About the Editor

Harvey D White

Harvey D White is Director of the Coronary Care Unit, Cardiovascular Research Unit and is an Interventional Cardiologist at the Green Lane Cardiovascular Service, Auckland City Hospital, New Zealand. He is also Director of the Green Lane Coordinating Centre and the John Neutze Scholar. He was awarded the 1998 Prince Mahidol Award for Medicine by the King of Thailand for introducing thrombolysis in many developing countries. He is an Honorary Clinical Professor of Medicine at the University of Auckland and Fellow of the Royal Society of New Zealand. He is also an Honorary La'auli Matai (high chief) in Lalomalava, Samoa. He gave the International Society and Federation of Cardiology lecture at the XV European Congress of Cardiology in 1993 and the Paul Dudley White International lecture at the American Heart Association Scientific Sessions in 2004 and the Paul Dudley White Lecture at the 44th Annual New York Cardiovascular Symposium Meeting in 2011. He was Chairman of the PRISM and HERO trials. He is a member of the Virtual Coordinating Centre for Global Collaborative Cardiovascular Research (VIGOUR) and Bleeding Academic Research Consortium (BARC) group and Co-Chairman of the Redefinition of MI ESC/ACC/AHA Consensus group and the STABILITY trial. He has served on the steering committees of many international trial groups including ISIS, GUSTO, LIPID and TIMI. His particular research and clinical interests are the management of patients with acute coronary syndromes.

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Foreword

Advances in acute coronary syndrome management

Harvey D White

Acute coronary syndromes (ACS) are a major burden on healthcare systems with over 4 million new patients presenting with ACS in the USA and Europe every year. The prevalence is expected to increase with rates of obesity and diabetes increasing. In the under-resourced developing world, the rates will reach epidemic proportions, with India expected to have the highest burden.

The pathogenesis of ACS involves a complex interplay between the endothelium, inflammatory cells and the thrombogenicity of the blood. Optimal therapeutic goals for the treatment of ACS are most likely to be achieved through the use of approaches that target both the platelet and blood clotting pathways together with revascularization. Increasing efficacy of these approaches has resulted in increased bleeding, and for the individual patient, decisions have to be made in respect of the individual risks of bleeding balanced with reducing the risk of ischemic complications.

Risk scores, including baseline demographics and biomarkers for risk of mortality and expanded composite end points, including myocardial infarction and revascularization, and separate risk scores for bleeding designed to support clinical decision making have been developed. These identify patients at increased risk and also may identify individual patients who may gain particular benefit from various treatments.

Despite improvements in the secondary prevention of ACS through the use of antiplatelet therapy, cardiovascular death, stroke and re-infarction still occur in 10–15% of patients within 12 months of an acute episode. There thus remains a large unmet need.

I am extremely grateful for the contributions of my colleagues, all of whom treat patients, and who are familiar with the challenges of clinical practice. On their behalf I would like to thank our patients who have taught us so much and who continue to give us much pleasure as we have the privilege of caring for them.

I would like to dedicate this book to Jan and my children Catherine and Michael for their ongoing encouragement, support and love.

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