

The prevalence, aetiology and management of heart failure <i>G C Sutton, P A Poole-Wilson</i>	551	Detecting depression in the elderly – what will improve our performance? <i>Amanda Howe</i>	552	Psychiatric illness in general practice <i>EC Hamlyn</i>	554
The investigation and management of patients with heart failure <i>Eric M Sanderson</i>	551	Mental health care professionals and general practice <i>Rebecca Lawrence, Ian Pullen</i>	553	Chronic pain in dementia – undetected or under-treated? <i>Rahul Rao</i>	554
Managing drug abuse <i>Trevor Stammers</i>	552	Asthma in the community and general practice <i>Tom Kennedy, Roger Jones</i>	553	Fragmentation of the health service and the future of general practice <i>Philip Cotton</i>	555
Patient satisfaction <i>Sarah Grogan, Mark Conner, Paul Norman, David Willits</i>	552	Saving money in general practice <i>John Struthers</i>	553	The DCCH examination <i>Antonio An Tung Chuh</i>	555
		Summative assessments for GP registrars <i>T Stuart Murray, L Malcolm Campbell</i>	554	Note to authors of letters: Please note that all letters submitted for publication should be typed with <i>double spacing</i> . Failure to comply with this may lead to delay in publication.	

The prevalence, aetiology and management of heart failure

Sir,
We were interested to read the paper by Mair *et al* (February *Journal*) reporting the prevalence, aetiology and management of heart failure in two group general practices (17 400 persons) in Liverpool.¹ They deliberately used the methodology that we described several years ago when we reported the prevalence and aetiology of heart failure in three general practices (30 204) in the North and West of London.² By comparison with our study, their findings revealed a three- to fourfold higher prevalence in the population, as well as in persons over 65 years of age. More cases were attributed to coronary heart disease and hypertension, and fewer placed in the category of 'unknown'.

Although the definition of heart failure used in the two studies was the same, the accuracy in making the diagnosis of heart failure remains a problem. In the London study, 87% of patients regarded as having heart failure had the diagnosis made in the hospital setting. This is an important point as it is known that the diagnosis of heart failure in general practice is only confirmed in about 33% of patients later assessed in hospitals.³ But even the hospital diagnosis of heart failure is likely to be biased by such factors as the interpretation of a chest X-ray, or the detection of physical signs (jugular venous pulse, abnormal cardiac impulse, or gallop rhythm). The London study may be reporting cases of established and more severe heart failure, while the Liverpool study could be taking a more liberal view of the diagnosis. Nevertheless, as Mair *et al* point out, the London practices were not as well organized for finding cases of heart failure (the study was carried out in 1988) as the Liverpool study 6 years later. It is certainly possible that the methods used in the London study slanted the outcome towards an underestimation, but it is equally possible that the procedures for case detection in the Liverpool study resulted in an overestimation. The latter would be particularly

true if relatively few of the patients had been referred to hospitals. In an incidence study, which we are currently carrying out, we have found that new cases of heart failure in the London area present four times as frequently to hospital as emergency admissions than to practitioners or hospital outpatients as 'cold' referrals.

The variation between the two studies, with respect to aetiology, may reflect a similar difference of emphasis. In a predominantly elderly population, detailed cardiac investigations to establish the precise aetiology of heart failure are uncommon. Thus, the proportion of cases due to ischaemic heart disease is likely to be a significant underestimation. The detection of abnormalities of left ventricular dysfunction by echocardiography (rarely done and about 30% in both studies) seldom allows certainty of an aetiological diagnosis. Why 'unknown' should be less common in Liverpool than in London, and ischaemic heart disease the reverse, is intriguing, but might reflect a similar bias as in the case definition. Whether there are true differences, both in the prevalence and in the aetiology between Liverpool and London, could only be assessed by a joint approach between the different practices.

Heart failure is a common condition with a poor prognosis. Whether the prognosis can be improved in an unselected population of heart failure, as in Liverpool or London as suggested by recent therapeutic trials whose patients seldom resemble those of the population at large, remains an unresolved and challenging issue.

G C SUTTON
P A POOLE-WILSON

National Heart and Lung Institute
Imperial College of Science, Technology and Medicine
Dovehouse Street, London SW3 6LY

References

1. Mair FS, Crowley TS, Bundred PE. Prevalence, aetiology and management of heart failure in general practice. *Br J Gen Pract* 1996; **46**: 77-79.

2. Parameshwar J, Shackell MM, Richardson A, Poole-Wilson PA, Sutton GC. Prevalence of heart failure in three general practices in north west London. *Br J Gen Pract* 1992; **42**: 287-289.
3. Remes J, Miettinen H, Reunanen A, Pyorala K. Validity of clinical diagnosis of heart failure in primary health care. *Eur Heart J* 1991; **12**: 315-21.

The investigation and management of patients with heart failure

Sir,
I was interested to read the paper by Mair and colleagues (February *Journal* p.77) in which a community investigation of cardiac failure was undertaken. The findings suggested that 'only a minority of patients are being fully investigated and receiving optimal treatment'. Echocardiography is suggested as the optimal investigation¹ and indeed, in the same edition of the *Journal*, Clubb and Clubb (p.122) make a case for open access cardiography for GPs.

Mair found that 'only' 30% of patients had had this investigation and that only 33% of patients were receiving an ACE inhibitor as part of optimal therapy.

In a recent audit, Clarke and colleagues demonstrated that 74% of patients who satisfied the stated criteria for heart failure were referred to hospital, where only 31% had an echocardiogram and only 17% were prescribed an ACE inhibitor. The authors state that most of the investigations were undertaken by hospital practitioners, most of whom were not cardiologists. Suboptimal investigation and management of patients with heart failure seems therefore to be widespread and the time is ripe for local and national guidelines to be developed in order to improve life expectancy for this important syndrome.^{3,4,5}

In 1995/96, Barking and Havering MAAG have been co-ordinating a district wide audit of diuretic prescribing. Following an educational afternoon facilitated by a consultant physician, criteria for quality were agreed by GPs and practice