

Heart Research

NEWSLETTER 1 2008

25 year follow-up study

The Heart Research Centre's Administration Manager, Prue Georgeson, has noticed over the past few months that Dr Marian Worcester, the Director, has been very busy talking on the telephone! Prue was interested to learn that all the telephone calls were part of a new project to locate and follow up 200 men who took part in a big study about cardiac rehabilitation 25 years ago at the Austin Hospital, led by Dr Alan Goble.

Dr Worcester said: "It has been a terrific experience for me, catching up with many of the patients I interviewed in the early 1980s. I did about four interviews with every patient over a 12 month period to find out how well they were recovering from their heart attack - physically, psychologically as well as how they got on at work and at home. What we are investigating in this follow-up study is the relationship between depression at the time of the heart attack, or soon after, and death. Do patients who experience marked or persisting depression after their heart attack die sooner than others? We have no answers yet as we have not started analysing the data. I still have another 30 or 40 patients to find!

Surprisingly, many of the men still live at their original addresses, which makes my task of tracking them down much easier. In one case where the patient lived in a caravan, it is proving very difficult; he had no relatives and even his age was uncertain. There are other men who were loners, who shunned company and social life and they too will be hard to find. It's a case of going through telephone lists and contacting doctors who were treating the patients at the time. I suspect a few patients who migrated from Europe will have returned there for their retirement and we will never be able to catch up with them.

Sadly, many of the men have died during the past 25 years. I suppose this is not surprising since many of them were in their 60s at the time of their heart attack in the early 1980s. I have found out about these patients either from their cardiologists or the Australian National Death Index. The Index tells us both the date and cause of death. In other cases, I learnt about the deaths of patients from the hospital medical records or from their wives. Reading about those patients who died of diseases such as lung cancer or strokes made me rather sad. I couldn't help noticing that many of the patients who had died of cancer had unfortunately started smoking again.

But it has been great chatting to those I have located. "You're the one who asked all those questions and made us fill in dozens of forms!" is the usual remark they make when hearing my name!" (Continued on page 3)

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Executive Director	Dr Marian Worcester



Three simple aids to good health:

- Regular exercise - daily walking is enough
- No smoking
- Regular monitoring by a GP or specialist

Heart Research Centre

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“The Metabolic Syndrome” - a modern disorder of epidemic proportions

As time passes, new terms enter the medical vocabulary, and old terms may disappear. In the past decade a cluster of clinical features has been put together and called “the Metabolic Syndrome”. This name implies an established medical condition. It is considered present (as a diagnosis) if there are three or more of the following features in an individual patient:

- High glucose level in the blood or definite type 2 diabetes
- High blood pressure
- High body weight, body mass index or waist girth - i.e., overweight or obese
- High triglyceride (fat) levels in the blood
- Low HDL (“the good”) cholesterol in the blood

Some accept this as a cluster of metabolic disorders. Others regard the condition as arising from being obese or overweight, with the known complications of obesity. However, it is possible to have high blood glucose levels, high blood pressure, high triglycerides and low HDL cholesterol without being overweight, so there is also a genetic element to the condition. This genetic component is also indicated amongst those who are obese but who do not have other features of “the Metabolic Syndrome”. However it is usual to be obese or overweight if one has two or three of the other ingredients of the clinical cluster. Those with the condition may regard it as bad luck or embrace genetic chance, thereby excusing themselves. Some doctors regard the condition as a true metabolic disturbance which merits permanent medication to control the tendency to diabetes, blood pressure, and abnormal lipid levels. They are supported in their view by pharmaceutical companies. Management of “the Metabolic Syndrome” is a potential multi-billion dollar business. Other doctors (of which the author is one) consider the condition to be a product of obesity or of being overweight, through “gluttony and physical indolence”, and correctable by weight loss and exercise. There is a vast amount of scientific evidence that increasing weight induces the other features of “the Metabolic Syndrome” and that lowering weight reduces those features. Lowering weight is best achieved by reducing portion sizes of meals and avoiding snacks and fast foods. The epidemic of obesity in industrial societies is probably the cause for the epidemic of “the Metabolic Syndrome”.

If you have acquired the diagnosis of “the Metabolic Syndrome”, you should take your prescribed medication. You should also eat less and be more active. These changes in behaviour could lead to the diagnosis no longer applying to you. Here we have a serious condition which could be cured by a change in health behaviours.



Dr Alan Goble
Cardiology Consultant

Unfortunately, most people who successfully lose weight regain much of it, as they revert to their previous less desirable habits. Weight loss leads to increased hunger; weight returns and the risks of “the Metabolic Syndrome” reappear. This lapse is bad for the person, disappointing for the doctor, but a joy for the pharmaceutical industry.

Just to add to the troubles of the overweight, there is strong evidence that obesity is also associated with other problems, which include industrial accidents, absenteeism, unemployment, depression, symptomatic coronary heart disease, invalidism, some cancers and premature death.

One can see why health authorities and governments would like to do something about obesity - if they can. Most of us are now overweight and heading for trouble which will result in increasing medical costs. “The Metabolic Syndrome” is just a part of the problem.

Abdominal fat is more hazardous than fat elsewhere. Do you have too much of it? Abdominal fat within and over the belly produces a ‘pot’, best observed in the mirror by viewing oneself from the side. Alternatively you can check for it by grabbing the fold below the umbilicus. If you are significantly overweight, you will get a handful of fat in addition to two layers of skin. If these simple tests are positive, you should be checked by your doctor to determine whether you do or do not have other features of “the Metabolic Syndrome”.

If you are already overweight, I wish you the best of good fortune in your weight control program.

(Continued from page 1)

“Several recall how much they enjoyed participating in the rehabilitation program because it “got them going” and taught them how to continue in the future. I usually ask them why they think they have remained in relatively good health. A lot of them have said it’s probably because they continue to have regular check-ups with their GP as well as their specialist doctors. Regular monitoring and treatment by doctors does seem to be a key factor in their longevity and good health. Several have told me that they have continued to be physically active, maintaining a regular program of light exercise, such as walking or bowls. A lot have had bypass surgery since I knew them at the Austin, either soon after their heart attack or more recently. They all seem to be doing very well, taking advantage of their new lease of life. I remember these patients very well because I did virtually all the interviews over the four years of the study. I can remember to this day the feelings they described in trying to cope with their heart attack and how it affected their lives.

Even though most of those I’ve spoken to are doing quite well from a cardiac point of view, a number of these men have developed different diseases. One, who was previously a prison warden, said he was doing pretty well at the age of 82, despite having diabetes. He said he had all his faculties still, and following his coronary bypass operation a few years ago, was doing very well. He thought that it was a bit of luck, having lived so long, but he also recognised that giving up smoking at the time of his heart attack in the early 1980s was an important factor.

Yesterday I finally managed to track down one patient who had eluded me who originally came from Ireland. I had established excellent rapport with him during the original study. We kept in touch for quite a while afterwards as well. He was astonished to hear from me but we were both delighted to make contact again and plan to catch up in the near future. He was thrilled to hear about the work of the Heart Research Centre and to learn that Dr Alan Goble was also at the Centre. Quite often Dr Goble walks into my office while I am talking to one of these patients on the telephone. He also has a chat with the patients which they greatly appreciate! I’ve recently been told that several cardiac patients attending our new cognitive behaviour therapy program at The Royal Melbourne Hospital are really thrilled to know that so many of the patients in my study are still alive after 25 years. It gives them great hope that they, too, will have a long life.”

Motivational interviewing: helping patients change their health behaviour



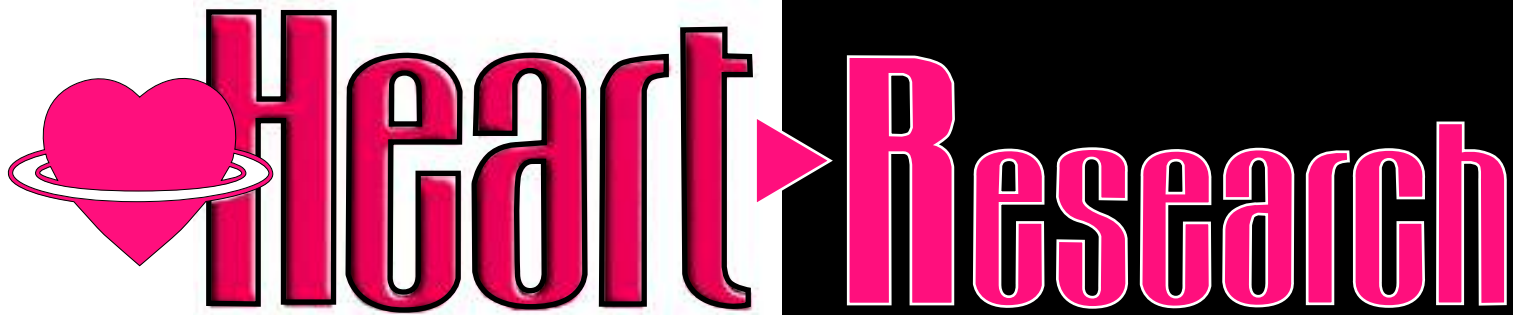
*Professor Stephen Rollnick and Dr Debora Cohen
from the University of Cardiff*

Patients who have a heart attack or undergo heart surgery are usually advised to change their lifestyles. Sometimes they are advised to make several changes simultaneously, such as losing weight, doing more exercise, reducing their dietary fat intake and stopping smoking. While doctors and other health professionals explain why such changes are necessary, it is nevertheless very difficult for cardiac patients to change bad habits, especially long-term ones.

Helping patients to improve their lifestyles requires considerable skill. One technique which has been found to be particularly effective is motivational interviewing (MI). To find out more about it two of the Centre’s Research Fellows, Rosemary Higgins and Fiona Mitchell, recently attended a workshop in Adelaide. The workshop was presented by Professor Stephen Rollnick who, along with Dr William Miller, is credited with developing MI. Professor Rollnick and his co-presenter Dr Debra Cohen are from the University of Cardiff in Wales.

MI is a method of changing behaviours such as smoking by looking at the factors which sustain the habit and the factors which drive the need to change. It does not involve coercion or direct persuasion. It is a quiet, eliciting, counselling style.

The workshop opened up possibilities to incorporate a greater MI focus in the Centre’s latest project involving cognitive behavioural therapy (CBT). This project is currently being conducted at The Royal Melbourne Hospital and Melbourne Private Hospital to improve risk factor profiles of cardiac patients. MI and CBT promise to be effective methods of facilitating behaviour change after a heart event.



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RAFFLE NEWS 1 2008

The "Midas touch"



Prue Georgeson handing Tony Hynes the keys to his brand new BMW E87-120i

Mrs Beth O'Grady has the "Midas touch"! She has been supporting the Heart Research Centre for a number of years. As a nurse she feels the work done by the Centre is very important and she regularly buys tickets, then fills in the names of her family members against each ticket.

So when Prue Georgeson, the Administration Manager, rang the number on the raffle butt to tell Tony Hynes he was the latest winner of the sparkling graphite BMW E87 -120i. automatic with sunroof and alloy wheels, neither he nor his wife knew anything about why she should be calling!

Tony was at work and his wife, a nurse who had only just got up from her sleep after a shift on night duty, was not too keen to give his number as he was so busy and really didn't want one more interruption. It was with difficulty that Prue convinced her that, busy though he was, he would want to receive this call.

Tony is busy both at work and at home at present as he and his wife are building their first home. However he was pleased to hear from the Centre and his parting comment was "it has been a pleasure to hear from you!"

The Heart Research Centre thanks Mrs O'Grady for her support and sends good wishes to Tony, Claire and their baby daughter.

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Happy shopping for the Early Bird prize winner!

Mrs Dingwall was also very happy to receive a phone call telling her she had won the Heart Research Centre's Early Bird Prize of the Myer \$5,000 Gift Card drawn on 26 November 2007. Her reaction couldn't have been more enthusiastic: "Have I really, that's fantastic, that's wonderful, what a bonus!" Initially Mrs Dingwall wasn't sure how she would spend the money "I don't know what I'll do, I'll probably go mad!" However after some thought she decided to buy an outdoor setting of table and chairs, a gold chain for herself that she had been wanting for a long time, and a laptop computer. Apparently many people on hearing of her good fortune have said "I didn't know anyone actually won those things!" Mrs Dingwall supports the Heart Research Centre as her mother had a pacemaker and she feels "you never know when your own heart is going to play up"! Our thanks to Mrs Dingwall for her continuing support of our raffles; the money from these helps to fund our research programs.

The raffles are overseen by the Victorian Commission for Gambling Regulation and audited by WHK Day Neilson.

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