

The new SIGN guidance on CHD and its implications for primary care

The Scottish Intercollegiate Guideline Network (SIGN) has published five new guidelines on heart disease with the aim of helping reach the Scottish Executive's target of reducing deaths from coronary heart disease (CHD) in those aged under 75 years by 60% for the period 1995–2010. It is hoped the new guidance will help further reduce mortality, which has already fallen by one third between 1995 and 2005. The new guidance covers acute coronary syndromes (SIGN 93), cardiac arrhythmias in coronary heart disease (SIGN 94), the management of chronic heart failure (SIGN 95), the management of stable angina (SIGN 96), and risk estimation and the prevention of cardiovascular disease (SIGN 97). The full guidance is available at www.sign.ac.uk. Here, Dr Alan Begg gives a primary care perspective on the new guidance.

The primary care perspective

The four recently published SIGN guidelines on CHD and the one on the prevention of cardiovascular disease (CVD) are important to general practice in terms of future workload, changes to Quality and Outcome Framework (QOF) indicators and pressure on prescribing budgets.

General practitioners (GPs) will welcome the consistency with the Joint British Societies 2 (JBS2) guidelines in regarding all patients with a $\geq 20\%$ 10-year risk of a CVD event as high risk.¹ Adding in social deprivation and family history to risk assessment may be important in populations, such as in Scotland, with a high incidence of CVD but the evidence on how this is used in primary care is limited.² If the ASSIGN score is to be accepted, it needs to be incorporated into practice computer systems, with data collection being simplified as much as possible. The current work to create a CVD risk dataset is a welcome start towards a national screening approach for patients aged 45 to 64 years, although the measurement of total and high-density lipoprotein cholesterol levels needs to be added at the earliest opportunity.³

GPs will continue to deal initially with acute coronary syndrome (ACS) patients despite national campaigns encouraging patients with acute chest pain to call 999.⁴ There will be cost implications for general practices if defibrillators are provided within health care facilities, as recommended, as well as training in their use for staff with life support skills. Setting up



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primary percutaneous coronary intervention (PCI) services will take time so there remains a major role for GPs, especially rural GPs, to continue their involvement in community thrombolysis. Initial aspirin therapy is accepted practice in the community but, in certain circumstances, the addition of clopidogrel may need to be considered.

Primary care has an important role in the initial assessment of patients presenting with symptoms suggestive of stable angina, bearing in mind that the proportion of patients presenting with chest pain who may have CHD is low. The use of brain natriuretic peptide (BNP) to inform on the need for an echocardiogram in suspected heart failure will have a significant impact on current practice but only when the test is more widely available.

Taken together, the guidelines provide comprehensive guidance on the drug groups for both managing CHD and preventing CVD. Patients with symptomatic CHD can now expect to be on antiplatelet therapy, a statin, a beta blocker and an angiotensin-converting enzyme (ACE) inhibitor. The other points to highlight are the length of use of dual antiplatelet therapy in ACS, the need for cardiology assessment if angina symptoms are not relieved with two anti-angina drugs and the use of ACE inhibitors and beta blockers in all classes of heart failure. Although the benefits of anticoagulation in well-tolerated atrial fibrillation are not covered,

rate control in preference to rhythm control is recommended, with the use of digoxin restricted to those who are less physically active.

Changes to QOF

Primary care teams will be interested to find how the evidence underpinning the recommendations is likely to impact on any future changes to the QOF. The lack of evidence to support a lowering of the present cholesterol quality target of 5 mmol/L is the most notable. The benefits of intensive statin therapy in those with established CVD are important, so in these patients we should still work towards the JBS2 target of 4 mmol/L. For others, initiating treatment with a standard statin dose with a low acquisition cost, such as 40 mg simvastatin, is seen to be a cost-effective approach if the funds are available. Individuals with symptomatic CVD should be considered for blood pressure-lowering therapy at a systolic blood pressure (SBP) > 140 mmHg, and/or a diastolic blood pressure (DBP) > 90 mmHg with an even lower threshold if there is other evidence of end organ damage. The current QOF SBP target of 150 mmHg will need to be reviewed in the light of this, bearing in mind the difficulty we all have in reducing blood pressure further.

The effect of psychological issues in patients with CHD features highly within the guidelines. The introduction to the QOF of screening for depression in patients on the practice CHD register, despite the extra work involved, is an important step towards providing psychosocial interventions and addressing health beliefs and cardiac misconceptions.

Lifestyle change and behaviour modification remain important. The way help is provided at practice level will depend on the resources and skills available as well as local arrangements. Long-term follow-up remains the responsibility

of the primary care team although specialist input from others, such as heart failure nurses, who can help reduce hospital readmissions is also important. A well motivated and informed primary care team is essential for successful implementation. A welcome start would be to ensure a fully funded primary prevention programme as set out in the accompanying resource impact assessment.

Conflict of interest

The author is a member of the SIGN CHD Guideline Steering Group and chair of the Angina Guideline Development group.

Editors' note

An article on the implications of the new SIGN guidance for secondary care, by Dr Kevin Jennings, will appear in the next issue.

References

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