

SPECIALISTFOCUS

(continue from page 9)

Cholesterol Goal Attainment

Cholesterol goal attainment is a multifactorial process, with a range of potentially operative factors including starting doses, dose titration, and medication compliance.

In the A-SACT study, a retrospective analysis of patients with CHD in Singapore from 2000 to 2002, most patients (69.4 per cent) did not achieve the consensus LDL-C goal of <100 mg/dL. The finding that most CHD patients did not achieve LDL-C goals extends prior data in other populations showing that CHD patients and those with higher LDL-C are less likely than lower-risk patients to achieve cholesterol goals.

Reasons for this lack of goal attainment include physician and patient factors. The former includes prescription of statins of low to medium equipotency and failure to uptitrate statin dose. Patient factors include failure of compliance with medication regime, which in term is related to insufficiency of patient education and support.

Disease management strategies will facilitate the attainment of LDL cholesterol targets. These would include having case-managers contact patients post-hospital discharge to ensure patient compliance with statin dose, and appropriate up-titration of dose in the outpatient setting. Provision of patient-education measures is especially important to facilitate patient buy-in of life-style modifications.

The success of secondary prevention of CHD is reliant on a strong partnership between patients, case-managers and physicians. It is through multifactorial approaches like those outlined above that LDL cholesterol goal attainment will become a reality.

(continue from page 10)

The recommendation for the use of echocardiograms and exercise electrocardiograms is not as clear.

Exercise ECG offers better detection of cardiac abnormalities among athletes that are missed by resting, or baseline, ECGs. This is based on a study reported online 3 July 2008 in BMJ by Dr Francesco Sofi (University of Florence, Italy). This study is unique in that it identifies an older population of athletes who are at risk of coronary artery disease. The majority of those with abnormal exercise ECGs had normal resting ECGs suggestive of ischemia or arrhythmias. Importantly, most of them would have been overlooked on history and physical examination alone.

For cardiologists, the identification of important cardiac abnormalities and the decision to ground athletes remain one of the more complex aspects of clinical practice. The 36th Bethesda guidelines may provide recommendations based on the current consensus but decision to sideline athletes have to be tailored to the individual.

What is as important is comprehensive emergency planning to ensure efficient response to a sudden cardiac death. Having an on-site defibrillator only solves half the problem. A structured emergency action plan is critical. This involves early activation of EMS, early CPR, early defibrillation and early transition to advanced cardiac life support.