

Will screening for cardiovascular problems be effective?

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Last week the government in England closed its consultation on the effectiveness of vascular checks for high-risk individuals aged 40-74, to be rolled out in 2009-10, but will this strategy be worthwhile? Experts debate the issue on bmj.com today.

The Department of Health suggests that up to 9 500 heart attacks and strokes and 2 000 deaths could be prevented each year by vascular screening and managing high-risk individuals aged 40-74 in England.

This screening programme will be cost effective and result in significant health improvements if appropriately targeted, write Professor Rod Jackson and colleagues from the University of Auckland in New Zealand. The greatest benefits will come from treating the relatively few patients at very high risk who have had a cardiovascular event, who are easy to identify, and who are more likely to be motivated than patients without symptoms, they write.

Recent data from the World Health Organisation suggests that in the short term, targeting very high-risk patients with treatments such as aspirin, off-patent statins and blood-pressure lowering drugs would prevent more events than population-based interventions to reduce salt intake, obesity and cholesterol levels, and be very cost effective.

They point out that between a third and a half of all major coronary disease events in 35-74 year olds occur in 5-6% of the population who have had a previous cardiovascular event. They argue that if half of these

high-risk patients were given triple therapy with aspirin, statins and blood pressure lowering drugs, there would be a 10% fall in the national coronary disease event rate in less than 10 years.

But at present most patients with cardiovascular disease are not receiving this effective triple therapy.

The authors warn against lowering the risk thresholds for drug treatment until the highest risk patients have been identified and treated. Lower thresholds, they say, will result in large numbers of patients becoming eligible for treatment which will have a substantial impact on workload and costs.

According to the authors, GPs should be encouraged and rewarded for managing patients with existing cardiovascular disease first.

But Professor Simon Capewell from the University of Liverpool, argues that public health approaches targeting the whole population are both cheaper and more effective than tablets.

He points to a large body of evidence that shows that even with generous resources screening programmes have substantial drop-outs. They also favour affluent and educated individuals, thereby increasing inequalities.

According to Capewell, the inherent message of such a screening programme is that "the doctor can fix it". But contrary to expectations, he says, even with continuing treatment, over half the cardiovascular risk remains.

Furthermore, he says, drug treatment does not eliminate underlying disease, and he likens it to putting a sticking plaster over the problem—if treatment is stopped the risk rapidly returns.

This NHS strategy will also mean that over 80% of English men aged 65-74 will be categorised as high risk. It will therefore commit the majority of middle aged adults to life-long drug treatment and a lower quality of life, at huge cost to the NHS, he says.

Capewell argues that this high-risk screening strategy diverts attention from cheap policy interventions which reduce risk factors for cardiovascular disease across entire populations. For instance, banning trans fats (Denmark), or halving the salt hidden in food (Finland), or banning smoking in public places (UK, Ireland, and Italy).

Even small reductions in population cholesterol, smoking or blood pressure would translate into substantial reductions in cardiovascular events and death, he concludes.

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