High time to join hands between family medicine and cardiology!

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This editorial refers to 'Achievement of guideline-defined treatment goals in primary care: the German Coronary Risk Management (CoRiMa) study' by J.C. Geller et al., on page 3051

In many countries there is a steady deterioration of cardiovascular health, leading to cardiovascular disease (CVD), due to an inappropriate lifestyle. Few people achieve the recommended levels of regular physical activity and correct nutritional habits, or succeed in preventing stress and obesity. Smoking still remains one of the prime risk factors. Recently, an alarming first report has been published on the increase of CVD mortality in younger males and an attenuation of the decrease of mortality in younger women. In contrast, the World Health Organization (WHO) states that more than half of the CVD mortality could be prevented through simple methods at the population level.

At present the prevention challenge is met through both political and medical initiatives. On the political level, the European Heart Health Charter marks an EU cornerstone, political and medical initiatives. On the political level, the 2007 guidelines of 10 joint European societies on CVD prevention are the recent contributions to prevention in clinical practice. The task of the joint society's prevention committee to implement the 2007 document is in full progress, representing engagement of a broad group of experts from family medicine, cardiology, diabetology, and other disciplines.

Important initiatives indeed, but will they reach their ambitious targets? The study of Geller et al. provides clear and sobering reading. In this large cohort of German patients with CVD and/or diabetes mellitus, the management of known risk factors in primary care needs urgent improvement: 9–36% of the treatment targets are met, and only one in seven high-risk patients receive an adequate lipid control in spite of a remarkably high number of visits to the family doctor's office (once a month in the average 3 years of the study). If the treatment targets were reached, one could expect a 5-fold decrease in the numbers of events among patients at high CVD risk using the Framingham algorithm, or a >2-fold reduction applying the SCORE model! The authors have shown that electronic documentation systems can be used to witness the real life data of clinical practice.

There are shortcomings in the study: a positive selection bias (centres volunteered to participate in the study) and a lack of data on smoking and lifestyle intervention, eating habits, and body mass index (BMI) or waist circumference.

Yet, this major study, together with growing evidence from other parts of the world, raises an important question: is there a collective failure of primary care medicine in preventing cardiovascular disease? If so, why do CVD and other guidelines fail in changing the habits of physicians; what are the obstacles that should be overcome? In a 2002 survey, general practitioners (GPs) identified as main obstacles a lack of patient's compliance, a lack of time, and a lack of reimbursement for preventive counselling. Guidelines were too theoretical and lengthy; short concise versions were called for. However, the study by Geller et al. does show that at least in Germany there are excellent opportunities for frequent visits to the GP, thus creating a solid resource for improvement.

Are the targets values for blood pressure, cholesterol, and glycaemic control too ambitious to reach, contributing to therapeutic resignation? The European branch of the World Organisation for Family Medicine (WONCA) has contributed to a considerably larger degree to the 2007 guidelines, which has resulted in adding the term 'if feasible' to several target values. A physician should not be deemed guilty if target levels are not reached in all patients, but they should rightly be questioned if not all options of evidence-based medicine were used.

The CoRiMa team concludes correctly in their report that major changes are required to achieve better implementation of guidelines and their treatment goals. What could these changes be? Health care providers must acknowledge the priority for preventive counselling; time and adequate reimbursement are needed. Regular audits of the quality of preventive care will be needed to monitor the improvements in care. Through accepting the EU Heart Health Charter and creating professional alliances on the national
level, decision makers will be obliged to provide the needed health care funds.

Early identification of persons at risk for CVD mortality is a direct task of the family doctor. The joint European societies advocate the use of the SCORE model and its electronic version Heartscore, a web-based version provided by the ESC team (www.heartscore.org). Through the introduction of a relative risk equation in SCORE, advising younger persons at risk has been made more accessible. Heartscore is at present available in 11 languages and has almost 9000 users throughout Europe. An updated version including the relative risk assessment will be presented in 2008, and a stand-alone version will be provided for physicians facing difficulties with online web communication. It may be expected that easy access to risk calculators may improve adherence to guideline targets.

Should new models of care be considered? In the 2007 CVD guidelines, lifestyle issues have gained importance, promoting the use of multiprofessional teams to obtain long-lasting cardio-protective habits. Among the different new models of care, three recent examples can be mentioned: first the primary care arm of the ESC demonstration project EuroAction. The model consists of risk identification by the family doctor, counselling by a trained nurse, and a standardized follow-up for patients at high CVD risk and their nearest relatives, in agreement with the priorities set in the 2003 and 2007 guidelines.6

Secondly, in the USA, the concept of case management (CM) nursing as a resource for the family doctor appears to be effective.7 Stafford and Berra demonstrated a statistically significant reduction of the Framingham risk score when comparing CM plus primary care vs primary care alone.

Finally, in Kalmar County, Sweden, the use of HeartScore as risk assessment followed by a first motivating contact with the family doctor has been extended to all primary care centres.

Patients in need of lifestyle support are referred to nurse-based counselling in close co-operation with resources in the local community. At 1 year this model contributed to a significant reduction of CVD risk using the SCORE algorithm.8

Even postgraduate education in preventive cardiology for the family doctor is called for. In Italy, the Ministry of Health has conducted primary care education over the past 10 years, the Progetto Cuore. Over 2000 GPs have been trained in risk identification and management using an Italian risk database.9 An ambitious programme with regional courses and rehearsal meetings has extended the Progetto Cuore as a preventive service to a substantial part of the population.

In summary, there is a growing population in need of preventive cardiology, there is a high-level EU agreement in the Heart Health charter, and there are robust models of risk identification and management. There are concise guidelines, evidence-based target levels for risk factors, and effective medication if needed. If applied widely, the efforts may well contribute to an attenuation of the CVD pandemic.

In this respect, the ESC has constituted a ‘Council for Primary Cardiac Care’ at the 2007 annual congress in Vienna which has been given the task of building a bridge between family medicine and cardiology. The confounding results from the report by Geller et al.4 do provide a convincing rationale for the work of this new council: it is indeed high time to join hands between family medicine and cardiology!

Conflict of interest: none declared.

References