In this issue

16 JUNE

DEFINING AND REFINING PREVENTIVE HEALTH

Before we can reform preventive health services in Australia, we need to clarify what they are, nominate those responsible for carrying them out, determine how they will be paid for, and develop measures of their effectiveness, say Russell et al (*page 715*). In an environment where prevention can mean anything from an advertising billboard to a rectal examination, it's no wonder that we are confused. Yet if the government's rhetoric translates into a robust public health strategy that encompasses all the important aspects of prevention, all the semantics and soul searching will not have been in vain.

DOCTORS' PUBLIC ROLES

If you're looking to be challenged in your role as a doctor, turn to Gruen's editorial (*page 684*). As epidemiological evidence accumulates, we know that illnesses are not random and that health is determined by environmental and political factors. Is there a place for evidence-based advocacy as well as clinical excellence in modern medical practice?

ANOTHER TIME ... ANOTHER PLACE

The health of the people is really the foundation upon which all their happiness and all their powers as a State depend.

Disraeli

MATTERS OF THE HEART

... Abnormalities of cardiac repolarisation, such as the long-QT syndrome, are less rare than once thought, says Smith, in a thought-provoking editorial (*page 688*). There are at least 10 genetic mutations associated with long-QT syndrome, and a new entity of short-QT syndrome, also with a genetic basis, has recently been recognised. Fainting or seizures during exercise or with emotion, or a family history of sudden death should arouse suspicion of one of these syndromes.

... Another increasingly recognised condition, Takotsubo cardiomyopathy, can also be triggered by stressful events. There is often minimal myocardial necrosis associated with Takotsubo cardiomyopathy, but a recent case was nonetheless complicated by Dressler's syndrome (*Notable Cases, page 725*).

... When a young person with type 1 diabetes dies, the death is often unexpected, and "dead-in-bed" syndrome, in which apparently well patients are subsequently found dead in bed with no obvious signs of disturbance, requires further investigation. So say Tu et al (*page 699*) after auditing 26 682 autopsies performed at the Department of Forensic Medicine in Sydney. Among 67 deaths in patients with type 1 diabetes aged ⩽40 years, diabetic complications, unnatural causes and sudden and unexpected death were the predominant causes, and 10 deaths were attributed to dead-in-bed syndrome.

...Finally, the experience of Higgins et al at the Royal Melbourne Hospital (*page 712*) should encourage other hospitals to adopt best practice referral and recruitment practices for cardiac rehabilitation (CR) after coronary artery bypass grafting. By using strategies such as automatically referring all eligible patients, including CR patients in planning, and personally inviting all patients to CR, they achieved an attendance rate of 72%.

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HEALTH FOR THE OVER-100s

Some of us are feeling it more than others, but all Australians are getting older! And the fastest growing age segment of our population is centenarians. According to Richmond (*page 720*), the 2006 census recorded 3154 people aged 100 years or over (0.12% of the population), and the annual growth rate of centenarians has been 8.5% over the past 25 years. The growth in the numbers of very elderly is set to continue, and health care planning needs to take account of the needs of this group.

INVASIVE MANAGEMENT BEST FOR ACS?

The results of a large Australian audit indicate that "invasive management" (early angiography, and revascularisation where clinically indicated) may be underused in patients with acute coronary syndromes (Chew et al, *page 691*). The Acute Coronary Syndrome Prospective Audit (ACACIA) followed the care of 3402 patients admitted to 39 metropolitan and non-metropolitan hospitals with suspected acute coronary syndromes between November 2005 and July 2007. Invasive management was more common in patients with ST-segment-elevation myocardial infarction (89.7%) than in those with non-ST-segment myocardial infarction (70.8%), unstable angina (44.8%) or stable angina (35.8%), and was associated with higher risk status on admission, being male, and having an onsite surgical service at the admitting hospital. Overall, patients who did not receive invasive management were almost twice as likely as those who did to die in the year after the event. While Scott applauds the existence of well designed large registries such as ACACIA (*page 686*), he points out that the benefits of invasive management are of a lesser magnitude when examined in randomised controlled trials, and argues for more evidence-based management of acute coronary syndromes all round, including appropriate medical therapies.