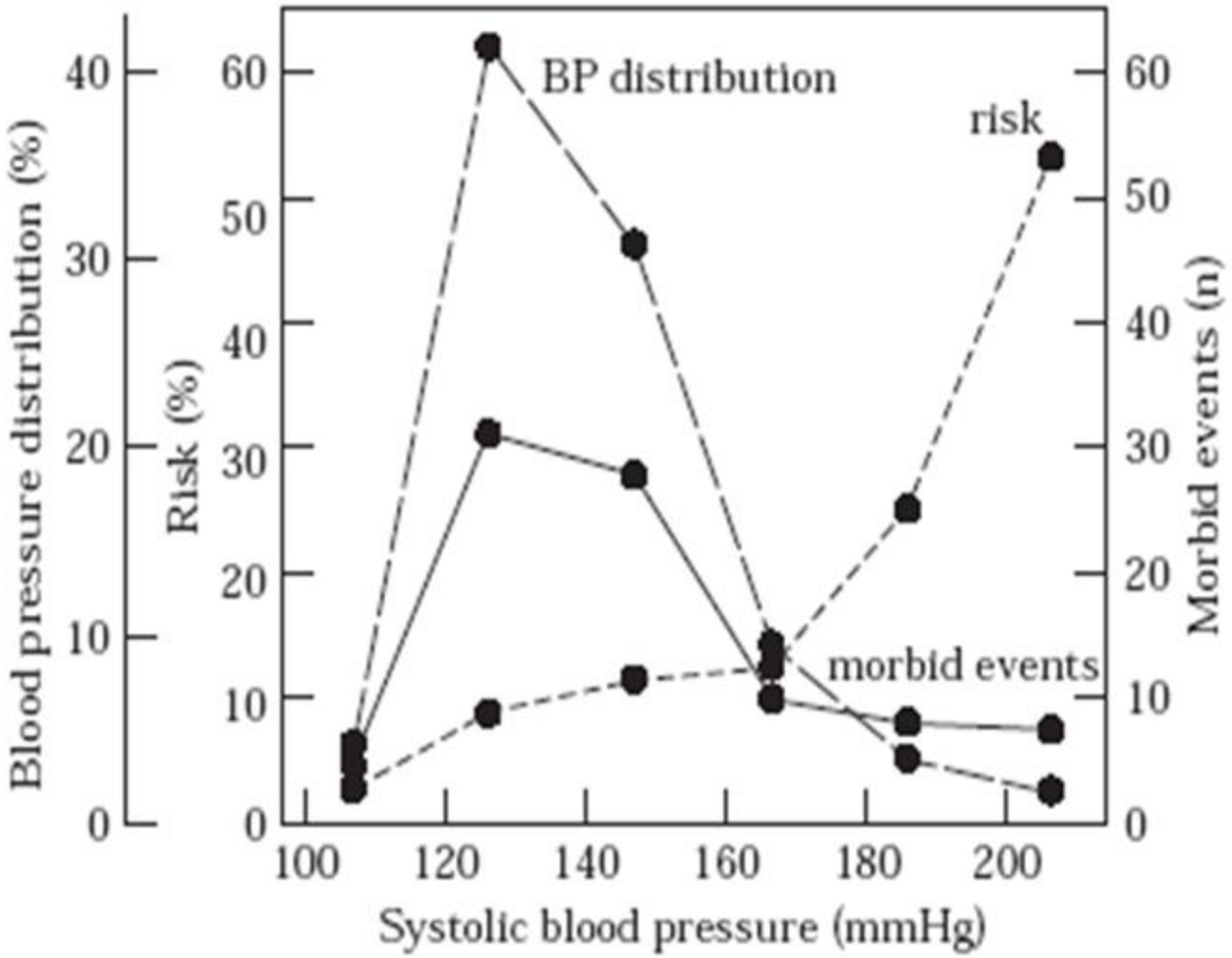
- High risk individuals gain most from preventive measures- but most CVD deaths come from subjects with only mildly increased risk because they are so numerous
- The three strategies should be complementary, not competitive

- Policy is defined further in the Osaka declaration

"Small but widespread risks: a public health disaster?" Geoffrey Rose

- "A large number of people exposed to a small risk may generate many more cases than a small number exposed to a large risk"

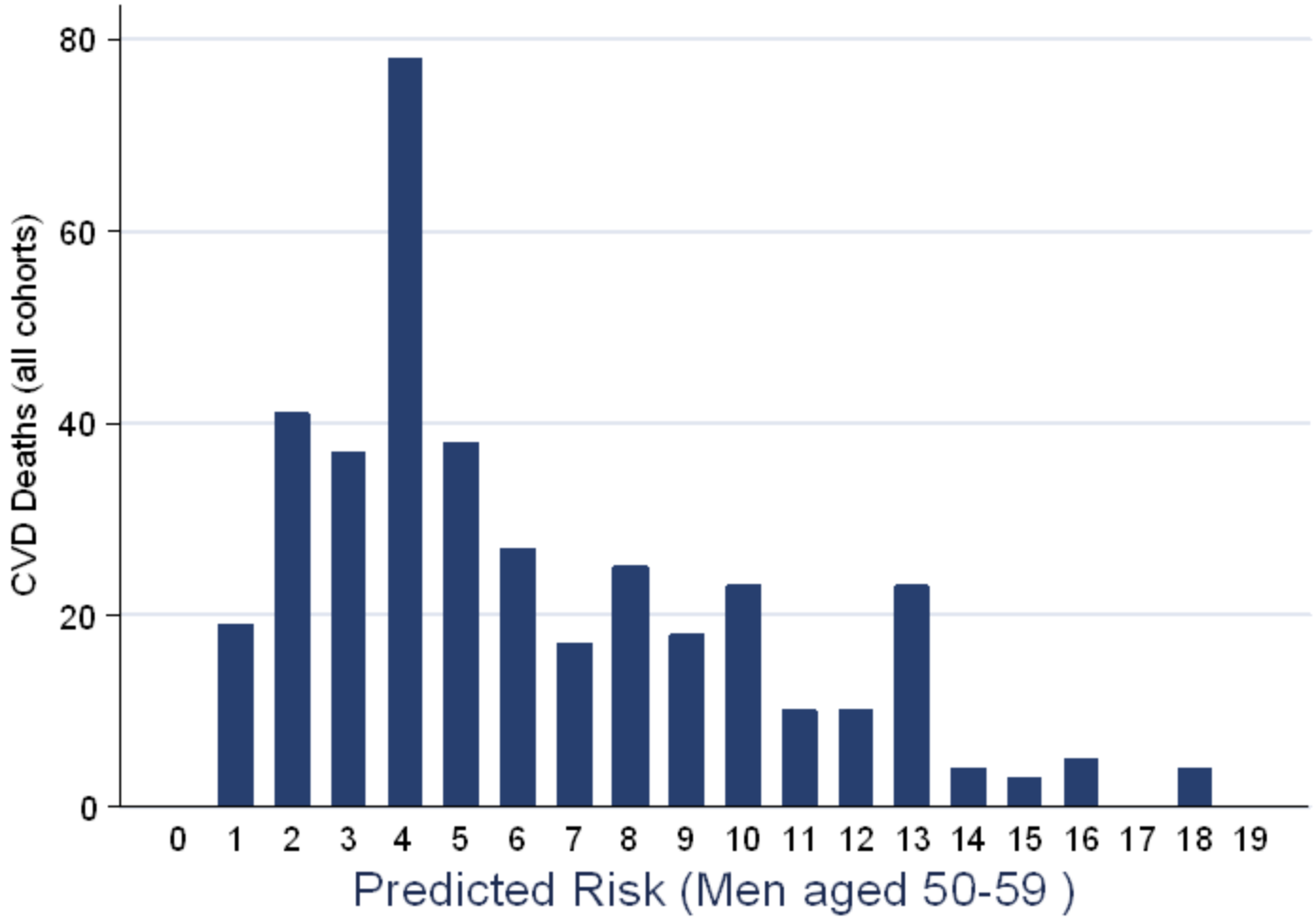
- The prevention paradox: "A preventive measure that brings large benefits to the community offers little to each participating individual"



Wilhelmsen L. Salt and hypertension. Clin Sci 1979;57:455S-8S

Fig 1

The expected number of CVD deaths at increasing levels of predicted risk. Illustration of the fact that most events occur in low risk subjects with few deaths among high risk subjects.



Re-evaluating Rose: Benefits of population and high risk prevention strategies

M-T Cooney, A Dudina, P Whincup, S Capewell, A Menotti, P Jousilahti, I Nolstad, R Oganov, T Thomsen, ATverdal, H Wedel, L Wilhelmsen, I Graham

On behalf of the SCORE investigators

M-T Cooney performed the statistical analyses.

I Graham is project leader of the SCORE project

Methods

- Study population: SCORE dataset – high risk countries only.
- Excluded those with previous CVD and diabetes
- Over 125,000 individuals included
- Calculated SCORE risk (10 year risk of CVD mortality) for each individual

Conroy et al, The SCORE (Systematic Coronary Risk Evaluation) Project, 2003, Eur Heart J

Population or high risk? Examples

Population reduction of 5% each in cholesterol, BP and smoking	High risk approach, 40% uptake, 100% compliance	High risk approach, 60% uptake, 100% compliance
5403	**2911**	**4372**
But how much of the benefit will be realised how soon? See North Karelia experience	Compliance estimate unrealistic so benefits exaggerated.	

Conclusions

- The population and high risk strategies should be seen as complementary and not competitive
- Both are still applicable
- Population strategies -
  - appropriate mechanism for reducing the incidence of disease
- High risk strategies -
  - reduce risk of CVD in those already at high risk
- We have calculated the effects of the differing levels of intervention
- This may be of assistance to health planners

Challenges for the future of CVD prevention 1

- The problem: CVD is rising worldwide. Asia is set to suffer a far greater epidemic than experienced in the West.
- Research: Epidemiology can work with and inform basic science and genetics. There is already ample knowledge to justify increased applied research into implementation including personal, social and political aspects. Greed versus need? EHLBI?
- The evidence base for Guidelines: Current grading systems are insufficient and give excessive weighting to drug treatments. Both research and consensus are needed

Challenges for the future of CVD prevention 2

- Guidelines: The partnership concept and philosophy adopted by the European Guidelines are appropriate. JTF5 Guidelines should be short, succinct, accessible and transparently evidence-based
- Implementation: The principles are easy but the practicalities are complex because of the diversity of European interests. How much can National co-ordinators realistically achieve? Need to engage at a higher level; ESC European Affairs Committee critical
- Audit: EuroAspire has shown us the way. Is a pan-European simpler audit such as E-SURF realistic?

Challenges for the future of CVD prevention 3

- Society and prevention: Community and high risk approaches are complementary
- The likely benefits of each can be quantified
- "Medicine and politics cannot and should not be kept apart

- The real challenge for health professionals is to make the issues accessible so that people can make their own decisions regarding both personal risk and the extent to which they expect governments to make policy decisions that enhance health

"The primary determinants of disease are mainly economic and social, and therefore the remedies must be economic and social. Medicine and politics cannot and should not be kept apart"

Geoffrey Rose

Thank you

My doctor's issued his decree
That too much wine is killing me,
And furthermore his ban he hurls
Against my touching naked girls.

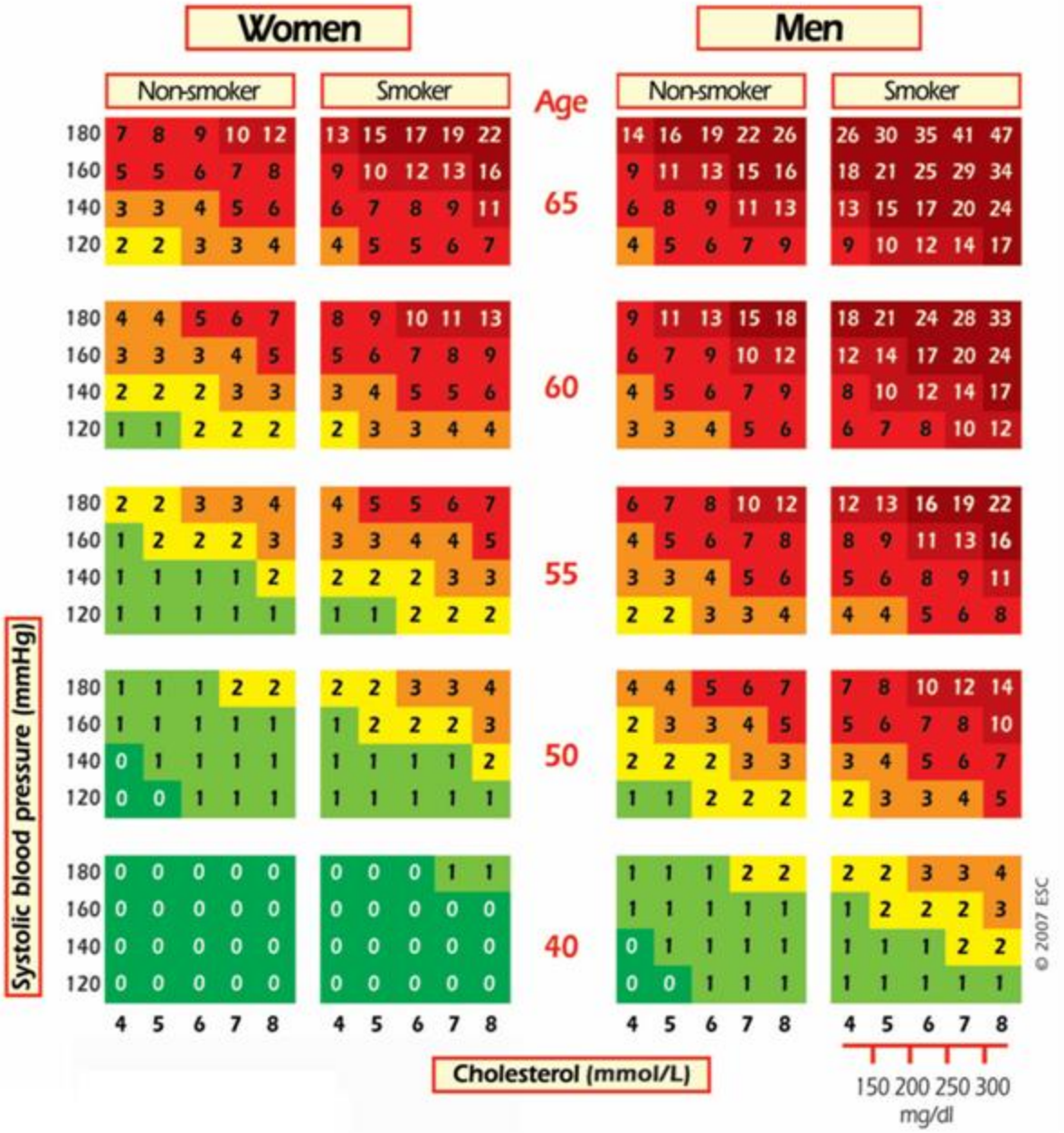
How then? Must I no longer share
Good wine or beauties, dark and fair?
Doctor, goodbye, my sail's unfurled,
I'm off to try the other world.

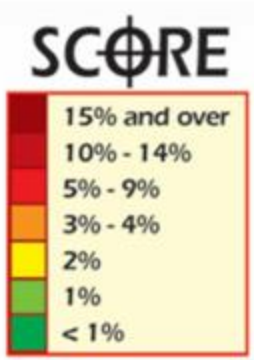
-Dante Gabriel Rosetti, 1867

CVD Prevention: CHALLENGES

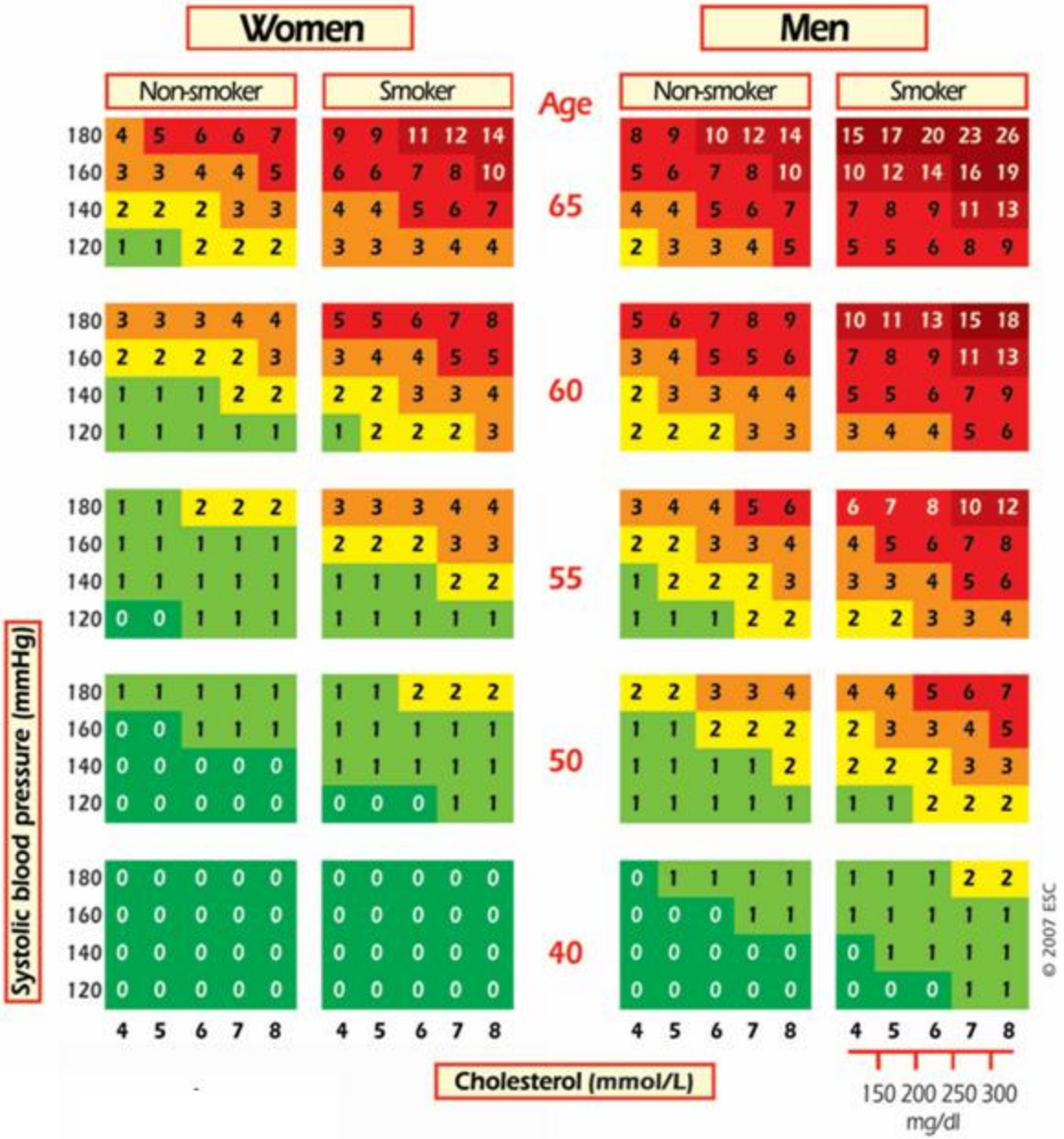
- Inactivity
- Obesity
- Stroke
- Heart failure
- Gender and social class inequalities
- Renal failure
- Implementation

10 year risk of fatal CVD in high risk regions of Europe



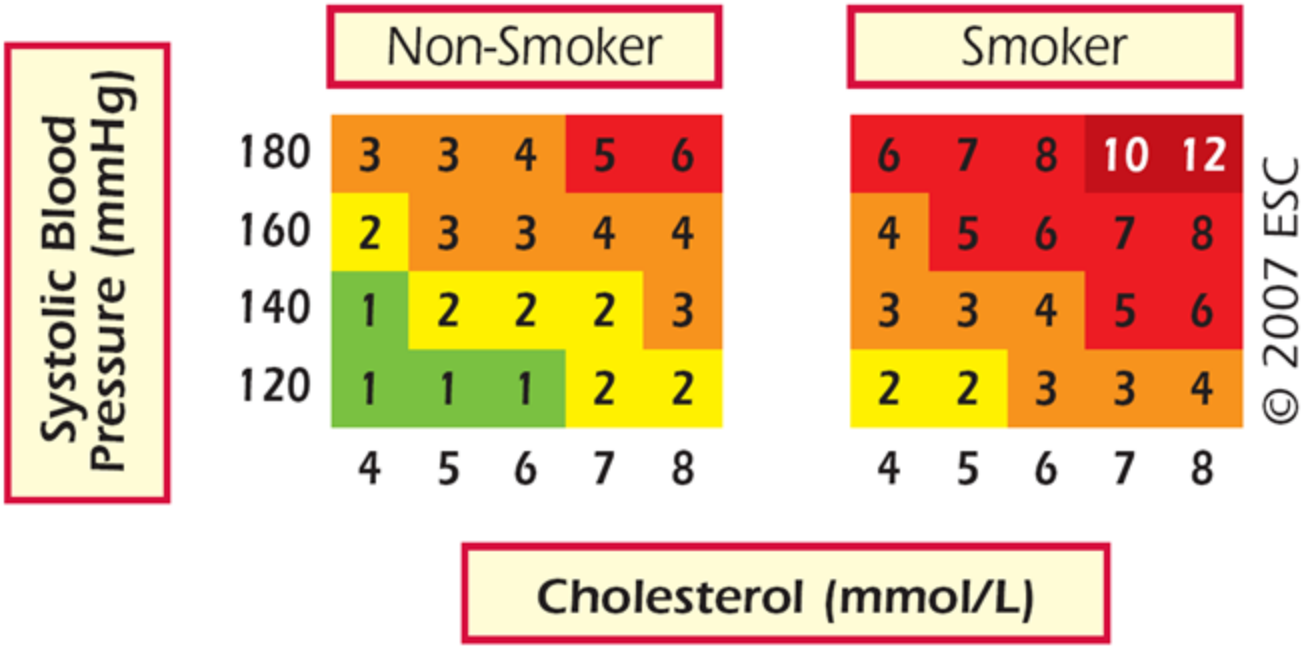


10 year risk of fatal CVD in low risk regions of Europe



Relative Risk Chart

This chart may used to show younger people at low absolute risk that, relative to others in their age group, their risk may be many times higher than necessary. This may help to motivate decisions about avoidance of smoking, healthy nutrition and exercise, as well as flagging those who may become candidates for medication



JTF5 - will it be different?

- Chairperson- Prof Joep Perk
- Detailed suggestions to simplify the process available (IG)
- Electronic version of JTF4 available
- Single format for submissions essential
- SCORE developments
- Will rehabilitation be included? logical (but political...)
- ? Make pocket guidelines the summary
- Continue to use figures in main text
- One page card critical
- Tie more closely to interactive teaching?

Additional knowledge needed?

- Commissioned surveys on what additional information is needed to inform strategy (by EACPR?)
- Modelling exercises on effects of implementation strategy (by EACPR?)
- Inventories of prevention in different countries to allow benchmarking
- Subsequent development of educational materials

Joint Prevention Group

EACPR Implementation Committee

Prevention Implementation Committee

The implementation of current CVD prevention guidelines

Ian M Graham

Give me a doctor partridge plump,
short in the leg and broad in the rump,
an endomorph with gentle hands,
who'll never make absurd demands
that I abandon all my vices,
or pull a long face in a crisis,
but with a twinkle in his eye,
will tell me that I have to die.

-W H Auden

Give me a doctor underweight,
computerised and up to date.
A businessman who understands
accountancy and target bands.
Who demonstrates sincere devotion
to audit and to health promotion-
but when my outlook's for the worse
refers me to the practice nurse

-MariaCampkin


Provided you eat sensibly stay off the beer, cigarettes and whisky, don't take any strenuous exercise and keep away from women Mr Coard, you could live for another twenty minutes.
Prof. Ian Graham
M Coard

Implementation strategies: National level

1. Adapt the European Guidelines to suit the local culture
2. Formation of a multidisciplinary implementation group: professional bodies, medical and other health professionals, basic scientists, educators, business people, politicians. Needs to be more than merely advisory: should inform and shape health policy
3. Multi-faceted communications using all available media to doctors, medical and para-medical students, and ultimately all adults and children, including schools

Implementing prevention: Basic requirements-

- National Co-ordinators to lead a multidisciplinary implementation group which will develop-
- National guidelines
- Partnerships between politicians, health professionals, educators and business
- A defined communication strategy
- An evaluation strategy
- BUT it must have teeth. This requires high level political representation if it is not to be a talking-shop

The future of prevention

Reality depends upon your point of view


IRELAND
THE AMERICAN VISION


IRELAND
THE BRITISH VIEW


IRELAND
THE EUROPEAN VIEW


IRELAND
THROUGH IRISH EYES

Changing Asia

Janus ED. Circulation 1996;94:2671-73

- 50% of the world's population
  >1 bn China, 1bn India, >200m Indonesia
- Very varied cultures, demography & economic development
- Rapid epidemiological transition in many parts to the Western way of death
- Fat intake <20%- >30% of total calories
- Cholesterol levels 2.8 mmol/l (110 mg/dl)- 5.7 (220)
- Cigarettes 30-70% in men, 3-10% in women
- Hypertension and stroke major problems, especially in Northern Asia
- ~50 % of thee world's diabetics live in China
- Metabolic syndrome may be less well tolerated
- QUESTION: Are American and European risk estimation systems, priorities, objectives and targets and strategies relevant? In Beijing? In rural China?