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History of cardiology in India

Keywords:
Ayurveda
Sushruta
Preventive cardiology

Sir,

The scholarly paper on 'History of cardiology in India' is a revealing account of how cardiology developed in India over a period of some 70 years with valuable information on 'Indian Heritage of Cardiovascular Sciences'.[1] Few points need worth mentioning. It is correct that out of four Vedas, namely Rigveda, Samveda, Yajurveda, and Atharwaveda, Ayurveda owes its origin mostly to Atharwaveda.[2] However, there is a bit of spelling mix-up in the text; Rigveda has been spelt as Rik, Samveda as Sham, and Yajurveda as Yadu. Further, Sushruta, though primarily a surgeon, was the first to give the concept of atherosclerosis, diabetes, and angina and the role of exercise in prevention of diabetes to the world. How revealing it is that such a concept was laid in 5000 BC.[3]

Most importantly, the evolution of 'Preventive Cardiology' during last 50 years deserved a special mention in this paper.[4] We are well aware that India is currently passing through the pandemic of coronary artery disease, hypertension stroke, diabetes, and stroke. Steps to prevent and reverse this trend were conceived by Dr. Padmavati, Dr. KS Mathur and several others including the writer of this communication during these years.[4,5] We now have a exclusive editorial section related to preventive cardiology in Indian Heart Journal in order to strengthen the academic and professional aspects of this much needed sub-specialty. Last but not the least, the increasing trend of incorporating translational research in cardiology practice about herbal drugs like *Terminalia arjuna* (arjuna), *Eugenia jumbolana* (jamun), *Curcuma domestica* (Turmeric), *Allium sativam* (Garlic), *Commiphora mukul* (gum guggal), etc.[6] These herbs though currently advocated their exact role and overall cost benefit ratio is yet to be explored and defined.

Conflicts of interest

The author has none to declare.

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Consensus statement on the management of dyslipidemia in Indian subjects: Our perspective

Keywords:
Lipid guidelines
Hypercholesterolemia
Primary prevention
Risk stratification

Dear Editor,

We read with interest the commentary by Enas A. Enas and colleagues[1] on the recently published Consensus Statement on Management of Dyslipidemia in Indian Subjects (CSMDIS)[2] and thank them for their insightful comments. It is heartening to see that the document has generated such interest and has drawn attention of such world-renowned leaders in the field of lipid management.

We are in agreement with many of the observations made by Enas A. Enas and colleagues about the current understanding of the role of statin therapy in reducing cardiovascular (CV) morbidity and mortality. As highlighted by them, there is unequivocal evidence to show that statins are currently the most powerful pharmacological agents available to reduce CV risk. More importantly, the beneficial effects of statins are observed in direct proportion to the baseline CV risk and occur regardless of the low-density lipoprotein cholesterol (LDLC) levels. Accordingly, most guidelines today recommend initiating statin therapy based on the estimated CV risk rather than the absolute LDLC levels. We also agree that there is now increasing data to suggest that lifetime CV risk may be a more appropriate metric, rather than the short-term (i.e. 10-years) CV risk, for guiding management decisions in primary prevention of CV disease, particularly in young individuals. However, we wish to emphasize that there is currently no validated risk assessment tool available for estimating short-term or lifetime CV risk in Indians. The risk assessment algorithm proposed by the International Atherosclerosis Society (IAS)[3] is simple to use but its use in Indians has practical limitations, as highlighted below. In addition, we also notice that the interpretation by Enas A. Enas et al. of the recommendations for initiating statin therapy is different from what has actually been proposed in the CSMDIS. We discuss below these issues in greater detail.

1. IAS algorithm for estimation of lifetime CV risk

The algorithm proposed by the IAS for estimating lifetime CV risk was first developed by Lloyd-Jones et al. based on the Framingham study data.[4] This algorithm considers only four risk factors – diabetes, smoking, systolic blood pressure (SBP), and total cholesterol (TC). Both diabetes and smoking are considered to be major risk factors, whereas SBP and TC are graded as minor, moderate, and major risk factors depending on the actual levels (SBP: minor – 120–139 mmHg, moderate – 140–159 mmHg, and major – >160 mmHg; TC: minor – 180–199 mg/dL, moderate – 200–239 mg/dL, and major – >240 mg/dL). Based on the number of minor, moderate, and major risk factors, lifetime CV risk can be estimated in any individual. For nonwhites, the IAS document also provides appropriate ethnic-specific calibration factors in order to derive more accurate risk estimates in different population groups. Thus, IAS risk algorithm is simple to use, does not require elaborate laboratory testing, and is well suited for clinic-based estimation of CV risk.