

heart disease in clinical practice:
recommendations of the Task Force of the
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Guidelines

Prevention of coronary heart disease in clinical practice: recommendations of the Task Force of the European Society of Cardiology, European Atherosclerosis Society and European Society of Hypertension

Kalevi Pyörälä*, Guy De Backer, Ian Graham, Philip Poole-Wilson, David Wood, on behalf of the Task Force¹

SECTION 1: BACKGROUND

Introduction

Coronary heart disease (CHD) mortality has declined significantly in a number of European countries during the past two decades, but has remained unchanged or increased in others. CHD remains the leading cause of mortality in men over 45 years and in women over 65 years throughout Europe [1–3]. In addition, CHD causes substantial morbidity and premature disability and it is a major burden on the cardiological, medical and social services of all European countries.

Major advances have been made in the understanding of the pathogenesis of CHD and in the development of diagnostic methods and treatment modalities for this disease. The medical community has adopted an increasingly aggressive approach to the management of CHD, including

the widespread application of diagnostic techniques, new drug treatments and myocardial revascularization procedures. This enthusiasm for the application of 'high technology' has not been paralleled by a similar enthusiasm for measures aimed at CHD prevention based on the modification of those lifestyles and risk factors that are known to be causally linked with the development of atherosclerosis, the underlying disorder for CHD, and superimposed thrombotic phenomena. Yet there has long been evidence indicating that risk factor modification is effective in reducing the risk of recurrent CHD events in patients with clinically manifest CHD and, more recently, evidence that this can lead to a retardation, or even a halt to the progression of coronary atherosclerosis (secondary prevention). It is also known that risk factor modification reduces CHD risk in asymptomatic high risk persons (primary prevention).

The relatively slow progress in integrating CHD prevention into the clinical practice of cardiologists and physicians working in the field of internal medicine and primary health care has not been due to a lack of recommendations on this issue. Since the 1970s CHD prevention has been a subject of careful scrutiny. International and na-

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