Cardiac Experience at St. Luke's Hospital From 1966 to 1983

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I first visited St. Luke's in 1966 and for some years previously 'screened' Maltese patients referred to U.K. for possible cardiac surgery. As they came individually, accompanied by a doctor and nurse, I proposed that it might be more economic if I saw a large number by paying a visit to Malta. The High Commission in London doubted if I would have more than six patients so I only arranged to stay two nights and one day. I still recall 7 p.m. that one day, when after seeing 30 plus patients and feeling distinctly hypoglycaemic, Dr. Captur arrived with a contingent of seven cyanosed children with complex, congenital heart lesions to round off my day's visit. Thereafter, these visits have lasted a week during which time I have been reviewing 200-240 patients annually. My surgical colleague Mr. Bromley started accompanying me to review postoperative patients, and now his successor, Mr. Rex Stanbridge, has taken over this task. As of 1983 I have also called in Dr. Hallidie Smith as well to help with paediatric cardiology.

Over the years I have seen a total of 1729 new patients and up to the end of 1981, 579 had been operated, mostly by Mr. Bromley at St. Mary's.

My figures show how congenital and rheumatic heart disease then dominated the cardiac surgical scene (Fig.1).

Rheumatic mitral stenosis was the single commonest cardiac surgical condition encountered and 185 were operated on by the closed technique using a Tubbs dilator, with only one death, (170 being first operations). Rheumatic fever used to be both common and severe in Malta causing tight mitral stenosis at a younger age than was initially encountered in the U.S. or U.K. at the time mitral valvotamy was first started. Fig. 2 shows the changing pattern of rheumatic mitral stenosis over these years in Malta, by comparison with the earliest large series from U.K. The first four year period shows the large proportion of youngsters needing operations; and only in the second four year period did it compare with the initial Edinburgh experience. Now it resembles any European series. Unfortunately, operation at an early age usually leads to restenosis from continuing low grade rheumatic activity and 14 from this series needed second operations. The bottom line showing the numbers of new patients referred, illustrates the declining problem of mitral stenosis over this period of time. A number of patients with mitral stenosis have never developed sufficient disability to justify surgery, and the same is true of mitral regurgitation and aortic valve disease. Surgery in these last two conditions carries the additional hazard of life-long anticoagulants in the presence of valve prostheses. Therefore, I am fairly conservative in these conditions, many of whom remain under regular observation, unoperated. In aortic valve disease we have operated on 31/85, mitral regurgitation 31/112 and multiple severe valve diseases only 5/32 patients.

Congenital heart disease however, has remained a fairly constant population comprising 46% of all new patients seen every year, the only difference being a drop in the proportion of cyanotics by half. Presumably an initial 'backlog' was present. The prevalence of the different types of congenital heart disease and the numbers operated are shown in Fig. 3. The different proportion needing surgery is of interest, although it must be remembered, as in all populations, some refused operation when it was advised - notably in patent ductus. However, only a quarter of V.S.D's came to operation compared with 60% of A.S.D's. This reflects the frequency of spontaneous closure in the former condition. In both pulmonary and aortic stenosis, many were only of mild degree and often needed cardiac catheters to confirm one's clinical impression.

The large 'miscellaneous' group included many with heart block requiring pacing, at that time not being practised at St. Luke's, as it is now. Tachyarrhythmias and cardiomyopathies have remained a constant 2% each year of the populations referred. Coronary artery disease was rarely seen in the early days but has been referred in increasing numbers over the past two years. Thus, from 1974-1979 I saw only 21 coronary patients. Now that coronary bypass grafting has become the most common cardiac surgical procedure, I am sure the Maltese referrals will continue to increase.

Total Maltese patients seen 1966 - 1981

	Nos	Operations
Congenital Heart Disease	784	279
Rheumatic Heart Disease	451	252
Miscellaneous	253	48

Figure. 1.

Mitral Stenosis (first operations)

Ages	'66-'69	'70-'73	'74-'77	'78-'81	Logan & Turner Edin. 1953
< 20	19%	2%	5%	0	1%
20-39	63%	63%	32%	35%	58%
40 +	18%	35%	63%	65%	41%
Total patients:	51	64	41	14	100

Figure 2.

Congenital Heart Disease ('66-'81)

	Nos		Operations
Ventricular Septal Defect	254	(31%)	60
Atrial Septal Defect	100	(13%)	62
Patent Ductus	29	(4%)	24
Pulmonary Stenosis	76	(10%)	28
Aortic Stenosis	81	(10%)	16
Coarctation of Aorta	30	(4%)	25
Mitral Regurgitation	39	(5%)	0
Other Acyanotic C.H.D.	84	(11%)	0
Fallot's Tetralogy	59	(8%)	56
Other Cyanotic C.H.D.	32	(4%)	8
Totals:	**784**		**279**

Figure 3.