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Short communication

The preference of the physicians in diagnosis and treatment of cardiovascular diseases

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ABSTRACT

Objective: To evaluate opinions and applications of physicians related to cardiovascular diseases in their daily practice about current diagnosis, treatment and prophylaxis of coronary artery disease, acute coronary syndrome and hypertension.
Method: In this study, a questionnaire survey was performed with cardiologists, internists, family physicians and neurologists about the current diagnosis, treatment and prophylaxis in cardiovascular diseases.
Results: A total of 208 physicians participate in the study. Most of the physicians were working in the specialty of cardiology (88.94%). Majority of physicians (47.6%) had a professional experience of more than ten years and 56.25% of them were working in the training and research hospitals or state hospitals.
Conclusion: The clinical applications of physicians are mostly in compliance with the treatment guidelines.
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Introduction

In recent years, new evidence has been obtained related to the diagnosis and treatment of cardiovascular diseases. As a result, many pharmacologic and nonpharmacologic treatment methods have been introduced into clinical practice.[1–6] Comprehensive improvements in diagnosis and treatment have taken place. In this questionnaire survey, evaluation of the opinions and applications of the physicians related to cardiovascular diseases in their daily practice about current methods of diagnosis, treatment and prophylaxis of cardiovascular diseases was aimed.

Methods

In this study, a questionnaire survey consisting of a total of 21 questions was performed with cardiologists, internists, family physicians, emergency medicine specialist and neurologists about current diagnosis, treatment and prophylaxis in cardiovascular diseases (Table 1). The physicians were invited to participate in the survey only via e-mails and questions were responded via e-mail. At the end of the questionnaire survey, the physicians were asked if their responses could be used for scientific processes and the responses of the assented physicians were analyzed. Approval of the local ethics committee for the study was obtained (2016/047).

Results

The questionnaire was completed by 214 physicians and 208 physicians allowed the data retrieved from the questionnaire to be analyzed within the frame of the study. The physicians participating in the study consisted of those working in the specialties of cardiology (n = 185; 88.9%), internal medicine (n = 9; 4.33%), emergency services (n = 7; 3.37%), family medicine (n = 62; 88%) and neurology (n = 1; 0.48%). The majority of the physicians (47.60%) had a professional life longer than ten years. The 56.25% of the physicians were working in training and research hospitals or state hospitals, 28.37% in universities, 12.5% in private hospitals and 2.88% in medical centers. (Table 2). The 66% prescribed ACE-inhibitors as their first choice in stage 1 hypertensive patients. More than half of the physicians had not used cardiovascular risk scoring system. The 73.5% of the attendees stated that outcomes of SPRINT study would not change target blood pressure value. Fixed-dose triple-combination was required >20% in clinical practice of

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[1] Yalım Z, Isgandarov K, Yüksek U, Uygun T, Çelebi ÖÖ, Esin M, Emren SV, Canpolat U, Dolay C, Akçay M, Taşcanov MB, Bayar N, Çelik O, Göktuğ A, Karaarslan O, Kilit C, Günaydın ZY, Ekmekçi C, Yurtdaş M, Yüce Eİ, Akyüz AR, Çelebi AS, Asarcıklı LD, Kalyoncuoğlu M, Dönmez C, Işık IB, Kemal HS, Boyraz B, Unğan I, Sımsır IY, Kocabas U, Günes H, Özgür V, Gülcan M, Hoşcan Y, Örnek E, Aksakal A, Alkan MB, Kadı H, Günay S, Bozdemir H, Güven A, Turgut O, Kış M, Şimşek EC, Çatırlı S, Eren H, Doğan A, Uzun HG, Buğan B, Çetin N, Keçegil HT, Güvenç TS, Çekici Y, Demirkıran S, Çelik A, Akıl MA, İlkay A, Harbalıoğlu H, Kanbakan A, Ballı M, Yetim M, Yayla Ç, Keleş F, Demir FA, Tunç E, Aytemiz F, Çamkıran V, Umdu E, Özde C, Akıncı S, Doğan T, Tosun V, Sökmen Y, Kılıç S, Gül S, Kırdar C, Karademirci M, Seçen Ö, Kalçık M, Baysal S, Gümrükçüoğlu HA, Yenerçağ M, Alıcı H, Duz R, Tarı ÇK, Usalp S, Akyüz A, Çelik A, Kurmuş Ö, Tülüce K, Hoşoğlu Y, Demirelli S, Yılmaz GM, Adalı MK, Okyay K, Çiçek M, Doğan YH, Akyel S, Süner A, Tülüce SY, Yayla C, Ulupınar H, Karaaslan ÖÇ, Ertaş F, Şalk N, Çabuk G, Sığırcı S, Serin SO, Çakır H, Şahan AG, Kudat H, Demir V, Samsa M, Oktay V, Vuran Ö, Yerkesikli B, Şenerdem ME, Ekinözü İ.Peer review under responsibility of The Society of Cardiovascular Academy.

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Table 1
Questions (Q) of the questionnaire survey are seen.

Q1: Please select your area of specialization.
Q2: How many years have you been working as a physician?
Q3: Please indicate your academic status.
Q4: In which institution do you work?
Q5: Which the cardiovascular risk scoring systems do you use in your daily practice?
Q6: Do you require an 8-hour fasting condition while evaluating your patient's lipid panel?
Q7: Which patient population is your target in your daily practice of PCSK9 inhibitors?
Q8: Which of the following do you prefer as a primary treatment in a patient with AF who didn't undergo stenting after STEMI and has a CHA2DS2VASc score of 3?
Q9: Which of the following would you prefer as the first drug option in the pharmacological cardioversion for a patient with sudden AF, if the patient has hypertension, LVH and is hemodynamically stable?
Q10: When do you prefer Ticagrelor treatment instead of aspirin for the long-term treatment for secondary prevention?
Q11: In which order do you prefer the following combinations in the treatment of hypertension? (put them in order from 1 to 5)
Q12: At which rate do you need fixed-dose triple combination therapy in the hypertension treatment?
Q13: At which rate do you prefer Clopidogrel after ACS?
Q14: Do you think that too much statin is used in our country?
Q15: Which drug group do you prefer most in the treatment of stage 1 hypertension?
Q16: Who should evaluate CT angiography?
Q17: Which of the following patient profile(s) is/are not at high risk according to you?
Q18: What is your preference of the treatment for a case with STEMI diagnosis?
Q19: Did the results of the SPRINT study alter your target blood pressure value in high-risk group patients?
Q20: A 42-year-old asymptomatic patient who had an anterior MI one month ago and underwent primary PCI was referred to your polyclinic for routine control. You see that the medical treatment continues as suggested by guidelines, but the LVEF value is between 25–30%. What would be your ICD preference for this case?
Q21: For which patients do you prefer a bioresorbable stent?
Q22: Do you allow the answers given in the current survey to be used for scientific purposes?

18.27% of the attendees. The 29% believed that statins are prescribed much more than needed. Most of the physicians participating in the study would prefer PCSK9 inhibitors mostly in cases with familial hypercholesterolemia. The 67% of participants performed PCI for seven days a week and 24 h a day or they transferred these patients to a center where PCI could be performed. However, the half of them still preferred clopidogrel following acute coronary syndrome (ACS). Moreover, 53% of participants did not use any cardiovascular risk-scoring tool.

Discussion

Cardiovascular diseases are among important causes of morbidity and mortality worldwide. Their prevalence gradually increases because of prolongation of expected life span, variations in life style and technologic developments in the field of medicine.[7–9] In recent years, despite raised awareness of cardiovascular diseases and steps taken during the fight against risk factors, these diseases are important causes of mortality both in developed and developing countries.[10,11]

Cardiovascular disease is still the main cause of cardiac death worldwide. Therefore, the identification of risky population and assessing the risk of cardiovascular disease is essential.[12,13] Numerous risk-scoring models like WHO model, SCORE, JBS-2, QRISK, and ASSIGN are available.[14,15] In our study, we have detected that more than half of the physicians had not used cardiovascular risk scoring system however the majority of users had a preferred SCORE risk scoring system (Table 3).

Atherosclerosis is the most frequent cause of cardiovascular diseases. Lipids play a role in the development of atherosclerosis. Treatment of hyperlipidemia is associated with decreased cardiovascular mortality.[16] Decreasing LDL-cholesterol levels gains priority in the cardiovascular prophylaxis.[17] In clinical application, lipid panel is evaluated after 8–12 h of fasting. However, most of the individuals eat three main meals and snacks every day and feel fullness all day long. This condition has created concerns in that fasting lipid panel would not reflect cardiovascular risk. However, when fasting and postprandial lipid panels were compared, the difference was detected to be clinically insignificant.[18] Hyperlipidemia Guideline of European Society of Cardiology indicated that lipid panel could be performed during both fasting and state of satiety. However, the guideline-recommended follow-up of the patients during fasting state in case of hypertriglyceridemia.[19] In the study, during evaluation of lipid panel by physicians, most of the physicians indicated that they stipulated for fasting condition. A small percentage (17.3%) of the participants reported that they made case-focused decisions (Table 4).

Currently, statins are the most frequently used agents in the treatment of hyperlipidemia. They are recommended for primary and secondary prophylaxis against cardiovascular diseases.[20,21] However,

Table 2
The table shows the institutions in which physicians participated in the survey are working.

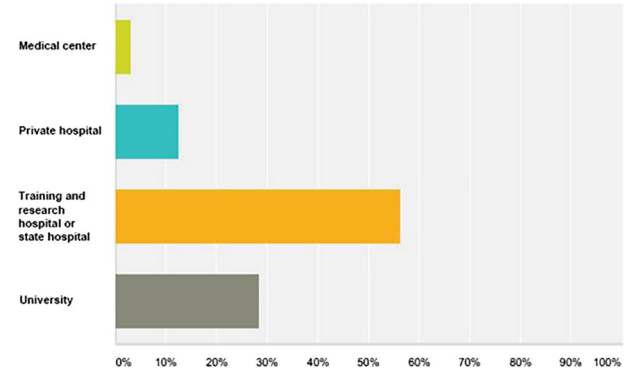


Table 3
The cardiovascular risk scoring systems preferred by the physicians in daily practice are seen.

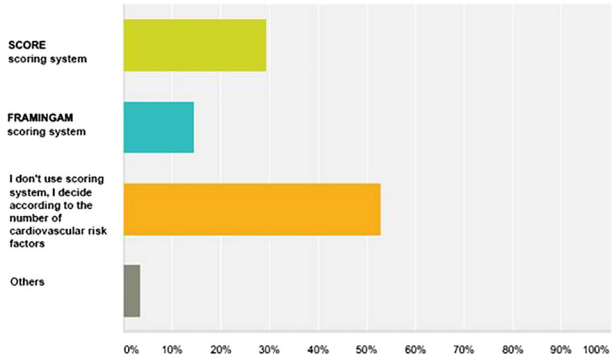
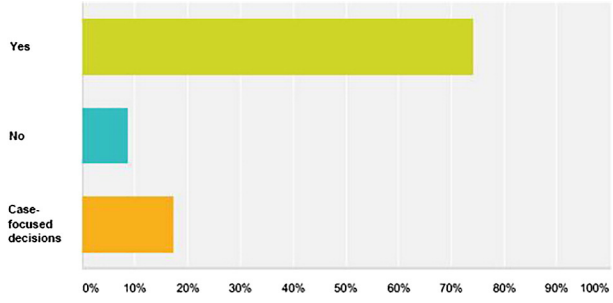


Table 4
Table shows the answers regarding whether physicians were looking for 8 h of fasting before investigating lipid profile.



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