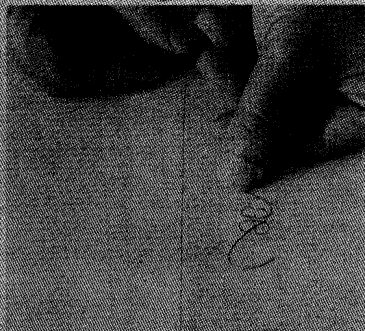


VOL. 7, NO. 1

JANUARY-FEBRUARY, 1978

Clinical Trends in CARDIOLOGY

'Magic' Wire



Straight wire (left) made of new space alloy turns itself into a clover-leaf blood clot filter when introduced into vena cava through angiographic catheter. For story, see page 8.

Outpatient Therapy Seen Possible

Self-Injected Heparin Reported Effective Against Thrombophlebitis

SELF-ADMINISTERED heparin provides effective outpatient therapy for persons with acute or subacute thrombophlebitis. Dr. Richard M. Stillman told the American Heart Association meeting in Anaheim, Calif.

Dr. Stillman reported on 407 patients treated over the past 10 years at the State University of New York Downstate Medical Center in Brooklyn. "Our protocol induced symptomatic resolution in under two months in half of those patients with acute or subacute conditions, and in under six months in 75 percent," he said.

Within those two categories, Dr. Stillman added, patients are excluded who have pulmonary involvement or whose condition is so severe as to confine them to bed; hospitalization and intravenous heparin would be better in their case.

The first step in applying the Downstate regimen, which was developed by Dr. Philip Sawyer, chief of vascular surgical services there, is to classify patients according to the status of their disease: acute, subacute or chronic. Those who present with markedly swollen calf and a positive Homan's sign are considered to have acute thrombophlebitis and, in the absence of fever and leukocytosis, are put on the outpatient protocol immediately.

Subacute thrombophlebitis is indicated by aching, tender, somewhat swollen calves and a negative Homan's

Continued on Page 4

Arrhythmia Prevention Called Critical

Deceptive Signs, Altered Drug Responses Held Common Pitfalls In Managing MI in Elderly Patient

The detection and treatment of myocardial infarction in elderly patients present the physician with first-rate clinical challenges.

In an exclusive interview, Dr. Raymond Harris, chief of cardiology at St. Peter's Hospital, Albany, N.Y., clinical associate professor of medicine at Albany Medical College, and president of the Center for the Study of Aging, drawing upon his extensive experience with elderly patients, suggests approaches to differential diagnosis and effective management.



Dr. Harris

Q — Dr. Harris, in your experience, what are the main differences between the geriatric patient and younger persons so far as myocardial infarction is concerned?

A — Statistically, cardiovascular disease is more than twice as prevalent in people over 65 as it is in younger persons. Of course, there are some people under 65 who are physiologically much older and therefore subject to the same risks as the geriatric patient.

The aging process usually means decreased cardiac function, increased collagen in valves and endocardium, apparent shrinkage and loss of muscle fibers, focal hypertrophy of individual fibers, calcification of the media, and the likely presence of additional chronic disease including brain changes. Because of this, symptoms in the elderly person may be misleading, attenuated or simply absent, making the diagnosis of MI more difficult than in younger patients and causing many cases to go undetected in the older population.

Complications from MI may be more serious if the elderly patient survives the attack, because his vascular system may already be compromised and his body defenses cannot fight back as effectively.

Q — What, specifically, makes the diagnosis more difficult?

A — Often the symptomatology differs from the classic clinical presentation. Instead of an alarming chest pain radiating into the arm or the back, there may be little if any pain. Sometimes the older patient may report a sensation typical of gastrointestinal discomfort. So-called "silent infarction" is quite common—occurring in anywhere from one third to almost two thirds of these patients. Also, the ECG may be ambiguous when not downright misleading.

Q — How, then, do you approach the diagnosis?

A — When taking the history or examining the patient, the physician should look

Continued on Page 5