Speaking from the heart

I read Dr. David Rapoport's article "Death by coronary" (*Can Med Assoc J* 1997;156[12]:1733-4) with great interest. However, I am not as enthusiastic about coronary artery bypass grafting (CABG) as he is. It was the worst experience I have ever had.

In my early 50s I had mild hypertension and stable coronary artery disease that was easily controlled by medication. After retiring I consulted a cardiologist and underwent echocardiography, a stress test and angiography. The diagnosis was severe coronary sclerosis with triple-vessel disease, and the cardiologist said CABG was the only solution. After the operation the surgeon said that only a double-bypass procedure had been performed. I never found out why and never heard from him again. After the operation I experienced excruciating pain and sleepless nights, and was discharged in miserable shape.

In 1988, 2 years after the operation, I experienced coronary discomfort and lost consciousness while on a flight to Florida. At a Miami hospital I was told that both bypass grafts were blocked and that because of my serious situation surgery was not recommended. I was then transferred to a Vancouver hospital by air ambulance.

After that frightening experience I led a marginal existence and looked for help wherever I could find it. My doctor's only suggestion was another operation. That's when my daughter heard about chelation therapy, which was available from 2 Vancouver physicians. I started this therapy in 1989 and after 30 treatments experienced mild but noticeable improvement. This prompted me to continue with 10 to 15 treatments a year. My condition improved to the point where I was able to enjoy family life and travelling, all without the pain and suffering that existed before the treatments.

Placebo you say? Read my lips! I am now 83 years old and still enjoy life. CABG let me down, while chelation therapy gave me what I was looking for in the first place: a chance to enjoy my remaining years in dignity.

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[The author responds:]

Dr. Neumann's advice on chelation therapy is useful, and I sincerely hope that it will join the growing list of treatments and preventive measures available for coronary artery disease.

To lower our lipid levels, my at-risk patients and I have tried garlic and fish oil, with limited success, and lipid-lowering agents, with outstanding success. We are taking coated Aspirin, vitamin E and so many other remedies that I am reminded of 19th-century snake-oil days. We walk quickly. We jog. We watch our waistlines with variable results. In our leisure time we exchange remedies and we eagerly acquiesce to angioplasty and bypass grafting without so much as a second opinion. We feel disappointed if we are denied such interventions.

Neumann received his grafts in 1986 and they proved fruitless, but we are fortunate that this rarely occurs today. The 1980s and 1990s have brought life-saving advances that benefit most patients.

If we really want to attack heart disease, though, we should seek out the real culprits. I blame the cigarette companies, the fast-food companies and everyone else who is at work clogging our arteries. As we jog by the evil fast-food dens in our flashy track suits we can give "the Colonel" and his colleagues a glare, but this is best done in our 20s and well before a CABG rather than in our 50s and well after it.

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Where's the evidence?

The recent article "Translating guidelines into practice" (*Can Med Assoc J* 1997;157[4]:408-16), by Dr. David A. Davis and Anne Taylor-Vaisey, reviews the steps in translating clinical practice guidelines (CPGs) into practice. They analyse what has actually happened, and why CPGs so often appear to have had little impact. One problem may be in the cascade they outline. In this era of evidence-based medicine it is not enough to put forward CPGs and then merely have them approved by a "credible body." Surely the guidelines need to be tested, a step that should be taken before widespread implementation, not after. Until CPGs have been shown experimentally to improve outcomes or decrease costs (or both), these benefits cannot be assumed.

In a recent study on CPGs for radiography of the lumbar spine, we found that if published guidelines to reduce the utilization of radiographs had been followed, more rather than fewer x-ray studies would have been carried out.[1]

Unfortunately, although CPGs are normally based on the best available evidence, that evidence may simply not be good enough and indeed is far too often no more than "expert opinion." In the excellent accompanying editorial "Recipes or roadmaps?" (*Can Med Assoc J* 1997;157[4]:403-4), Dr. Donald R.E. Farquhar suggests that users of CPGs should familiarize

themselves with the quality of the evidence, but surely it is the proposers who should be "up front" about this aspect of their work. We believe that one reason for a common lack of enthusiasm for CPGs is the feeling that many of them may well be invalid.

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Reference

1. Suarez-Almazor ME, Belseck E, Russell AS, Vackel JV. Use of lumbar radiographs for the early diagnosis of low back pain by family physicians. Proposed guidelines would increase utilization. *JAMA* 1997; 277:1782-6.

Factors in low birth weight

In the article "Recent trends in infant mortality rates and proportions of low-birth-weight live births in Canada" (*Can Med Assoc J* 1997; 157[5]:535-41), based on a study of Canadian data, Drs. K.S. Joseph and Michael S. Kramer report an increase in low-birth-weight live births in Ontario and suggest that part of this change may be attributable to errors caused by truncation of weights recorded in pounds and ounces. However, they also note that this explanation does not account for the increases in each of the birth weight categories when examined by 250-g weight groups.

In his commentary "A warning from the cradle? Because they may signal a deterioration in the nation's health, trends in infant mortality and low birth weight bear watching" (*Can Med Assoc J* 1997;157[5]:549-51), Dr. Graham Chance rightly points out that the low-birth-weight live birth rate is a sensitive indicator of population health, and he calls for more standardized reporting. To ensure accuracy in reporting I would make a plea for the use of electronic scales that record birth weight in grams; the conversion to pounds and ounces, which all parents request, should be a secondary consideration.

Nonetheless, my experience in high-risk neonatal care in the Metropolitan Toronto area for over 20 years leads me to believe that there have been real increases in the incidence of low-birth-weight live births that have nothing to do with inaccuracies in reporting but that have major implications for health care planners and others.

At Women's College Hospital, one of the tertiary perinatal facilities for the Central–East Region of Ontario, there has been a marked change in the demographics of very low-birth-weight infants (less than 1500 g at birth). In contrast to a major database to which we contribute data (the Vermont–Oxford project, which involves more than 150 neonatal inten-