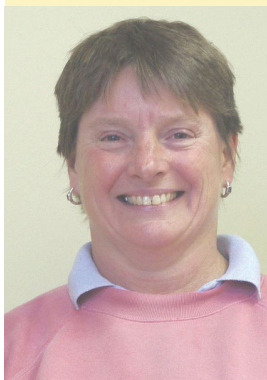


EDITOR'S COMMENT

Have a heart



BRIDGET FARHAM

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As a final-year student I had still never heard a diastolic murmur. Numerous people had attempted to coach me through the process of listening to murmurs and, while systolic murmurs seemed to leap out at me, the diastolic variety continued to elude me. Then in my final exams I had a cardiology patient. The history was suggestive of a cardiac complaint that would lead to a diastolic murmur, but for the life of me I couldn't hear it. Rather than fudge my way through I admitted that I had listened for the expected diastolic murmur, but failed to hear it, and elaborated on the history and the rest of the examination, leading to the usual case presentation. My very pleasant examiner, a consultant I had often been taught by, tried very hard to point out the murmur to me, even lending me his specialised stethoscope to listen. It still eluded me and I now realise that I have never heard a diastolic murmur. However, I passed, since, of course, you are not examined on the minutiae of medical examination but on your ability to take a good history, to know what you should be looking for and to present a sensible differential diagnosis.

When I arrived in clinical practice as a GP trainee in Scotland I realised that cardiology problems would form a large part of my day. It was a relatively elderly practice population, spread across a wide area of north-east Scotland and a large number of the patients had hypertension, type 2 diabetes and the consequent cardiovascular disease. I still never heard a diastolic murmur, but I started to learn an enormous amount about the long-term consequences of a lifetime of smoking, overeating and lack of exercise. The morbidity was quite overwhelming – men in their 50s with appalling effort tolerance, angina that was difficult to control and call-outs in the early hours of the morning to heart attacks. During that time we were one of many practices around Britain who were participating in trials of thrombolytic agents in acute myocardial infarction, so there was a whole protocol to follow when attending an MI. The practice was particularly well equipped for emergencies. We carried a defibrillator in our cars when on call. This terrified me! Fortunately I never had to use it.

Then I moved to Labrador, with possibly one of the most unhealthy patient populations I have ever come across – and this from a doctor trained in South Africa! It was a small population of people whose origins were in the south-west of England and the Channel Islands. When I looked at how these people had arrived and settled there they should have been hardy, and their ancestors almost certainly were. They were the fishing families that had, illegally, settled on the Labrador coast in the 19th century, working for the fishing barons of the time, all of whom were based in Britain. They colonised that inhospitable coast at a time when there was no gas-fired heating to counter the winter temperatures of between -30°C and -40°C and no freezers to preserve food during the short but warm summers. However, a combination of poor diet, lack of exercise and a few genetic bottlenecks over the decades conspired to provide me with a patient population where at least 80% of the people over 50 had advanced cardiovascular disease, with all its attendant morbidity and mortality.

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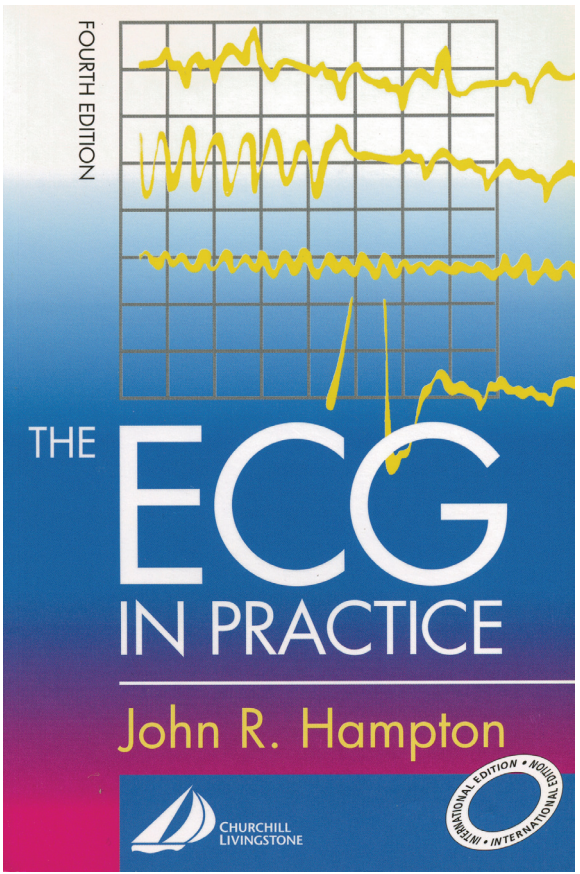
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The point of all this is that my relatively short time in clinical practice gave me a lot of experience of cardiovascular disease, highlighting its importance for any generalist. I was in the same class as David Kettles at medical school and it gave me great pleasure to invite him to use his experience as a busy cardiologist in private practice to put together such a distinguished team of cardiologists to provide this excellent edition of *CME*. The topics have been chosen to provide information on the most common problems seen by private general practitioners and generalists in secondary hospitals and will provide a valuable reference work.

This edition carries new guidelines issued by the Renal Society of South Africa with their recommendations for early detection and management of chronic kidney disease. I urge all readers to place this page prominently in their rooms and remember its contents. It is now possible to manage renal disease that is detected early in a way that will delay, or even prevent, renal failure and the need for dialysis and transplant. Early detection and management could save someone years of pain and disability and prevent premature death.

Enjoy your read.




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