From 1980 to 2004, mortality due to cardiovascular disease has fallen by 52% in France [1]. This reduction is a major cause of satisfaction for the cardiological community. The improvement in prognosis is due to the management of cardiovascular disease and its risk factors. This large fall of cardiovascular mortality masks an important increase in the prevalence and costs generated by this chronic disease. Population registries are necessary to detect the best means of improving management of atherothrombosis. Clinical trials will always provide the ultimate proof of the efficacy of a treatment in a selected sample. Nevertheless, the most recent clinical trials show that this remarkable management of cardiovascular disease does not necessarily reflect the real situation in the field.

The French REACH registry presented in this issue by Sabouret et al. [2] is an observational study. The one-year follow-up results for this cohort have been presented at international level [3-5] and are discussed for France in this article [2]. The REACH registry is not above criticism, as bias may be introduced during selection of the doctors taking part in the study and patients enrolled in this registry. This registry should consequently be considered to provide an optimistic view of the real situation. The outstanding finding of this study is the major cardiovascular event rate which increases from 11.7% at one year for a single atherothrombotic lesion to 22.3% at one year for several atherothrombotic localizations. It should be noted that the REACH registry includes patients with established atherothrombotic disease whereas a high prevalence of asymptomatic lesions is known to exist in patients presenting disease in a given territory [6,7].

What lessons may be learned from the REACH study? The REACH study is first of all a superb example of the evaluation of professional practices. This evaluation may be made at a cross-sectional or longitudinal level. A cross-sectional approach is used to assess the appropriateness of prescriptions with recommendations whereas cohort studies evaluate the impact of management on cardiovascular events. The registry REACH data underline the need for a harmonization of practices in the treatment of a single disease, atherothrombosis. Screening and management must be harmonized in the face of a common physiopathology. The community of doctors and researchers concerned by atherothrombosis has not yet made any final recommendations about the harmonization of screening after the detection of a first cardiovascular event in a given territory. Should all atherothrombotic patients with peripheral arterial occlusive disease be screened by measuring the ankle-brachial pressure index [8]? Is it necessary to screen for carotid arterial disease in all patients after an acute coronary syndrome [9]? Should a test for ischemia or a coronary CT-scan be conducted in all patients with peripheral arterial occlusive disease or another atherothrombotic lesion [10,11]? The data of many studies including the REACH registry seem to suggest that it is necessary to screen for disease in other territories once a first symptomatic localization is detected. From the point of view of therapy, the increasing harmonization of practices seems easier to achieve now that numerous studies have brought together cardiologists, neurologists and vascular specialists. This must not be restricted to university hospital collaboration and doctors working in the wider community must also benefit from these advances. Registries must therefore be multiplied as they provide an educational link between researchers and doctors practicing daily in the field of cardiovascular medicine. These registries make it possible to assess professional practices and measure the gap between the results of clinical trials and a real life setting. In all events, the REACH registry has achieved its main goal of making the cardiovascular community aware of the need for common global management of atherothrombotic disease.

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