

Тромболитическая терапия, как было показано в клинических исследованиях GISSI и ISIS-2, или перкутанное коронарное вмешательство, если таковая технология имеется, могут и должны быть использованы в соответствующих временных рамках.

Медицинский центр Дартмаут-Хитчкок — это расположенный в сельской местности академический

медицинский центр, который решает проблему оказания, в рамках доказательной медицины, помощи пациентам с острыми коронарными синдромами, проживающим разбросанно на большой территории. Будет представлена успешная последняя инициатива, направленная на снижение смертности от ИМПИСТ у нашего населения.



H. Greenberg

ECONOMIC AND PUBLIC HEALTH IMPERATIVES FOR ACTING AGGRESSIVELY TO REDUCE THE INCIDENCE OF ACUTE, LIFE-THREATENING COMPLICATIONS OF CARDIOVASCULAR DISEASE

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Supported by data collected over the past several decades, it is a truth universally acknowledged, nearly, that chronic diseases, most particularly cardiovascular disease (CVD) and diabetes mellitus (DM) are the dominant health issues confronting the less developed economies. The recent WHO report may well herald the end of the era of the struggle to achieve problem recognition and confirmation. This era began with Abdul Omran's paper 35 years ago; 25 years later the Global Burden of Disease study collected and displayed the data; and now, a decade later yet, WHO has embraced and endorsed the observation. If, then, problem recognition is drawing to a close, notwithstanding the need to further refine current data in nearly every country, what follows needs to be an era of implementation. Global health assistance as currently constructed is not designed for or capable of leading an aggressive assault on the chronic illnesses afflicting the emerging economies. In our report, *A Race against Time*, published by the Earth Institute at Columbia in 2004 we began to describe a methodology for combating these diseases.

Our model is that of a 3 legged stool that supports a platform that can begin the assault on chronic disease. The three legs are: 1) a universal primary health care de-

livery system, 2) a health promotion system, 3) a macroeconomic repositioning of public health within the broader government bureaucracy and portfolios and the nation's commerce. The characteristics of each leg differ from key elements in current global health assistance. I will explore these.

My remarks will focus on barrier to adoption of these methodologies by assistance organizations and host countries. The traditional impediments to intervening on chronic diseases include opinions that they are restricted to the elderly; that since they are incurable, their course cannot be effectively modulated; that they are diseases of affluence; that they are self-induced by free choice behavior and hence not the responsibility of the state; and that the OECD countries focus on treating end organ impacts not prevention. The less obvious reasons relate to their duration and complexity. Because they last forever, management programs extend beyond any grant cycle. Establishing long term clinics is expensive and measuring outputs is complex. To function effectively, they must be locally run, thus limiting the roles for outsiders. How these concepts can be molded into effective programs will be explored.

Г. Гринберг

ЭКОНОМИЧЕСКАЯ ЭФФЕКТИВНОСТЬ ПРОФИЛАКТИЧЕСКИХ И ОБРАЗОВАТЕЛЬНЫХ ПРОГРАММ, НАПРАВЛЕННЫХ НА СНИЖЕНИЕ РИСКА РАЗВИТИЯ ОСТРЫХ СЕРДЕЧНО- СОСУДИСТЫХ ЗАБОЛЕВАНИЙ И ИХ ОСЛОЖНЕНИЙ

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Согласно статистическим данным, собранным за несколько прошедших деkad, проблема хронических заболеваний сердечно-сосудистой системы и сахарно-

го диабета была международно признана доминирующей в снижении темпа роста экономики развивающихся стран. В последнем докладе Всемирной организа-

ции здравоохранения был отмечен существенный прогресс в вопросах профилактики и диагностики этих заболеваний. Первые результаты научных исследований по этой проблеме прозвучали в докладе доктора Абдулу Омаран 35 лет назад. Но только спустя 25 лет статистические показатели заболеваемости из этого доклада были представлены публично "by Global Burden of Disease". На сегодняшний день эта проблема является приоритетной для Всемирной организацией здравоохранения. Выявлен критический недостаток информации статистического характера по данной проблеме. Обновление этой информации должно пройти почти во всех странах — участниках этого проекта. Структура системы глобальной медицинской поддержки на данный момент не способна на радикальную борьбу с хроническими заболеваниями, препятствующими прогрессивному росту и укреплению эко-

номики. В докладе, сделанном Университетом Земли (Колумбия, 2004), были предложены методики по борьбе с данными заболеваниями.

Предложенная программа борьбы с хроническими заболеваниями состоит из трех фундаментальных решений:

1. Универсальная "система доставки" первичной медицинской помощи населению.
2. Систематизированные мероприятия по охране здоровья населения.
3. Реорганизация макроэкономических планов в области общественного здравоохранения.

Данные решения будут предусматривать вопрос преодоления адаптационных барьеров новой методики и обеспечения нужной поддержки организациям, работающим с этим проектом на глобальном уровне по оказанию медицинских услуг.



Hiroyuki Hanada

IMPORTANT ROLE OF MECHANICAL CIRCULATORY SUPPORT AND REPERFUSION IN THE RETURN OF SPONTANEOUS CIRCULATION IN PATIENTS WITH METABOLIC PHASE OF VENTRICULAR FIBRILLATION

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It has been demonstrated that spontaneous circulation could not be obtained only by electrical shocks when ventricular fibrillation (VF) persisted for >10 minutes. This is referred as a metabolic phase, and effective treatment during this phase has not been established.

In the year of 2005, we had two male patients with acute coronary syndrome (ACS) and with incessant VF refractory to shocks > three times. Both patients were treated with extracorporeal circulation (percutaneous cardiopulmonary support and intra-aortic counter pulsation) and reperfusion therapy with percutaneous coronary intervention (PCI), and recovered without any brain damage. Since then, we have used the same therapeutic strategy in six patients (all men, mean age, 67 years old, range from 50 to 82) with ACS and with cardiac arrest. One patient had pulseless electrical activity and the other 5 incessant VF refractory to multiple shocks. Five of the 6 patients (83%) had spontaneous circulation returned after reperfusion by PCI, and the other one whose coronary angiogram showed occlusion of all of three major coronary arteries did not. All of the five patients were treated with hypothermia for 48 hours

after reperfusion. One died of multiple organ failure. Four patients successfully experienced weaning from the mechanical and medical circulatory support. However, only two patients discharged from the hospital without any neurological deficit. The remaining two patients could not respond to any stimuli, speak, or move, although they opened their eyes. These two patients were transferred from other hospitals while chest compressions being continued. The time had been from cardiac arrest to extracorporeal circulation were 20 and 25 minutes in the two recovery patient, while they were 35 and 45 minutes in the other two non-recovery patients. But after transference from our hospital to a rehabilitation hospital, these two patients neurologically fully recovered. They discharged the hospital on foot and returned to their own jobs. All of these 4 cases were suggested to be in the metabolic phase of VF and immediate extracorporeal support and direct approach to the cause of VF only were effective for return of spontaneous circulation. Effective and continuous chest compressions before extracorporeal circulation followed by hypothermia would be important for neurological recovery.