

## BOOK REVIEW

**Coronary heart disease epidemiology: from aetiology to public health.** Edited by Michael Marmot and Paul Elliott. Oxford: Oxford University Press, 1992. (Pp 547; £50) ISBN 0-1926-2124-6.

This is a big book, encompassing over 500 pages and 32 chapters from 51 authors. It marks the epidemiological and public health work of Geoffrey Rose, and many key chapters are written by his former students and colleagues. It is also a general textbook of epidemiology for postgraduate students in epidemiology and public health.

The book is a magnificent tribute to Geoffrey Rose as it offers a broad overview of the aetiology of coronary heart disease and its public health applications. The introduction and first chapters by Marmot and Elliott are colourful, historical descriptions of the coronary artery disease epidemic and the contribution of Rose's work to understanding of the aetiology of this disease. The fresh and intriguing perspective chosen by the authors is that of a personal account of the thinking behind the science of coronary heart disease epidemiology and how public health policy evolved from an understanding of the disease aetiology. Each of the chapters is well written and integrates the author's work with that of others and, whenever possible, that of Rose. This personal perspective makes the book a fascinating teaching tool and ties the book together in an easy to read, integrated whole.

However, as a current reference work on coronary heart disease epidemiology and public health policy the book has limitations. In many areas it provides up to date information on cardiovascular disease research: for example, body fat distribution, the role of meta-analysis in interpreting the results of clinical trials, the psychosocial factors in coronary heart disease, nutritional epidemiology, and the relation of coronary heart disease factors and non-cardiovascular disease are well reviewed. Its references too are up to date. None the less, because of its scope, many important topics are often discussed only briefly or in a cursory way. Each chapter is necessarily short and often lacks critical details. More importantly, the book is limited, despite the editing, and conflicting views from different authors are neither fully highlighted nor well integrated and discussed. For example, Kuller's proposal that the risk of vascular sclerosis is a function of the level and the duration of exposure to lipids implies that a lipid disorder is a primary and necessary defect in the development of atherosclerosis. Other risk factors, such as smoking and hypertension, contribute to the disease process only in the presence of an abnormality in cholesterol, whereas other authors imply that all risk factors are equal in their potential for causing atherosclerosis. Similar conflict occurs in the section on public health policy in which Rifkind's description of the differences between the United States' approach and the British approach to cholesterol management are minimised rather than highlighted. Such major controversies need to be highlighted for students or they may be missed entirely. The book would

benefit greatly from a major chapter by Marmot and Elliott noting some of the key differences between authors in their conceptualisation of the aetiology coronary heart disease.

Another weakness of the book is that many of the key topics in cardiovascular epidemiology are scattered through different chapters. One must search through several different chapters and authors in order to explore fully a particular topic, such as race and coronary artery disease. Moreover, there is little critical discussion on the case definition for coronary heart disease or the difference between the anatomical atherosclerotic findings of heart disease and coronary artery disease manifestations, such as myocardial infarction or angina.

An additional limitation of this book as a teaching tool is the lack of figures. Some key chapters have no figures at all, while most chapters rely heavily on tables to illustrate key points.

*Coronary artery disease epidemiology: from aetiology to public health* is a welcome addition to the literature on the aetiology of and public health interventions for coronary artery disease. Its use of a historical and personal perspective makes it easy and enjoyable reading, and it will be a welcome addition to my office. However, it is not a book that I would recommend to be adopted as a primary textbook in introductory courses in epidemiology. Students who rely on this book as a primary textbook will find that key components of cardiovascular epidemiology and public health policy are scattered throughout multiple chapters, that controversies are not fully highlighted, and that some of the basic concepts and models of cardiovascular epidemiology and public health policy are only briefly reviewed. The book's high cost is a further limit to its use as a primary textbook for epidemiology.

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## BRITISH CARDIAC SOCIETY NEWSLETTER

### Data Management: Read codes and HRGs

Advances in medicine and technology usually start in hospitals and universities and filter down into general practice. The Read codes—clinical terms which are the basis of an electronic system for storage, retrieval, and rapid transmission of medical data—are the brainchild of James Read previously a general practitioner. The British Cardiac Society, with other specialty groups and the Read Centre in Loughborough, has been given the task of revising and expanding the Read codes for introduction into the hospital service and general use in April 1994.

The Read codes are widely used in general practice because they are easy to use and simplify the doctor's work. Access to clinical terms is through ordinary clinical language and synonyms, and the hierarchical arrangement allows coding at simple or complex levels. Patients records are instantly accessible and legible and a patient profile is built up over the years. The system allows regular recall of patients for screening, facilitates the gathering of information for administrative purposes, and offers opportunities for clinical research in general practice. Some practices are now almost paperless.

Previous newsletters have discussed the Read codes and the clinical terms that are now being assembled and put into hierarchies. Under the guidance of Malcolm Towers, the researcher working part time with the Read Centre for Coding and Classification, small groups of cardiologists have agreed lists of terms that are clinically relevant in general cardiology (including ICD9/10 coding). In more specialist areas the work has been undertaken with the help of individuals from the appropriate affiliated groups. Cardiac surgical procedures are being reviewed and given Read codes by a group put together by the Society of Cardiothoracic Surgeons. The ultimate aim, once the full clinical terms project is completed and tested, is to develop a comprehensive EPR (electronic patient record).

Many clinicians will have been involved with the contracting process and will have recognised the difficulties consequent upon the coding and classification of diagnoses and procedures. The lack of agreed language of contracting has led to different providers offering services in different ways. However, the National Case Mix office under Dr Hugh Sanderson is now taking an initiative to get an agreement of the definition of Healthcare Related Groups (HRGs) to allow a common language of contracting, and the British Cardiac Society has been invited to participate in these important developments.

### Teach-ins

Interest in the Society's teach-ins has been considerable, and all have been heavily oversubscribed. It is disappointing to report, therefore, that on each occasion to date, the actual attendance of those pre-