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COMMENTARY

## Secondary Prevention of Ischaemic Heart Disease in Spain. Quo vadis?

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The priority in cardiovascular prevention are the patients who have suffered an ischaemic event; more time and resources should be dedicated to these patients, due to their increased risk of morbidity and mortality, to achieve the objectives laid out in the guidelines.

There is abundant scientific evidence which demonstrates the benefits of pharmacological and non-pharmacological interventions in these patients. Unlike in primary prevention, where there are doubts and different opinions on who

should be high risk patients, in secondary prevention there are no such uncertainties, and practically all the guides agree on the recommendations that should be carried out. However, the reality is, that for one reason or another, the evidence is not being transferred to clinical practice, and those objectives set out in the guides are not being achieved. This is a known fact as many national and international observational and evaluative type studies have been carried using cross-sectional or longitudinal designs, to

## Key Points

- The level of prophylactic drug use in the secondary prevention of coronary disease is below optimum.
- There is a wide variation in the results from different secondary prevention studies in Spain.
- The evidence on the effectiveness of secondary prevention programmes, or strategies to improve them in the primary care setting, is inconclusive.
- Intervention studies are currently being carried out in Spain, which in future can provide us with practically applicable results in primary care.

know exactly up to what point the objectives, in terms of prophylactic treatment and control of risk factors, are reached. The review carried out by Sanf elix et al in this issue of Primary Care,<sup>1</sup> clearly demonstrates that the level of prophylactic drug use is obviously below optimum, although a rising trend is observed, particularly when the results of studies carried out in the hospital setting are analysed.

Another interesting aspect demonstrated in this review is the variation in the results, which could partly be due to the different methodology used. The authors have reviewed 19 studies published between 1995 and 2004, which is an average of 2 published studies per year. Thirteen studies were carried out in a hospital setting, recruiting a total of 25 478 patients, while 6 were carried out in primary care, including a total of 2115 patients (in this latter setting those patients from the ICAR study have been included due to it being more appropriate to primary care). This very large difference in the number of studies and patients included is noteworthy, and more so particularly when we are not talking about an acute hospital treatment, but a preventive treatment to prevent new re-admissions and reduce the mortality of these patients. Secondary prevention must essentially be instituted at hospital discharge, when the follow up the patient is exclusively carried out by the family doctor, or shared with the outpatient cardiologist.

A review such as this one enables us to assess the results from a certain perspective, to observe what has been done up to now and where we are going, and is an exercise in reflection and self-criticism. If we could go back in time, and on looking at all these studies, the question we should ask ourselves is whether we would have done anything different. The answer, in my opinion, is yes, and the recommendation would have been to carry out a single study,

with information at hospital discharge and with follow-up information in the primary care setting, collecting information from the different hospital centres—urban and rural, tertiary and second level, university and non university hospitals—from all the autonomous communities. This same study, certainly more expensive than the 19 published, could be repeated once every 2 or 3 years, using the same methodology and, thus, the differences observed in the prophylactic treatments over time—if there were any—would be much more realistic. In a space of 10 years between 3 and 5 studies would be published, which would be more worthwhile in the long run, and perhaps with a higher scientific return. Now, we have to look forward, hoping that, in the future, any descriptive study in secondary prevention may take this review into account, and the need to carry out more studies or not should be evaluated. Perhaps now is the time to set ourselves new challenges, to design studies with other objectives, to try to answer questions still not formulated. Some of the studies in the review, such as the ICAR study or the PRESENTE study, already go along this line.

However, the evidence on the effectiveness of secondary prevention programmes, or strategies to improve them in the primary care setting, continues to be uncertain.

A systematic review of clinical studies on secondary prevention<sup>2</sup> concluded that these, improve medical care, can reduce hospital admissions, and improve the quality of life and the functional capacity of coronary patients, but their effectiveness in reducing mortality and re-infarctions were doubtful.

There is also evidence of studies that evaluate different strategies to improve the results in secondary prevention, using pragmatic designs of randomised intervention in primary care, with disparate results. One of these studies evaluated the effect of secondary prevention units staffed by nursing personnel and comparing it with the usual care in the family doctor clinics. Improvements in the use of anti-aggregants, in the control of blood pressure and lipids were observed, as well as the carrying out of physical activity and following a diet. These same investigators published after a follow up of 4 years,<sup>3</sup> and they observed a reduction in mortality and coronary events when both strategies were compared, although the authors themselves commented that these results had to be interpreted with caution due the low power of the study to detect these differences and due to the values of statistical significance (*P*) being borderline.

Besides, these studies have been carried out in different settings to ours and, therefore, their results are difficult to extrapolate, particularly because they involve very specific organisational and health system aspects. Other initiatives are currently being carried out in Spain within the framework of a European study, or exclusively in our country, which in the future could provide interesting results. The EUROACTION<sup>4</sup> study has as its objective to demonstra-

te that a multidisciplinary nursing team can help the patients and their families to follow the recommended life style and reduce the risk factors in primary prevention (patients at high risk) and secondary prevention of cardiovascular diseases. Eight European countries, including Spain, are taking part in this study, specifically the Valencia Community. The results will be presented at the next European Cardiology Congress in Barcelona.

The PREseAP<sup>5</sup> is a clinical trial carried out in the primary care environment in 42 health centres in 8 Autonomous Communities, which has as its objective, to evaluate the effectiveness of an integral programme of secondary prevention to reduce the morbidity and mortality in patients who suffered from a cardiovascular disease. The health centres in this study have been randomised, some to follow the usual care and others where an integral programme of secondary prevention is in place, where previously trained nursing staff are carrying out educational intervention to improve the control of risk factors and therapeutic compliance. It is anticipated that the study will finish at the end of 2007.

Without a doubt these studies will start to give us practically useful results, which will help us to improve the establishment of the recommendations in clinical practice.

Another interesting question, and depending on the answer, is to know what are the standards that we can adopt in the real control of risk factors in patients with a cardiovascular disease. From the results of a previous study<sup>6</sup> an approximation of the recommended standards in prophylactic medication of patients who have suffered from a myocardial infarction, has already obtained. These results are useful to produce health indicators in secondary pre-

vention of cardiovascular disease, whether in the smaller environment of the health centre or in the wider one of a health area, with the aim of establishing what are the optimum levels (which are never 100%) in the control of risk factors and in prophylactic medication.

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