Correspondence

Necessity of databases in context of Indian guidelines

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ICD

I have read the article “Are western guidelines good enough for Indians? My name is Borat”. It is an excellent review and surmises the healthcare issues plaguing India, which despite pockets of modernization is densely populated, economically backward, and not well insured. Many young lives are lost due to lack of financial support or access to tertiary care. I would like to bring to your notice certain additional points I believe, also corroborate the authors’ viewpoint. The article mentions reuse of materials. In a study done by Dr Yash Lokhandwala, it was concluded that Indians are using reused ICDs after sterilization without facing major complications. IHJ has earlier published an original article that concluded RA-LV pacing using VDD pacemaker is a safe, efficacious, cost effective technique of CRT. We need to ensure that lack of a database is not leading us to believe that there are no complications. For example, we have no documents of an endocarditis that was ever seen or reported. It should also be noted that our disease patterns are not the same as west and need different management; for example, myocardial tuberculosis has similarities to sarcoidosis seen by Japanese.

In the west, payment is linked to procedure and guidelines for insurance companies. However, most Indian patients pay from their pockets. Gradually, our system will move towards insurance for healthcare. Hence, it is important for us as a first step to promote indigenous databases – to look at our disease patterns and identify the areas which we need to manage differently. Then, we can bring changes and adopt new guidelines. We surely have no dearth of people who will unite themselves for the country’s benefit without vested interest.

Conflicts of interest

The author has none to declare.

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Correspondence

History of Cardiology in India published in the Indian Heart Journal recently 67:163-169, 2015

Dear Sir,

I have read with great interest the paper entitled “History of Cardiology in India” published in the Indian Heart Journal recently (Indian Heart Journal 67: 163–169, 2015). Following observations are presented for the consideration of concerned persons:

1. Central to any serious historical narrative is the methodology used to arrive at any of the stated conclusions. The paper does not spell out the methodology used for the search to establish historical facts. It does not even detail how and wherefrom “memories, traveller’s tales, fables and chroniclers’ stories, gossip and trans-telephonic conversations” were obtained to arrive at the reported conclusions. The few
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1. It is indeed very heartening to note that an article 'History of Cardiology in India' written on IHJ has created so much interest amongst our colleagues and members and we seemed to have achieved at least our first goal i.e. to evoke a gentle prod down the memory lane of collective memory, to bring out the facts before our cardiology community before they are lost forever. On our part we believe it represents an honest, unbiased and sincere attempt to lay down the facts pertaining to evolution and growth of the discipline in India. Given the poor track record of record-keeping in our country even after the boom of technology. For this report the authors had to rely mostly on published articles but very rarely on collective memory as well. Few concerns were raised by some esteemed members. We really value those concerns and welcome them from the bottom of our hearts.

2. While starting the project, we questioned ourselves: Should it be a book or should it be an article with important issues being touched upon? Since it was supposed to be published in Indian Heart Journal, we thought the latter approach was more appropriate (at the penalty of being brief and missing some information). That is why, in our attempt, we never went to be exhaustive as is done in a book or treatise. Our aim was to write an article which should be evidence-based (as much as possible), small, crisp and informative enough to create interest so that in future it could stimulate a much more detailed study on individual issues or branches of Cardiology.

3. In this attempt we followed the following methodology (it was not mentioned in the primary article due to space constraints). (i) Our first approach was to collect as many published articles from different journals and books as possible. (ii) Second source of information was the official

names mentioned under the head “Acknowledgements’”(!) at the end of the paper indicate the very limited inputs sought in this vast country. Even at the best of times, such inputs provide only possible leads for the search; they do not, by themselves, substitute for the research that is necessary to uncover factual information all of which may not be readily available. Researchers engaged in reporting on history know how painstaking it is to first identify possible sources of information and then dig into relevant archives to retrieve and cross-check on the veracity of that information. The hallmark of research in history lay in establishing the quality of information provided. The apologies offered at the end strangely under the head “Disclosures”(!) do not undo the damage done by this publication to the subject and the memory of several persons, dead and alive, who have contributed substantially to cardiac sciences in the country.

2. The account of knowledge in ancient times is rather sparing in detail especially regarding any practical applications of the knowledge prevailing at the time. It may well be difficult to find such information, but the effort in this regard is not reflected in the publication.

3. The period between vedic times and about the middle of the twentieth century (a span of almost 2500 years) also has not received any mention. Further, no mention is made about information from other systems of medicine during this period such as Unani, Siddha, Homeopathy, etc. Likewise, the outcome of efforts at resurrecting some of the ancient wisdom through contemporary research has not been provided.

4. Considering the impact of different fields of medical sciences on modern medical practice, the absence of mention of contributions from cardiovascular physiology, pathology, immunology, genetics, experimental studies, etc. is surprising. Chronicling of cardiovascular epidemiology, a vital input for structuring public health policies, is also conspicuously absent. Even for clinical cardiology practice, several areas seem to have escaped attention or received rather dismissive mention. These include Rheumatic Heart Disease, Cardiomyopathies, Pulmonary vascular disease, High Altitude Pulmonary Oedema etc. Developments in Cardiac Surgery have not received adequate mention.

5. A cryptic remark “In fact, there are very few innovations from India in modern Cardiology, which are worth mentioning” is most unfortunate and contrary to fact. Cardiac sciences, which include clinical cardiology, do reside substantially outside of the cardiac catheterisation laboratory. Such a myopic view is a very serious indictment of the huge amount of financial support provided by various research agencies, both governmental and non-governmental, over the years, as well as the contributions of several dedicated scientists.

6. The varying texture of language in various segments of the publication could be due to several possible reasons; I desist from further comment on the subject at this time.

7. The title page of the paper suggests that the paper has been spared the usual academic review process for reasons not mentioned.

8. The title page also suggests that the paper is being published on behalf of the Cardiological Society of India. Should that be the case, there is a need for that organisation to take cognizance of the matter.

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Dear Sir,

We read the article “Are western guidelines good enough for Indians? My name is Borat” by Sundeep Mishra and Vivek Chaturvedi in Indian Heart Journal and felt a drastic transformation in IHJ discussing more relevant and sensitive issues like never before. I fully support the author, who has very intelligently and appropriately discussed important factors for making, developing, and need for Indian guidelines. After going through the article, the important question coming to my mind is that ‘Do clinical practice guidelines (CPGs) whether Indian or others influence practice in Indian Scenario’. ‘Incredible India’ is a land of contrasts. This is nowhere more evident than in health care today. On the one hand, India boasts of brilliant doctors practicing state of the art medicine using the latest technology and guidelines, and on the other hand, majority of India’s health care services are unregulated, where majority of population do not have access to qualified medical care leaving them at the mercy of quacks putting a big question mark on implementation of CPGs.

In India, there is nonuniformity of the standards of the care of patients from state to state, city to city and hospital to hospital. Only the premier institutes in the country both private or government have ways and means to adopt state-of-the-art medical care, otherwise the state-of-the-art medical care is virtually absent in majority of government hospitals, small private setups and rural hospitals.

The most striking feature of the management of patients in India is its heterogeneity: from tertiary and teaching hospitals providing best possible evidence-based health care, to small private or government hospitals generally overburdened compromising on evidence based health care. The challenge for Indian healthcare lies in setting right this imbalance.

Registries and surveys collect data rapidly and efficiently, allowing an analysis of current trends in disease incidence, treatment and outcomes, but is still in infancy in India. Web-based secure communication systems have revolutionized data collection systems in medical research providing opportunities for studies with exceptionally large sample sizes and have the potential to provide timely information about various disease factors. Despite India’s internationally renowned websites of different cardiac societies and INTERNET. In the Internet, we clicked the subjects’ name with Indian perspective and tried to find out relevant information for our purpose. (iii) Last, we personally contacted several resourceful individuals /senior cardiologists and obtained information from them, which was subsequently cross-verified, either from Internet or journals (as far as possible).

4 THEN we classified the data into different categories: (i) High evidence - articles or abstracts published in peer-reviewed journals or in official website of professional bodies (ii) Intermediate evidence - articles published in text books or update books (iii) Low evidence - information gathered from individuals. Once we were satisfied that the subject indeed had evidence, we mentioned it in our article. We also mentioned the names of the place or Institutes wherever possible.

5 The prominence of surgery and invasive cardiology stems from the fact that there has been the trend in last three to four decades both nationally and internationally to have more publications (and therefore more hard evidence). However, we do feel that other areas should also be given more prominence. We believe there is a plan to bring out a series of such articles covering each sub-specialties of Cardiology.

6 We believe, this article is just the beginning (Mother of series of articles) and aims at revealing the truth of our (India’s) strength in the field of Cardiology which really started in pre-Vedic era. Understanding and interpretation of history is not absolute. Study of history enriches by writing same history from different angles and perspectives. There is no difference in opinions regarding this.

7 We re-iterate that we had a humble beginning based on evidence and the subsequent suggestions by our community members and esteemed seniors will be put forward to the Editor and these ideas, reflections, suggestions are certainly welcome by everyone including us.

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