Editorials

Distribution of knowledge

See page 1536 for the article to which this Editorial refers

The Board of the European Society of Cardiology (ESC) has a major responsibility to promote the dissemination of knowledge on the prevention and treatment of cardiovascular diseases. There are many ways of accomplishing this goal. The clinical and basic science publications of the ESC are the European Heart Journal and Cardiovascular Research. Intramural (at the European Heart House) and extramural training programmes are organized regularly throughout the year. The annual European Cardiology Congress is a major educational event. These activities are directed towards groups of participants, who by reading the journals and by participation in the courses and the Congress may improve their clinical and scientific skills. Allocation of clinical and scientific scholarships to individuals serves the purpose of promoting training and research, not only for the scholar but also for the institution from which these scholars originate.

A different approach to improving clinical practice is to bring together an international group of experts to provide recommendations for good clinical practice. Such guidelines may be of particular value when there is no general agreement on the proper handling of a particular medical problem. This lack of consensus may sometimes relate to insufficient or incomplete knowledge. It may also reflect the fact that available information can be interpreted differently by different authorities and that it is not unusual for medical practice to reflect local or national therapeutic traditions. In such situations recommendations by experts, clarifying areas of consensus and disagreement, allows distribution of the best possible guidance to the practising physician. It is, however, not only physicians that may benefit from guidelines and related documents. Guidelines promote the proper utilization of health care resources, a matter of particular interest for health care administrators and politicians with responsibilities for resource allocation. Guidelines can also be helpful in clarifying the reasonable need for diagnostic and therapeutic equipment, intensive care beds and not the least, sometimes expensive, medical devices. Moreover expert groups may, during the formulation of their recommendations, identify subjects that need further research or improved documentation. In this respect the group may outline the proper measures to be taken in order to accomplish these goals.

Task Forces of the ESC

The ESC has strict rules as regards recommendations. The subject areas are considered by the Committee for Scientific and Clinical Initiatives (SCI), initiated during 1994, before presentation to the Board. The SCI committee is chaired by the President Elect, which emphasizes the importance the Board gives this committee. Membership is by invitation of the Board and members are chosen to reflect the need for widespread European representation. The present ten members are well known cardiologists and scientists from nine European countries. Among its responsibilities the SCI committee prepares ESC guidelines via creation of Task Forces, considers innovative roles for ESC involvement in health economics and research and prepares Policy Conferences on important, although possibly controversial, topics in the field of cardiovascular science and/or practice.

A Task Force may be created not only as a suggestion from the SCI committee, but as a proposal from ESC Working Groups or National Societies. It is then commissioned by the SCI committee, having obtained ESC Board approval. Usually a Task Force contains around 15–20 European experts in the field to be covered. A Task Force report is subjected to review within the SCI committee and by appointed external reviewers. When published in the European Heart Journal, the final document has ESC Board support. Thus, the final document represents an official declaration prepared by the Task Force on behalf of the ESC Board. Examples of published documents are: Prevention of coronary heart disease in clinical practice[1], the management of myocardial infarction[2], the management of stable angina pectoris[3] and the treatment of heart failure[4]. A Task Force on the burden of cardiovascular disease mortality in Europe was published in the August issue of the journal[5]. From these examples it should be obvious that Task Forces are chosen to cover fields of broad...
clinical interest. When appropriate, a Task Force should preferably contain representatives from other important medical organisations. Thus the Task Force on prevention[1] was a joint endeavour of the European Society of Hypertension, the European Atherosclerosis Society and the ESC. Translations are encouraged, as are other initiatives to improve the distribution of Task Force reports. The report on prevention[1] is available in more than 20 languages. It is the ambition of the SCI Committee to create about three Task Forces each year. It is important to update previous Task Force reports, and a new version of the first report on prevention may be expected during 1998.

**Study groups**

Besides these broad and often multidisciplinary subjects, there are more specific topics in need of recommendations or consensus opinions. Such topics may be equally important, but cover a more narrow field of interest and expertise. For such items a Study Group may be the suitable format. These are established by the Working Groups of the ESC.

The task of the SCI Committee is to coordinate their activities, for instance by informing other Working Groups that may have an interest in the particular subject and to inform members of the ESC on the reports from various Study Groups. These reports may contain information of relevance for direct clinical practice. They may also summarize technical issues, not only of value for clinicians but also for the industry and health or licensing authorities. Ideas for future research may be identified. In the present issue there is such a report: Recommendations on stent manufacture, implantation and utilization[6]. This report is prepared by an ad hoc Study Group of the Working Group on Coronary Circulation.

An important difference between a Task Force report and a report from a Study Group is that the latter only reflects the opinion of the Study Group itself. Thus, the content does not represent the official opinion of the SCI Committee or of the ESC Board. Study reports are subject to the journal’s normal review process and are often also discussed in the SCI committee. Examples of other recent Study Group reports are: clinical investigation of anti-arrhythmic devices[7]; and heart rate variability, standards of measurement, physiological interpretation and clinical use[8]. Both these Study Group reports were simultaneously published in the U.S.A. and Europe, illustrating the important internationalization of scientific and practical progress.

**Issues to be addressed**

It may be foreseen that, due to the rapidity of advancing knowledge and the rather uneven distribution of health resources, guidelines and similar documents will, in the future, attract increasing interest. In the few years since the initiation of the SCI Committee within the ESC, Task Force reports and reports from Study Groups are numerous.

One important but unresolved question concerns the legal implications of these documents, and in particular of the ESC Board-approved Task Force reports. This question is presently being addressed within a Task Force which includes cardiological, administrative and legal expertise, and is expected to report at the ESC Congress in Vienna, August 1998. The question is complex, with implications not only for the practising physician but also for those responsible for the delivery of health care resources on one side, and for the organization responsible for the report on the other.

Another question is whether it will be possible to improve the general standard of preventive and therapeutic cardiovascular care in Europe by the utilization of Task Force and Study Group documents. In this respect it is crucial to obtain approval for this work by organizations such as the EU and European governments. To be successful, these documents need to be written by independent clinicians and scientists, with input from scientific and industrial representatives. The relationship between the industry and the ESC (and other related organizations) is an important subject for debate. A Policy Conference on this topic falls within the responsibilities of the SCI Committee to organize. Such a meeting is being planned, as is another dealing with the controversial subject of the re-use of devices and catheters in cardiology.

A third question is finance. So far the SCI Committee and the work within Task Forces and Study Groups has been partly financed by the ESC and its Working Groups and partly, and to a larger extent, by industrial grants, generously awarded. The subjects dealt with are so far rather neutral. It may become more difficult to raise this type of grant for more controversial subjects, such as the one on re-use of devices.

Policy Conferences, Task Forces and Study Groups need to recruit the best possible expertise. This is made possible via the ESC and its sub-branches. The work is performed with limited resources, essentially utilized to organize meetings between the participants, who generously put their knowledge in the hands of the organization without demanding reimbursement. The ESC may need to receive subsidies from the EU and other governmental
resources for the work, not only to improve clinical and scientific standards but also to accomplish efficient utilization of health care resources.

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References


Validation for coronary stenting: a permanent implant for interventional cardiology

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Coronary stenting has been accepted remarkably rapidly as a more definitive method of percutaneous revascularization than balloon angioplasty, or other newer alternatives such as directional or rotational atherectomy, or laser. In most laboratories where interventional procedures are commonly performed, at least 40-50% of the cases involve stent implantation. This veritable 'sea change' is the most radical transformation in the field of interventional cardiology since its birth in 1977. Indeed, permanent metal prosthetic implants in the coronaries have become an extraordinarily routine procedure. At least 350 000 patients worldwide will have at least one coronary stent implanted in 1997.

Fortunately, intensive clinical investigations have validated the use of stents in particular subsets of patients. Focal, de novo lesions in large, native coronary arteries are the most carefully studied subgroup,[1–8], but only represent a small proportion of patients undergoing the procedure. More recently, randomized trial data of patients with saphenous vein graft lesions, chronic total occlusions, and restenotic lesions, have all been quite favourable for the use of stents compared with balloon angioplasty. Interestingly, four small randomized trials of stenting for acute myocardial infarction collectively, demonstrated a 0-6% mortality as compared to a 6-6% in-hospital death rate for balloon angioplasty.[5,6] This new frontier for coronary stenting was an original absolute contraindication when stenting was first initiated in the late 1980s. This certainly confirms the radical changes that have occurred in the field.

In the current issue, the European Society of Cardiology Working Group on Coronary Circulation have published an important paper on stenting.[1] It