Various aspects of cardiovascular surgery are the focus of this monograph, one of a series published annually by the American Heart Association. These papers were sponsored by the AHA Council on Cardiovascular Surgery and presented at the AHA Scientific Sessions held at Miami Beach in November 1984. Selected topics include peripheral heart disease, congenital heart disease, valvular heart disease, coronary artery surgery, and other problems in heart surgery. Supplement to Circulation, September 1985. Monograph No. 113, soft cover, 279 pp.
Contraindications: Severe left ventricular dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. Warnings: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker (See Precautions). Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitals and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under Precautions) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been reported and one patient died. Because of verapamil's effect on AV conduction and the SA node, 1st AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1st or progressive 2nd or 3rd AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (HCHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, AV block, sinus arrest, pulmonary edema and/or severe hypertension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. Precautions: ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest a concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. Adverse Reactions: Hypotension (2.9%), peripheral edema (1.7%), AV block, 3rd-degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See Warnings). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, macules, spotting menstruation. How Supplied: ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984.
On nitrates, but angina still strikes...

After a nitrate, add ISOPTIN®
(VERAPAMIL HCl/Knoll)

Please see preceding page for brief summary of prescribing information.
AHA NEWS

cont’d from ad page 12

Inquiries: Debby Butler, Texas Heart Institute 3-276, P.O. Box 20269, Houston, TX 77225. Tel. 713-791-2157.

Sept. 25–28: The Fifth Annual Chicago Critical Care Symposium. Chicago Marriott (Downtown). Sponsored by the University of Health Sciences/The Chicago Medical School. Inquiries: Eric C. Rackow, M.D., Department of Medicine, University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago, IL 60064. Tel. 312-578-3291.

Sept. 28–Oct. 1: Sixth Conference on Neural Trauma: Brain Injury and Ischemia. Charlottesville, VA. Inquiries: J. Jane, M.D., Ph.D., Brain Injury Research Program, Box 180, School of Medicine, University of Virginia, Charlottesville, VA 22908.


1987


Abroad

1986

June 1–8: 32nd Annual Meeting of the Committee and Ninth Congress of the Mediterranean League Against Thromboembolic Diseases. Jerusalem. Sponsored by the International Committee on Thrombosis and Haemostasis. Inquiries: KENES, P.O. Box 50006, Tel Aviv 61500, Israel.


June 15–20: The First International Congress on Complementary Medicine. Jerusalem, Israel. Open to physicians and researchers of basic sciences. Inquiries: Dr. Z. Singer, Secretary of the Scientific Committee, The International Congress on Complementary Medicine, c/o OMEGA Tours, P.O. Box 482, Jerusalem, 91004, Israel.

June 19–21: CARDIOIMAGE 86. International Congress on Recent Advances in Cardiac Imaging. Congress Center, Monaco. Inquiries: Dr. J.P. Letouzey, Centre d’Echographie et d’Explorations médicales, 6, avenue de Messine, 75008 PARIS. Tel. 1 45639807. Telex 211897 F T E C E X P O.


June 22–25: Seventh Congress of the European Section, International Society for Heart Research, Reykjavik, Iceland. Inquiries: Guðmundur Thorgeirsson, M.D., Ph.D., Department of Medicine, Landspítalinn, 101 Reykjavik, Iceland.

June 23–25: Advances in Cardiac Imaging. Santa Margherita Ligure, Italy. Maria Serrato, M.D., and Mario Cornali, M.D., course directors. Official language: English. Organized by the Scuola Superiore di Oncologia e Scienze Biomediche, Villa Durazzo, 16038 Santa Margherita Ligure, Italy. Tel. 010-313674-316875.


June 26–28: First International Symposium on Lasers in Cardiovascular Disease. Sponsoring Dept., University of Vienna; Division of Cardiology, Stanford Medical Center; Ludwig Boltzman Institute for Cardiovascular Research. Inquiries: The Congress Secretariat, Interconvention, P.O. Box
AHA NEWS

80, A-1107 Vienna, Austria. Tel. 222-57 62 88, 57 63 05, or 57 64 50. Telex 11 12 10.

June 29-July 3: International Symposium on Cavernous Sinus (ISOSC), Ljubljana, Yugoslavia. Inquiries: Vinko V. Dolenc, M.D., Department of Neurosurgery, University Medical Center, Ljubljana. Prof. S. T. G. Zaloza, 71010 Ljubljana, Yugoslavia.


July 4-5: Fourth Meeting of the Working Group on Peripheral Circulation, European Society of Cardiology. Munich. Prof. D.L. Clement and Prof. L. Ursi, chairmen. Inquiries: Prof. Dr. D.L. Clement, Department of Cardiology, University Hospital, De Pintelaan 185, 9000 Gent, Belgium.


July 8-11: Eighth Annual Meeting American Section of the International Society for Heart Research and Satellite Symposium on Heart Metabolism for the 30th International Congress of Physiological Sciences. Winnipeg, Canada. Inquiries: Dr. R.E. Beamish, Experimental Cardiology Section, Dept. of Physiology, Faculty of Medicine, University of Manitoba, Winnipeg, Canada R3E 0W3.


July 19-21: IUPS Hypertension Satellite, (co-conjunction with International Physiological Congress, Vancouver, Canada.) Inquiries: Dr. Paul I. Korner, Baker Medical Research Institute, Commercial Road, Prahran, Victoria 3181, Australia. Telex: AA 31371.


Sept. 7-8: Satellite Symposium to the 11th Congress of the International Society of Hypertension. Applied Psychophysiology in Hypertension. Bonn, West Germany. August Wilhelm von Elff, chairman. Inquiries: Dr. H. Rüddel, Dept. of Internal Medicine, University of Bonn, Sigmund-Freud-Straße 25, D-5300 Bonn 1, West Germany. Tel 02 28-2 80 32 99. Telex: 8 869 546 KILBO D.

Sept. 7-8: A Satellite Symposium on Dopaminergic Systems in Hypertension. (Held in conjunction with the 11th Scientific Congress of the International Society of Hypertension.) Gent, Belgium. M.F. Lokhandwala and M.G. Bogaert, cochairmen. Inquiries: M.G. Bogaert, Heyman’s Institute of Pharmacology, University of Gent Medical School, B-9000 Gent, Belgium.


Sept. 14-17: Eighth International Symposium on Microsurgical Anastomoses for Cerebral Ischemia. Florence, Italy. Inquiries: Rolando Gagliardi, M.D., Dept. of Neurosurgery, USL 100/100, Follini Hospital, Florence.


Sept. 23-25: Blood Flow in the Brain in Parallel With Blood Flow in Artificial Organs and Cardiovascular Prostheses. Strathclyde University, Glasgow. In conjunction with the 26th Annual General Meeting of the Biological Engineering Society. Inquiries: Biological Engineering Society, Royal College of Surgeons, 35/43 Lincoln’s Inn Fields, London WC2A 3PN, United Kingdom. Tel. 01 242 7750.

Sept. 29-Oct. 4: Second International rCBF Workshop on Impact of Functional Imaging in Neurology and Psychiatry. Supetar, Brac, Yugoslavia. Inquiries: Dr. Sveo Knezevic, Department of Neurology, University Hospital Rijeka, Kispaticeva 12, 41000 Zagreb, Yugoslavia.


Obituary

Editorial Review

9-Alpha-Fluorocortisol-Induced Hypertension. A Review
Judith A. Whitworth, Aldona Butkus, John P. Coghlan, Derek A. Denton, Eric H. Mills, Campbell D. Spence and Bruce A. Scoggins

Original Papers

Mortality in Patients of the Glasgow Blood Pressure Clinic
Christopher G. Isles, Louise M. Walker, Gareth D. Beevers, Irene Brown, Helen L. Cameron, John Clarke, Victor Hawthorne, David Hole, Anthony F. Lever, James W.K. Robertson and Jean A. Wapshaw

Increased Sympatho-Adrenal Tone and Adrenal Medulla Reactivity in DOCA-Salt Hypertensive Rats
Michel Bouvier and Jacques de Champlain

Influence of Long-Term Antihypertensive Therapy on Cardiac Function, Coronary Flow and Myocardial Oxygen Consumption in Spontaneously Hypertensive Rats
Peter Friberg and Margareta Nordlander

Inhibition of the Enzymatic Reaction of Renin in Aggressive Mice
Knud Poulsen and Jørgen Jacobsen

Effects of Reversible Renal Denervation on Haemodynamic and Excretory Functions of the Ipsilateral and Contralateral Kidney in the Cat
Andrea Stella, Raffaello Golin and Alberto Zanchetti

Influence of Converting Enzyme Inhibition on the Hormonal and Renal Adaptation to Hyper- and Hyponatraemic Dehydration
Joelle Gardes, Marie-Françoise Gonzalez, Pierre Corvol and Joel Ménard

A Study of 48-Hour Faecal and Urinary Electrolyte Excretion in Normotensive Black and White South African Males
Richard J. Barlow, Martin A. Connell and Frank J. Milne

Effects of Potassium Loading in Normal Man on Dopaminergic Control of Mineralocorticoids and Renin Release
Helmut Witzgall and Jürgen Behr

Vascular Interactions of Serotonin and Norepinephrine in Renal Hypertensive Rabbits
Jan Willem R. Pott, Robert S. Moreland, Robin D. Gantzos, Charlene Babcock and David F. Bohr

Arterial Pressure and Renal Function in Two-Kidney, One Clip Hypertensive Rats Maintained on a High-Salt Intake
Cynthia Ann Jackson and L. Gabriel Navar

Aggressive Long-Term Antihypertensive Therapy with Pinacidil Does not Cause Regression of Cardiovascular Hypertrophy in the Spontaneously Hypertensive Rat
Leenard T. Jespersen, Ulrik Baandrup, Niels C.B. Nyborg, Ench O. Mikkelsen and Ole Lederballe

Body Sodium/Blood Volume State in Normotensive Members of Normotensive and Hypertensive Families
Carlo Beretta-Piccoli, Andreas Fischbacher, Andreas Rothenbühler, Andreas Gerber and Peter Weidmann

The Effects of Thiazide Diuretics Upon Plasma Lipoproteins
Brian F. Johnson, Richard Saunders, Roger Hickler, Raj Manwah and Joan Johnson

Nutrient Intake, Blood Pressure, Serum and Urinary Prostaglandins and Serum Thromboxane B2 in a Controlled Trial with a Lacto-Ovo-Vegetarian Diet
Ian L. Rouse, Lawrence J. Belin, Denis P. Mahoney, Barrie M. Margetts, Bruce K. Armstrong, Sally J. Record, Robert Vandongen and Anne Barden

Two-Kidney, One Clip Renal Hypertension in the Marmoset
Jeanette M. Wood, Neelam Gulati, Jean-Baptiste Michel and Karl G. Holbauer

Stress Levels of Adrenaline Amplify the Blood Pressure Response to Sympathetic Stimulation
Hieronymus H. Vincent, Frans Boomsma, Arie J. Man in 't Veld and Maarten A.D.H. Schalekamp

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1987

Feb. 11-15: Ninth Asian-Pacific Congress of Cardiology. Auckland, New Zealand. Inquiries: Dr. J.M. Neutze, Secretary-General, P.O. Box 84074, Auckland, New Zealand.


AHA Scientific Sessions
Future Meeting Dates

<table>
<thead>
<tr>
<th>Year</th>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>Dallas</td>
<td>Nov. 17-20</td>
</tr>
<tr>
<td>1987</td>
<td>Anaheim, Calif.</td>
<td>Nov. 16-19</td>
</tr>
<tr>
<td>1988</td>
<td>Washington, D.C.</td>
<td>Nov. 14-17</td>
</tr>
<tr>
<td>1989</td>
<td>New Orleans</td>
<td>Nov. 13-16</td>
</tr>
<tr>
<td>1990</td>
<td>Dallas</td>
<td>Nov. 12-15</td>
</tr>
<tr>
<td>1991</td>
<td>Anaheim, Calif.</td>
<td>Nov. 18-21</td>
</tr>
</tbody>
</table>

Xth World Congress of Cardiology, 1986

Advertisers' Index

Columbus Instruments ........................................... 2
Knoll Pharmaceutical .............................................. 14, 15
Marion Laboratories .............................................. 5, 6
Miles Pharmaceuticals ........................................... Cover 3, Cover 4
E.R. Squibb & Sons, Inc. .......................................... Cover 2, 1
University of South Florida ..................................... 11

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En garde against angina with coexisting cardiovascular disease

Brief Summary
ADALAT® (nifedipine) Capsules For Oral Use

INDICATIONS AND USAGE: 1 Vasospastic Angina: ADALAT (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: (1) pathologic exercise-induced ST-segment depression, (2) angina provoked by ergonovine, or (3) angiographically demonstrated coronary artery spasm. In patients with confirmed vasospastic angina, the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed; e.g., where pain has a variable threshold on exertion or in unattractive angles where electrocardiographic findings are compatible with intermittent vasospasm; or when angina is refractory to nitrates and/or adequate doses of beta-blockers. II Chronic Stable Angina (Clinical Effort-Associated Angina). ADALAT is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta-blockers and/or organic nitrates or who cannot tolerate those agents in chronic stable angina (effort-associated angina). ADALAT has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients is incomplete. Controlled studies in small numbers of patients suggest concurrent use of ADALAT and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is insufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or significant left ventricular abnormalities. When introducing such concurrent treatment, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See WARNINGS.)

Contraindications: Known hypersensitivity reaction to ADALAT. Warnings— Excessive Hypotension: Although in most patients, the hypotensive effect of ADALAT is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage increments. There may be a greater likelihood of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for ADALAT to be washed out of the body prior to surgery. Increased Angina: Occasional patients have had documented increased frequency, duration or severity of angina on starting ADALAT or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone. Beta Blocker Withdrawal: Patients receiving beta blocking agents may develop rebound sympathomimetic activity if these agents are abruptly withdrawn. ADALAT, being a calcium antagonist, is not likely to produce this activity, but it may be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a subset of beta blocker withdrawn and ADALAT initiation. It is important to note that beta blockers may be beneficial if possible, rather than stopping them abruptly before beginning ADALAT. Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure following ADALAT. Patients with light cardiac stress may be at greater risk for such an event. Precautions: General: Hypertension: Because ADALAT decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of ADALAT is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See WARNINGS.) Reduced Cardiac Output: Patients with reduced cardiac output and/or uncontrolled congestive heart failure may be at greater risk for such an event. Precautions: General: Hypertension: Because ADALAT decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of ADALAT is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See WARNINGS.)

ADALAT was administered Clometidine A study in six healthy volunteers has shown a significant increase in peak nifedipine plasma levels (50%) and area-under-the-curve (74%). After a one week course of clometidine at 1000 mg per day and nifedipine at 40 mg per day, furinolide produced smaller, nonsignificant increases. If nifedipine therapy is initiated in a patient currently receiving clometidine, cautious titration is advised. Carcinogenesis, Mutagenesis, Impairment of Fertility: Nifedipine was administered orally to rats for two years and was shown to be nongenotoxic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo mutagenicity studies were negative. Pregnancy: Category C: Nifedipine has been shown to be teratogenic in rats and embryotoxic in rats, mice and rabbits. There are no adequate and well controlled studies in pregnant women. ADALAT should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. ADALAT is not compatible with the following medicines: Amphotericin B, Colchicine, Dapsone, Fluorouracil, Heparin, Hydrocortisone, Methotrexate, Pentamidine, Propranolol, Sulfinpyrazone, Sulfapyridine, Thalidomide, or Warfarin.

ADALAT is not compatible with the following medicines: Amphotericin B, Colchicine, Dapsone, Fluorouracil, Heparin, Hydrocortisone, Methotrexate, Pentamidine, Propranolol, Sulfinpyrazone, Sulfapyridine, Thalidomide, or Warfarin.
En garde against angina

Adalat®
(nifedipine) Capsules

Adalat is indicated in vasospastic angina and in angina suggestive of a vasospastic component, as well as in chronic, stable angina without vasospasm in patients unresponsive or intolerant to beta blockers and/or organic nitrates.

Please see preceding page for a brief summary of prescribing information.