

Allopurinol Aids Patients With Stable Angina

BY MITCHEL L. ZOLER

BARCELONA — Allopurinol treatment for 6 weeks significantly improved symptoms of chronic, stable angina in a randomized, placebo-controlled, crossover study of 60 patients.

Allopurinol administered at labeled dosages produced three significant improvements during an exercise treadmill test, which were the study's primary end points: increased total exercise time, increased time to ST segment depression, and increased time to angina, Dr. Awsan Noman said at the annual congress of the European Society of Cardiology.

Although the means by which allopurinol produced these effects are not known, one hypothesized mechanism is sparing oxygen and cutting superoxide production by blocking xanthine oxidase. Allopurinol might also improve peripheral endothelial function, said Dr. Noman, a cardiologist at the Royal In-



firmatory in Edinburgh. The testing began because studies in animals had shown that it cuts oxygen demand in the heart without changing cardiac output.

The study enrolled patients with chronic stable angina and coronary artery disease. It excluded patients with recent myocardial infarctions or revascularization, patients with impaired left ventricular function, and those with impaired renal function. The researchers initially screened 101 patients and enrolled 65 to get the 60 who finished the study.

Patients were randomized to receive allopurinol at 100 mg orally once daily for 1 week, followed by 300 mg once daily for 1 week, and then 300 mg b.i.d. for 4 weeks, or 6 weeks on placebo. After 6 weeks all patients crossed to the opposite regimen, Dr. Noman said.

Average patient age was 64 years and 80% were men; 70% of patients had Canadian Cardiovascular Society class II angina, 15% had class I, and 15% had

class III. All patients were on aspirin, 97% were on a statin, 87% were on a beta-blocker, and many patients also received other medications.

After each 6-week regimen, patients underwent exercise treadmill testing. The allopurinol patients had significant increases in their total exercise time, time to ST depression, and time to angina compared with the placebo group and compared with baseline. (See box.)

These benefits were achieved without any changes in resting heart rate, blood pressure, or rate-pressure product. When patients were on allopurinol, their maximum heart rate was 5% higher and the maximum rate-pressure product was 8% higher. These findings "argue against allopurinol acting like a beta-blocker or other rate-limiting agents," Dr. Noman said.

Allopurinol also had the expected effect of lowering serum levels of uric acid, cutting the values by an average of more than half. Patients face no known risk from low blood levels of uric acid, he said.

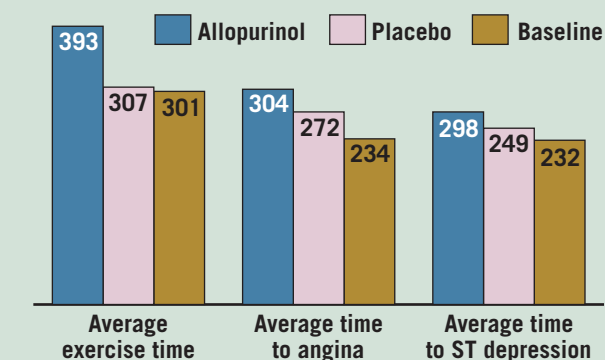
Further research needs to better define how allopurinol helps angina patients, and to identify an optimal regimen, Dr. Noman said.

Dr. Noman did not disclose any conflicts of interest. ■

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DR. NOMAN

Allopurinol Boosts Times on Treadmill Test (seconds)



Note: Based on data from 60 patients with angina.
Source: Dr. Noman

Performance Measures Assess Cardiovascular Risk

BY ELIZABETH MEHCATIE

Health care providers can now make use of 13 performance measures with which to assess adult patients' risk for cardiovascular disease.

These measures, which apply to adult patients aged 18 years and older, are not guidelines, but they translate existing guidelines for CVD prevention into steps that health care providers can easily use in their offices, according to Dr. Rita Redberg, professor of medicine, University of California, San Francisco, and the chairwoman of the writing committee (Circulation 2009;120:1296-336; J. Am. Coll. Cardiol. 2009;54:1364-405).

The measures were developed by the American College of Cardiology Foundation/American Heart Association task force on Performance Measures, in collaboration with the American Academy of Family Physicians, American Association of Cardiovascular and Pulmonary Rehabilitation, and Preventive Cardiovascular Nurses Association. They were endorsed by the American College of Preventive Medicine, American College of Sports Medicine, and Society for Women's Health Research.

The task force used guidelines supported by the strongest level of evidence, "the ones we really think make a difference in terms of patient care and patient outcomes," Dr. Redberg, director of women's cardiovascular services at UCSF Medical Center, said in an interview.

The lifestyle/risk factor screening performance measure, for example, entails an assessment of lifestyle and risk factors for development of CVD; the second measure on the list, dietary intake counseling, provides advice about maintaining a healthy diet.

The remaining 11 performance measures are as follows: physical activity counseling; smoking/tobacco use; smoking/tobacco cessation; weight/adiposity assessment; weight management; blood pressure management; blood pressure control; blood lipid measurement; blood lipid therapy and control; global risk estimation; and aspirin use. The Global Risk evaluation measure entails use of a multivariate risk score to estimate a patient's absolute risk for development of CVD.

Several appendices are included with useful references, such as a sample performance measure survey form, a sample data collection flow sheet, a table for calculating body mass index, and a guideline on how to measure waist circumference.

The task force is hopeful that the table will be a useful reference in the office. Incorporating the measures into electronic medical records would be the most practical and efficient approach, but she said the measures were designed to be accessible and user friendly for offices that use only paper records, said Dr. Redberg, who had no conflicts to disclose. ■

Web Site Targets Poor Communication

Primary care physicians who have struggled to get a cardiovascular disease patient to adhere to a drug regimen may find a wealth of practical advice in an online educational program aimed at improving physician/patient communication.

"Even though we think we are good communicators, all of us can learn from each other and from these best practices, and hopefully do a better job" communicating about cardiovascular disease, said Dr. Richard H. Carmona, chair of the advisory board for the program called Time to Talk CARDIO.

What doctors see as patient non-compliance may actually be the doctor's inability to effectively communicate, especially across cultural barriers, said Dr. Carmona, who served as U.S. Surgeon General from 2002 to 2006. He currently serves as president of the Canyon Ranch Institute, a nonprofit wellness organization based in Tucson, Ariz.

On the program's Web site, physicians answer a series of questions regarding communication with their most vexing patient. Based on their replies, the program generates a list of the top six most important skills that the individual physician needs to work on, along with a selection of video vignettes that demonstrate best practices for each specific communication skill. The videos may suggest, for example, different ways of confirming that a patient understands

what is being asked of him or her.

The Web site contains a library of more than 500 short videos showing doctors with patients discussing topics related to heart health.

The program is being pilot tested locally at several sites across the United States, and a national rollout is planned for February 2010, according to a press release.

Dr. Jason Dees, a family physician in New Albany, Miss., is pilot testing the program in his practice. The patient-centered medical home is about communication among the office staff as well as between doctor and patient, noted Dr. Dees, who said that he has shared information from the program with his partners, mid-level providers, nurses, and patient educators.

The Web site provides a worksheet for patients and providers to set goals and it has been "a huge help to us," Dr. Dees said. The program is easy for time-strapped physicians to use. "This is not a big, time-consuming training tool," he added.

To learn more about the program, go to www.timetotalkcardio.com.

Time to Talk CARDIO is supported in part by Merck/Schering-Plough Pharmaceuticals. It was developed in partnership with the American Academy of Family Physicians, Canyon Ranch Institute, and RIASWorks, a company that supports development of medical communication tools.

—Heidi Splete