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CONTENT:

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NEW EUROPEAN GUIDELINES FOR THE PREVENTION OF CARDIOVASCULAR DISEASES

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Clinical Hospital Rebro, Zagreb

On ESC Congress 2007 in Vienna, on the 3rd September 2007, for the first time new European guidelines for the prevention of cardiovascular diseases (CVD) were presented. The whole text of the guidelines (113 pages) was published in the supplement of the 2nd September issue of European Journal of Cardiovascular Prevention and Rehabilitation, while the summary of the guidelines was published in the same journal but in European Heart Journal and in the September issue of Atherosclerosis.
What is new in those guidelines, or how do they differ from the guidelines from the year 2003? One of the news is bigger accent on the need to evaluate complete cardiovascular risk, and not only to pay attention on only one cause of the risk, for example only on hypertension or only on hyperlipidemia and alike. It is emphasized that SCORE risk cards should not be used to calculate the risk of those who are evidently high risk patients: patients with certain coronary heart disease (CHD) or recovered myocardial infarction, diabetics type 2 or those with type 1 with microalbuminuria and among patients with significant hyperlipidemia (family hypercholesterolemia and alike). One more card risk was added that is meant to show that younger people with lower total risk are more endangered than they peer. That could help

doctors to motivate them to stop smoking, to start with healthier nutrition and to do regular exercise. Generally more attention is given to the way of living and its importance for CVD than in earlier guidelines. That especially refers to psychosocial factors: social-economic status, social isolation, depression and stress as important risks that cause and other risk factors such as smoking, unhealthy nutrition, not doing any sports and alike. From all this it is evident that there is a need for more intensive doctors' influence in order to change unhealthy way of living among patients who address them.
It is stressed out that women, although in reproductive stage of life have lower risk, altogether they die more because of CVD so the prevention among them should be much bigger than it was till now. The important stress is given on the prevention of peripheral arterial disease and cerebrovascular disease and it was clearly stated that those patients deserve the same attention concerning prevention, especially treating with statin, as the patients with CHD. Since the life long risk of diabetics is the same as among non-diabetics with proved cardiovascular disease, especially if there is some other risk factor present or they have microalbuminuria, it is necessary to work on prevention with more intensity, with the treatment with statin.
Among all new guidelines usually the highest attention (especially pharmaceutical industry because of their direct interest, and then consequently pressure on doctors) is raised by new aimed values of treatment. According to that, there were no new changes except that with already given aim of lowering total cholesterols among patients with high risk on 4.5 mmol/L, and LDL on 2.5 mmol/L, was stated that it would be advisable, if it is possible, to lower the total cholesterol on less than 4 mmol/L, that is LDL cholesterol on the value less than 2 mmol/L. It is based on the results of new clinical research, and the barrier "if it is possible" refers to difference in cultural, nutritional, economical and other circumstances in different countries, so this recommendation should be accepted within that context. As far as arterial hypertension is concerned, among patients with really high risk (those with diagnosed CVD, diabetics and patients with kidney disease or some other organ) blood pressure should be lowered to 130/80 mmHg, if it is possible.
It is also worth mentioning that it was clearly stated that all patients who are hospitalized due to acute coronary syndrome should definitely start to be treated with statin during their stay in hospital.

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SENIOR DRIVERS – GREATER RISK FOR A CAR ACCIDENT?

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3Bjelovar General Hospital, Bjelovar

In the countries of European Union in road accidents with fatal outcome 43.000 people get hurt. According to the statistics of Central Bureau of Statistics of the Republic of Croatia, processed by Croatian National Institute of Public Health, the number of fatally injured persons in 2006 due to the car accident in our country is 659 (rate 14.85/100.000) and such represents 35% of all accidents in that year. For the last couple of months we have been showered, almost daily, with the news dealing with heavy car accidents stating that the main cause of them were younger drivers.
Is that really so?
A few days ago in Austrian daily paper "Kurier" an article was published that influenced on the following way of thinking. The heavy car accident was described as one with two dead and one heavy injured person. It was caused by 78 year old driver. The fact is that in the last two years in Austria among 580.000 inhabitants older than 75, 92 died in car accidents, as opposed to 88 fatal injured persons on 610.000 inhabitants between the age of 20 and 24. According to the available data for the Republic of Croatia from all together 56.025 car accidents during the year 2005, drivers of the 65 age and older have caused 2.358 (4.2%) of all car accidents, whereof 35 died and 611 were injured. The percentage of drivers older than

65 who caused the accident with the fatal injury in 1996 was 4.7%, and in 2005 was risen to 7.3%. Among car accident with only injured people, the percentage of population of the same age was 2.6% in 1996, and 4.2% in the year 2005.
We are aware of the fact, and that is approved by the statistics, that the drivers of younger age are the most frequently the cause of all road accidents (speed, risk tendency), nevertheless the maternal age is extended, and thus the percentage of senior drivers as the cause of the accidents is becoming bigger. By this statement very delicate matter is being opened and that matter is: Is it possible that the health capability of the drivers who are 18 years old for A and B category when they get their drivers' license is not being checked till the age of 80? Austrian, Slovenia and Croatia and 5 other European countries have become the exceptions among developed countries because they have renounced health control of driver's capability among senior citizens. For Croatia it is valid from the year 2004. It is also worth mentioning that in our neighboring country Hungary, drivers should get medical check up when they reach 40 in order to prolong valid driver's license.
Of course that we agree that getting old is not a disease. By getting older it is inevitable to go through some changes in medical capability which can influence on safe driving. Some are very easy to see (for example poor eyesight, disorders in motor control) while other like cardiovascular diseases need medical surveillance and corresponding treatment.
Cardiovascular diseases are number one cause of death in Croatia. Since there are no detailed statistical data about car accidents whose participants are senior citizens who suffer from cardiovascular diseases, it is worth to quote the colleagues from the Croatian National Institute of Public Health from Zagreb according which by looking in all medical paper of 314 checked patients older than 65, pathological changes on cardiovascular system are found among 75%. It is well known fact that among people older than 60, more than 60% have higher values of blood pressure that asks for appropriate treatment and control. While driving we are constantly put under some kind of stress that can result in changes of blood pressure and cause the disorders in hearth rhythm, cause anxiety and lead to heart attack and stroke.

The intention of this paper was not by any chance to reduce the freedom and independence of senior citizens while driving. The car is usually necessary to senior citizens, but it is necessary that they don't represent danger for themselves and the others.
Finally, one seemingly funny remark from the above mentioned "Kurier", if you notice senior driver with a hat or a cap run from him. It is well known fact that "cover" on the head is not usually worn at home, or in the car where we should feel at home.

Literature

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2nd CROATIAN ECHOCARDIOGRAPHY CONGRESS WITH THE INTERNATIONAL PARTICIPATION
OPATIJA, 11TH – 13TH OCTOBER 2007

Viktor Peršić on behalf of Organizational Committee
Special Hospital for Medical Rehabilitation of Heart and Lung Diseases and Rheumatism
Thalassotherapia, Opatija

We have organized 2nd Croatian Echocardiography Symposium with international participation in order that it becomes traditional scientific and expert manifestation. At this gathering we are celebrating 50 years of Thalassotherapia in Opatija and we are trying to point out to our development and achieved results which are surveyed by symbol of inauguration of acute cardiac department. The above mentioned happening, among the introduction of monograph of institution and artistic program, will be honored with the presence of the President of the Republic of Croatia Stjepan Mesić, the Minister of Health Professor Neven Ljubičić,
We are looking forward to seeing you!
All information about congress is available on official sites of congress (http://www.thalasotherapia-opatija.hr) of Kardio.hr portal.

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CARDIOVASCULAR ULTRASOUND: FROM IMAGING TO KNOWLEDGE IN THE PRACTICE OF CLINICAL CARDIOLOGY

Wednesday, October 10, 2007
Thursday, October 11, 2007

ECHOCARDIOGRAPHIC WORKSHOP FOR BEGINNERS

Thursday, October 11, 2007

15.00 – 18.00 REGISTRATION
18.00 OPENING CEREMONY

SCIENTIFIC PROGRAM

Friday, October 12, 2007

09.00 – 10.30 PLENARY SESSION I
Chairpersons: N. Nanda (Birmingham), I. Sokol (Zagreb), Ž. Mavrić (Rijeka)

09.00 – 09.10 Wellcome and Announcement
V. Peršić (Opatija)
D. Miličić (Zagreb)
09.10 – 09.30 Echocardiography today: State of the Art
N. Nanda (Birmingham)
09.30 – 09.50 Echocardiography in Cardiac Resynchronization Therapy: State of the Art and Future Directions
J. Gorcsan (Pitsburgh)
09.50 – 10.10 The Role of Echo in the Assessment of LV Filling Pressures
F.J. Pinto (Lisbon)
10.10 – 10.30 Stress Echo and Sustainability of Cardiovascular Imaging
E.Picano (Pisa)

10.30 – 11.00 Refreshment Break

SCIENTIFIC SESSION # 1

11.00 – 13.00 VALVULAR HEART DISEASES
Chairpersons: F.J. Pinto (Lisbon), V. Peršić (Opatija), J. Vincelj (Zagreb)

11.00 – 11.20 Comprehensive Evaluation of Aortic Stenosis
V. Peršić (Opatija)
11.20 – 11.40 Aortic Regurgitation: Moderate or Severe – How Can I Be Sure?
J. Gorcsan (Pitsburgh)
11.40 – 12.00 Prognostic Value of Echocardiography in Assessing Mitral Regurgitation
F.J. Pinto (Lisbon)
12.00 – 12.20 Stentless versus Superstentless Aortic Bioprostheses in Terms of Survival Advantage
I. Sokol (Zagreb)
12.20 – 12.40 Ehocardiography in Tricuspid Valve Disease
D. Planinc (Zagreb)
12.40 – 13.00 Echocardiography in Valvular Endocarditis
J. Vincelj (Zagreb)

13.00 – 15.00 Lunch

SCIENTIFIC SESSION # 2

15.00 – 16.20 LEFT AND RIGHT VENTRICULAR FUNCTION
Chairpersons: I.Vlasseros (Athens), V. Nikolić-Heitzler (Zagreb), L. Zaputović (Rijeka)

15.00 - 15.20 Echocardiographic Assessment of Left Ventricular Long Axis Function
G. Bajraktari (Prishtina)
15.20 – 15.40 2D and 3D Transthoracic Echo Diagnosis and Assessment of Left Ventricle – non compaction
N. Nanda (Birmingham)
15.40 – 16.00 The Diagnosis of Right Ventricular Failure by Echocardiography
I. Vlasseros (Athens)
16.00 – 16.20 Echocardiography in Pulmonary Embolism
V. Nikolić – Heitzler (Zagreb)

16.20 – 16.40 Refreshment Break

SCIENTIFIC SESSION # 3

16.40 - 17.40 STRESS ECHO IN ISHEMIC HEART DISEASE
Chairpersons: G.Miličević (Zagreb), D. Planinc (Zagreb), D. Žagar (Rijeka)

16.40 - 17.00 Role of Stress Echo in Patient Management
G. Miličević (Zagreb)

17.00 – 17.20 ECHO DIAGNOSTICS OF CARDIAC MASSES
Cardiac Tumors
D. Žagar (Rijeka)

Saturday, October 13, 2007

08.30 – 09.10 PLENARY SESION II
Chairpersons: D. Miličić (Zagreb), J. Gorcsan (Pitsburgh), A. Matana (Rijeka)

08.30 - 08.50 Incremental Value of 3D Echo over 2D Echo/Doppler in the Assessment of Valvular Regurgitation
N. Nanda (Birmingham)

08.50 – 09.10 Clinical Uses of Tissue Doppler
J. Gorcsan (Pitsburgh)

SCIENTIFIC SESSION # 4

09.10 – 10.30 AORTIC DISEASE AND DISSECTION, HEART FAILURE
Chairpersons: D. Miličić (Zagreb), J. Gorcsan (Pitsburgh), A. Matana (Rijeka)

9.10 – 09.30 Echocardiography in the Assessment of Aortic Dissection
D. Miličić (Zagreb)
09.30 – 09.50 Aneurysm of Sinus Valsalva
A. Matana (Rijeka)
09.50 – 10.10 Echo – Doppler Prognosis in Heart Failure
J. Gorcsan (Pitsburgh)

10.10 - 10.40 Refreshment Break

SCIENTIFIC SESSION # 5

10.40 – 12.00 ECHO TECHNIQUES AND THERAPEUTIC MODALITIES
Chairpersons: J. Šeparović (Zagreb), J. Mirat (Zagreb), R. Bernat (Krapinske Toplice)

10.40 - 11.00 Echo Techniques for CRT Patient Selection and Device Optimization
J. Šeparović (Zagreb)
11.00 – 11.20 Monitoring of Patients with Implanted Devices
J. Mirat (Zagreb)
11.20 – 11.40 Echo-Based Non Invasive Cardiac Angiogenesis Therapy
I. Vlaseros (Athens)
11.40 - 12.00 Percutaneous Closure of Patent Foramen Ovale and Atrial Septal Defect – the Role of Transesophageal Echocardiography
R.Bernat (Krapinske Toplice)

12.00 Lunch

Kardio list Online 2007;2(9):54. KARDIO LIST – SPONZOR'S PAGE

THE EFFICIENCY AND SAFETY IN USING SIMVASTATIN (VASILIP) AMONG HIGH-RISK PATIENTS WITH HYPERLIPIDEMIA REGARDLESS WHETHER THEY SUFFER OF CARDIOVASCULAR DISEASE OR NOT: THE RESULTS OF META-ANALYSIS*

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2Krka, Novo Mesto, Slovenia

Objective of the study: The aim of the study was to confirm efficacy and safety of simvastatin (Vasilip) in 1.637 high-risk patients (pts) with hypelipidemia and with or without cardiovascular diseases (CVD).
Method and patients: Altogether, 1.637 high-risk patients with hyperlipidemia and with or without CVD from 11 clinical trials were included into meta-analysis. Clinical trails were performed in 10 countries according to the same design, short-term (12 weeks), opened, nonparallel. Pts were treated with 10 to 40 mg of Vasilip to reach target levels of LDL-cholesterol (LDL-C). Main outcome measures were changes in LDL-C and other studied parameters, safety profile at different doses of simvastatin, and relationship between simvastatin and concomitant use of some drugs known to cause clinically important adverse effects.
Results: 29% of pts included into the meta-analysis were older than 64 years and 37% were in the range of 55 to 64 years. 45.6% pts were at high-risk without CVD and 54.4% were pts with history of CVD. The risk factors such as hypertension, diabetes, and smoking were present in high percentage (72.4%, 23.5% and 25.7% respectively). The average dose of Vasilip at the end was 21.3 mg and resulted in relative reduction of LDL-C by 35%, total cholesterol by 26%, triglycerides by 12% and relative increase in HDL-cholesterol by 10%.

Systolic and diastolic blood pressure was also significantly reduced by 7 mm Hg and 4 mm Hg respectively. One hundred fifty five pts (9.5%) reported one or more adverse effects possibly caused by the drug. Twenty-two pts (1.3%) discontinued the trial due to adverse effect. None of them met the criteria to diagnose myopathy. Meta-analysis of these data showed no excess risk in people allocated to different doses of Vasilip (38 pts – 10% on 10 mg of Vasilip, 76 pts – 8% on 20 mg of Vasilip and 31 pts – 10.6% on 40 mg of Vasilip). After 12 weeks of treatment only 7 pts (0.5%) had alanine aminotransferase (ALT) increased more than twice than upper limit of normal level, aspartate aminotransferase (AST) in 2 pts (0.1%) and creatine kinase (CK) was increased more than three times than upper limit of normal level in 4 pts (0.3%). There were no cases of raised ALT and AST ? 3 times the upper limit of normal levels and no cases of raised CK ? 10 times the upper limit of normal level. Using c2-test we consider correlations between the most common reported adverse effects and other concomitant medications patients were receiving during the trial. Meta-analysis showed statistically significant correlation between constipation and myalgia and taking dihidropiridine calcium antagonists; dyspepsia and taking beta blockers; headache and taking diltiazem; general weakness and taking nitrates and peripheral vasodilators.
Conclusions: The meta-analysis confirmed the therapeutic efficacy of simvastatin (Vasilip) in 1.637 high-risk pts with hypelipidemia and with or without CVD. Two thirds of pts reached target level of LDL-C below 3 mmol/L. The expected adverse effects were mild and subsided during the course of the trials. Vasilip therapy was safe and withdrawal rate was comparable to published data for simvastatin.

*Paper was presented on the 5th Croatian Congress on Atherosclerosis, Zadar, 21 -24 Sep 2005 and it was first published in Liječ Vjesn 2005;127 Suppl 3;62-3.

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VASILIP, simvastatin
Pills of 10mg, 20mg and 40 mg.

Indications: coronary heart disease, hyperlipidemia.
Dosage: recommended starting daily dosage is 10 or 20mg. The ultimate daily dosage is 80mg. For the organ transplanted patients who take cyclosporine recommended dosage is 10mg.
Contraindications: Active liver disease. Inexplicable constant elevation of serum transaminaze level. Hypersensitivity to any drug ingredients. Porphyry. Pregnancy and breast feeding.
Interaction: Taking simvastatin and cyclosporine, derivatives of fibirc acid, niacin, erythromycin, clarythromycin, ketokonazole, itrakonazole, nefazodone and ritonavir at the same time can result in myophaty with rhabdomyolysis and kidney function cancellation. Taking simvastatin and varfarine at the same time can intensify the impact of warfarin on coagulation and thus raise the risk of hemorrhage. Among patients who take simvastatin and digoxin at the same time the level of digoxin in serum can be raised; accordingly these patients should be thoroughly monitored.
Side effects: Most patients can tolerate simvastatin well. Its side effects are usually mild. Nausea, constipation, flatulence, dyspepsia, stomach ache, diarrhea, vomiting, headache, sleeping disorders and decreased level of liver enzyme can appear. Dizziness, tiredness, muscular weakness, itching and excessive falling of hair are much rare side effects. Important but very rare group of simvastatin side effects belong to muscular disorder (myophaty) which is manifested in muscular stiffness and pain and higher level of creatine-phosphokinaze (muscular fraction) in blood. Rhabdomyolysis can develop rarely and it can cause kidney function cancellation.
Package: 20 and 28 pills of 10 mg and 20mg; 28 pills of 40mg.
Date of the text preparation: July 2007.

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SYMPOSIUM "ACUTE CORONARY SYNDROME – FROM PRIMARY AND URGENT MEDICINE TO COUNTY AND CLINICAL HOSPITALS"

Mijo Bergovec, Boris Starčević, Miroslav Raguž, Dražen Šebetić, Hrvoje Vražić
Clinical Hospital Dubrava, Zagreb

In Clinical Hospital Dubrava in Zagreb, Symposium "Acute coronary syndrome – from primary and urgent medicine to county and clinical hospitals" was held on the 6th July 2007. The Dept. for Cardiovascular Diseases of Clinical Hospital Dubrava, Zagreb, Medical Faculty of the University in Zagreb, The Academy of Medical Science in Croatia and Croatian Cardiac

Society organized the symposium. The symposium moderator was Mijo Bergovac, PhD, Professor, leaders were Boris Starčević, PhD, and Miroslav Raguž, MD, MS, and secretary were Dražen Šebetić, MD and Hrvoje Vražić MD. There were altogether 20 lectures, pro et contra discussions and Round table on the subject of "Successes, failures and problems of pilot project STEMI treatment in north-west Croatia". The participants were: Academician Vladimir Goldner, Academician Željko Reiner, Mijo Bergovec, PhD, Professor, Velimir Božikov, PhD, Professor, Davor Miličić, PhD, Professor, Vjeran Nikolić-Heitzler, PhD, Professor, Željko Romić, PhD, Professor, Anton Šmalcelj, PhD, Professor; Jure Mirat, Assist. Prof., PhD; Inge Heim, chief physician, PhD; Vjekoslava Raos, chief physician, PhD; Boris Starčević, PhD; Mirjana Jembrek

There were 320 doctors of different profiles on the symposium - general practitioners, emergency department physicians, interns, specialists of internal medicine, internists, and cardiologists from the City of Zagreb, County of Zagreb, and counties from north-west part of Croatia and other counties from the whole country, and Slovenia and Bosnia and Herzegovina.

In the afternoon part of the Symposium that lasted for two hours, very informative, useful and constructive Round-table was held. The topic was "Successes, failures and problems of pilot project STEMI treatment in north-west Croatia". On that Round-table apart from moderator M. Bergovac also participated D. Miličić (Zagreb), V. Nikolić-Heitzler (Zagreb), B. Starčević (Zagreb), K. Šutalo (Koprivnica), M. Ivanuša (Bjelovar), R. Hranilović and N. Krčmar (Čakovec), D. Tršinski (Varaždin), I. Horvat (Karlovac), I. Jelić (Sisak) and K. Pešek (Zabok). On the very end, in the evening hours, the participants of the Symposium hang out in the garden of Clinical Hospital Dubrava enjoying in appropriate banquet and the concert of the quartet Tuba XL of Zagreb Philharmonic. Symposium is graded according to the Croatian Medical Chamber. It is worth mentioning that the Symposium was really well attended from its beginning till the end itself (Friday, July). That shows the great

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