War in Bosnia broke out in March 1992 as a result of tensions that came from the break up of the former Yugoslavia. Hostilities finally ended with the signing of the Dayton Peace Agreement in December 1995. It has been estimated that during the war about 100,000 civilians and military personnel were killed and a further 1.8 million people were displaced. The capital, Sarajevo, was effectively under siege for 4 years (Figure 1).

Over a decade later, Bosnia and Herzegovina (Figure 2) has a population of around 4 million and has taken “great steps” towards economic revival. Dr Aida Pilav, MD, MSci, head of the Department for Health Statistics and Informatics in the Federal Public Health Institute, Sarajevo, Bosnia, says, “The poor economic situation, unemployment, unhealthy and unsafe food, and an increasing trend towards smoking and unhealthy lifestyles have shifted health concerns towards high levels of cardiovascular disease, diabetes, and cancer.” She explains, “Before the war, the system of primary health care in the country had been well organised, but, as with the rest of the infrastructure, this crumbled to the point where it barely existed.”

A detailed analysis in 2002 showed just how much an impact the lack of a good primary healthcare system and public health strategy had on cardiovascular health in the country. With the help of a loan from the World Bank, Dr Pilav found that major cardiovascular risk factors such as smoking and hypertension had hit high levels and a vigorous intervention strategy was urgently warranted. Five years later, policies based on her findings are starting to become reality.

“Our system was totally destroyed, including the health system,” she says, “and when we started with an economic recovery, we were faced with demographic transition, a high percentage of elderly people, and a high prevalence...
of noncommunicable diseases such as hypertension, diabetes, and cardiovascular disease.”

Taking information from a random section of the adult population, Dr Pilav found that almost 40% of participants were hypertensive, with women having higher rates than men, about three quarters of men and women were overweight, and 50% of men and 30% of women reported they were daily smokers. The prevalence of hypertension was higher than in other countries in the region such as Albania and Hungary, and rates of cardiovascular disease mortality had increased in the postwar period.

According to a World Health Organisation health survey published last year, the burden of cardiovascular disease in Bosnia and Herzegovina is 30% of the total disease burden, compared with 19% in Albania, 27% in Croatia, 29% in Serbia and Montenegro, and 25% in the former Yugoslav Republic of Macedonia. Without shifts in these vascular risk factors, Dr Pilav warns, “the country faces excess health losses.”

To address these concerns, the Public Health Institute has come up with a 3-pronged attack. “The Ministry of Health needs to encourage a healthy lifestyle as part of our health policy, and we have put this in our strategy documents, for example, by banning cigarettes and improving food labelling,” she explains. “At a tactical level, the Public Health Institute will continue to produce the data, and it is also our intention to prepare the educational curricula for family practitioners to give them the necessary knowledge and skills, as well as to prepare public campaigns for the whole population.”

The third part of the strategy involves setting up an efficient primary healthcare system. The Federation of Bosnia and Herzegovina is looking to the United Kingdom and Scandinavia for a good model. “But,” Dr Pilav says, “although laws were adopted after the war for a healthcare system based on cost-effective interventions, including health promotion, disease prevention, early detection of diseases, timely treatment, and rehabilitation, this needs to be strengthened, and funding is a big hurdle.” Better staffing and resources for family medicine teams are needed and the governments of Bosnia and Herzegovina are still searching for ways to establish more efficient and accessible healthcare systems.

Several projects to improve cardiovascular disease management in primary care are being funded by the World Bank, the European Union, and the World Health Organisation. “Family doctors should regularly monitor risk factors for their patients to give them the appropriate advice. This should be part of their everyday job: integrated management, specially directed to hypertension, smoking, healthy food, and physical activity,” Dr Pilav comments. “But our big problem is how we are going to finance the family medicine team. Just now, we don’t have a real provider to pay the salaries, and we don’t have a real set of outcome indicators.”

However, Dr Pilav is optimistic that cardiovascular health will improve, and some success has been achieved with anti-smoking campaigns. Smoking is already banned in educational institutions, health and social protection institutions, and some other public buildings. Plans exist to extend the ban along the lines of the World Health Organization Framework Convention on Tobacco Control.

Dr Pilav wishes to carry out another health survey to monitor the impact on rates of smoking, but this is another area where funding is incredibly limited. “We found that 50% of men were smokers, but since 2002 we have had 2 big campaigns, so it would be very interesting to have the results. I am sure we have made some progress.”

Cardiovascular disease is a priority of the public health team, along with diabetes mellitus. Dr Pilav believes the incidence of this condition is also unacceptably high in the population. “Two years ago we started to prepare our strategic paper for the early detection of diabetes, and our paediatrician expert said it would be better to start with risk among children and teenagers. So now we are thinking it will be most important to develop a monitoring system for early detection among children,” she says.

Whether all the hard work to mitigate the public health fallout from the war is having any effect remains to be seen, and Dr Pilav regrets it may take a long time to find out. But she adds, “It is interesting. We’re part of this big family of transition countries in southeast Europe. We now need to try and conduct the next follow-up study. It’s the best way to measure the outcomes of our health reforms.”

Emma Wilkinson is a freelance medical writer.

References
An Unusual Team of Cardiothoracic Surgeons

Ina Ennker, MD, and Juergen Ennker, MD, Make Up a Husband-and-Wife Cardiothoracic Surgical Partnership.

Women cardiothoracic surgeons are rare, but Ina Ennker, MD, is particularly unusual. She is married to Juergen Ennker, MD, who is the chief surgeon at the Heart Institute in Baden, Germany, where they both work. Despite their hectic work schedules, they have a family of 3 children. Ingrid Torjesen, BSc, speaks to them about their life, work, and expectations.

While half of medical students in Germany are women, women comprise only 5% of doctors in cardiothoracic surgery. Ten years ago, that figure was only 2%. Against this backdrop, any woman embarking on a career in cardiothoracic surgery has to be determined, because she will face an uphill struggle and will have to be prepared to make compromises in other areas of her life.

Dr Ina Ennker, the only German member of Women in Cardiothoracic Surgery, has succeeded despite the overwhelming odds against her. She explains, “It is definitely harder for a woman to become a successful cardiothoracic surgeon, particularly in a leading position. Many female physicians are afraid of the long working hours and physical exhaustion that go along with cardiothoracic surgery. They stay away from this field, especially if they want to have children.”

She admits that the situation has improved in the last few years for women who are prepared to sacrifice a family life, but she acknowledges that it is still very difficult for women who want to have children. About 20% of the cardiothoracic surgeons in her hospital are now women, but she predicts that they, and other women surgeons like them, will not have large families.

“Many of my colleagues won’t have children or will just have 1,” Dr Ina Ennker says. “If you do want to have 1 or more children it is very difficult, because you cannot work full time during pregnancy, you can’t do the night shifts, and you can’t work all day with 2 or 3 children to look after.”

Until 2 years ago, Dr Ina Ennker worked full time, and now she has a 70% commitment. Apart from a personal understanding of her situation, she says, working with her husband, who is chief of department, does not give her any benefits. “People always imagine that I have advantages out of this situation, but it is just the opposite.”

The 2 Dr Ennkers (they both shared the same surname even before marriage) met in the 1980s at the German Heart Institute in Berlin. In 1985, Dr Juergen Ennker, having recently finished his surgical training at Hannover Medical School, was asked by Roland Hetzer, MD, to move to Berlin and start the German Heart Institute with him. Dr Juergen Ennker says, “It was fascinating to learn how to bring up a brand new institution from the start and what difficulties had to be overcome. Also, I was born in Berlin and wanted to make a special contribution to this city, which was at that time still divided.”

Dr Ina Ennker came to the Institute to do a cardiothoracic rotation under Dr Hetzer as part of her surgical education at the Hannover Medical School. On graduating, she became a consultant in general and transplantation surgery in Hannover. However, the birth of her first son changed things. “I sacrificed my career in abdominal surgery in Hannover and moved again to be with my husband in Berlin so I could stay with my son and my family,” she says. Dr Ina Ennker could not find a post as assistant professor in general surgery in Berlin, so she began a further qualification in thoracic surgery in Berlin-Heckeshorn under Dirk Kaiser, MD. She later gave birth to her second child and the first of 2 daughters.

In 1994, the family moved to Lahr/Baden to the newly established Heart Institute, Dr Ina Ennker to take a post as a consultant in cardiothoracic surgery and her husband to take the post of chief surgeon—and they are still there. She says that she does not regret sacrificing her career in abdominal surgery. “I wanted to stay together with my family, and there were not so many options 20 years ago. There were not many female surgeons, maybe 3% or 4% in general surgery and none in cardiothoracic surgery. I was one of the first in Germany.”

The Heart Institute in Lahr/Baden specialises in off-pump coronary bypass surgery (see Figure). Although only 8% to 9%...
of coronary bypass operations are done off pump in Germany, the Heart Institute treats more than half its patients using this technique, and in 2006 Dr Juergen Ennker operated on 94% of his patients off pump. He explains, “Nearly 10 years ago, my wife and I started doing bypass surgery off pump. We started with patients with neurological deficits and other special risks, because as you do not need to have an aortic occlusion, there is no surgically induced risk for stroke. We learned that actually all patients can benefit, and our philosophy is that all bypass patients should have the operation without a pump. There is a big advantage to this, especially if you use mammary arteries as the Y graft.”

Dr Juergen Ennker is also interested in stentless valve surgery in the aortic position. He and his team have used a large number of Medtronic Freestyle valves (produced by the Medtronic Company, based in Minneapolis, Minn) in the aortic position, and they use the technique in subcoronary versus total root replacement.

Meanwhile, Dr Ina Ennker is expanding her skill set into other areas of medicine, currently training in plastic surgery at Hannover Medical School. In the future, she wants to be able to combine her cardiothoracic and plastic surgery expertise to treat infective mediastinitis complications in cardiothoracic patients. “I want to focus on reconstruction and endocarditis,” she says. “Maybe I can help other cardiac surgeons who want to send these patients to special plastic surgery treatment. Maybe I can take over their care.”

Another of Dr Ina Ennker’s interests is the care of women patients. “Women are not so easy to operate on, and many of our male colleagues did not want to operate on women,” she says. “Only about 30% of patients in the cardiac surgery department are women, but there are more women dying of this disease, so there must be more reasons why females do not come to surgery.”

When it comes to their children, the Enkwers would neither recommend that they enter cardiothoracic surgery nor deter them from doing so. Dr Juergen Ennker says that their children will obviously look at their parents as an example of life in the world of medicine. “But I will not influence them by any means,” he emphasises. “They have to make their decisions for themselves.”

Dr Ina Ennker agrees. “It is a very nice profession, and it is very satisfying, but you have to know that you do not have a lot of private life. My hobbies are my children, my family, and maybe the dog, but there is no time for friends. I do not go out for parties or anything like that. I drive my car, play with my children and the dog, and that’s it.”

Ingrid Torjesen is a freelance medical writer.

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**History of Cardiology: Sir John Parkinson, MD**

All cardiologists have heard of Wolff–Parkinson–White syndrome, but who was the European amidst the 2 American physicians who helped to define this abnormality? Diane Berry investigates the English member of the trio.

Sir John Parkinson, MD, was born in Thornton-le-Fylde, Lancashire, United Kingdom, in 1885. He first attended Manchester Grammar School in England and later University College, London. Dr Parkinson’s medical training was at the University of Freiburg, Germany, and subsequently at the London Hospital, where he obtained his MD in 1910. He worked for a time as house physician at the London Hospital, and then he returned to Freiburg to work with Ludwig Aschoff, MD. During his time in Germany, he encountered the work of Sir James Mackenzie, MD, through reading a translation of Sir James’ book on heart disease. When an opportunity arose to take up the medical registrarship at the London Hospital, Dr Parkinson was delighted to become chief assistant to Sir James, who would have a considerable influence on Dr Parkinson’s life’s work.

Unfortunately, the outbreak of World War I interrupted Dr Parkinson’s further training; on joining the army, he was posted to a casualty clearing station in France. Although he regretted the interruption to his training and cardiac research, Dr Parkinson recognised his army work as essential, and he even wrote about some of the cases he saw. These included 2 patients with angina pectoris and 1 with acute nephritis. Fortunately, this keen young doctor remained in the forefront of the planning of Sir James, who outlined to Dr Parkinson plans for the use of 400 beds in Mount Vernon Hospital, Hampstead, London, for the study and treatment of cardiac cases among army personnel.

In 1916, the hospital in Hampstead became a special army research hospital. It was divided into 3 units, for which Dr Parkinson assumed responsibility. One of the main projects was research into effort syndrome or disorderly action of the heart, commonly known as soldier’s heart. Dr Parkinson took an active part in the research; in typical cases, he could find no evidence of cardiac disease. Rather, he thought the culprit was a disease of the nervous system. Assessments were carried out at the Military Hospital, Hampstead. As an author of an article later published in the *British Medical Journal,* he set out a specific group of symptoms and attempted a clearer definition of...
the affliction to which the term “irritable heart” should apply. The authors decided that this term should describe patients “in whom few or none of the graver symptoms of heart affection can be detected, but in whom there is a complaint of breathlessness, palpitation, giddiness or actual fainting, easy exhaustion, and praecordial pain in varying degrees.” The authors concluded that exercise was the most beneficial therapy.

In 1917, Dr Parkinson left Hampstead and, as an army officer, went to Rouen to take charge of a cardiac unit.

It is interesting to note that in the postwar period, general rather than specialised medicine was the approved pathway for young physicians; specialisation was viewed with some suspicion. During the war years, the London Hospital cardiac department undertook care of the wounded, but Sir James Mackenzie retired before Dr Parkinson had left the armed forces.

Dr Parkinson might have taken over the department if he had been available, but reestablishing the cardiac unit proved difficult when he was appointed assistant physician to the London Hospital. He had no designated cardiac beds, and he was expected to treat general cases. He also was distressed by a lack of progress in research, and he sought support from Sir James in his application to the National Heart Hospital.

Sir James had received a bequest from a Miss Patterson to be spent on cardiac research, and he created the Patterson Research Scholarship, of which Dr Parkinson was the first holder. Sir James suggested that Dr Parkinson carry out research into the action on the heart of digitalis (a drug that Dr Parkinson found to be useless in treating disordered action of the heart) and other drugs. He also suggested that Dr Parkinson should endeavour to elucidate the true nature of heart failure.

Dr Parkinson was a tireless, excellent researcher and practitioner, and he was determined to improve on the diagnosis of heart disease and related cardiac therapies. In an article in the *Lancet* in 1928, Dr Parkinson and Evan Bedford, MD, set out recommended therapies for myocardial infarction and coronary thrombosis, claiming that “morphine is the first essential in treatment, and gr.¼ to gr.½ may be given subcutaneously as often as necessary to reduce or overcome the pain … even if there is vomiting it should not be withheld.” Amylnitrite and trinitrin seemed powerless because they further lowered blood pressure and might induce tachycardia. Drs Parkinson and Bedford recommended digitalis for its ability to reduce the pulse rate and relieve congestive failure. They also recommended complete physical rest in bed for at least 1 month.

Some 5 years later, in his article on the radiology of heart disease, Dr Parkinson extolled the value of modern equipment such as the sphygmomanometer, the electrocardiograph, and the x-ray machine. He wrote, “Such instruments represent the current demand for precision, even at the expense of simplicity. An instrumental method eliminates main fallacies inherent in the personal factor.” He went on to point out how the “electrocardiograph excels in the recognition of abnormal heart rhythms, not to mention certain myocardial defects which nothing else can reveal.”

Dr Parkinson is, however, perhaps best remembered for Wolff–Parkinson–White syndrome (see Figure); with his coauthors, Louis Wolff, MD, and Paul Dudley White, MD, he described a form of bundle branch block with a short P–R interval. Dr Parkinson first met Dr White at one of Sir James’ clinics in 1913. Dr White became professor of medicine at Massachusetts General Hospital, Boston, and later, in 1955, he attended US President Dwight D. Eisenhower when the president suffered a heart attack. Dr Wolff, whom Dr Parkinson met on a visit to America, was chief of the electrocardiographic laboratory at the Beth Israel Medical Center, New York, NY.

The cardiac preexcitation syndrome they described in 1930, in which normal sinoatrial impulses are conducted to the ventricles both by way of the atrioventricular node and by an abnormal pathway, turned out to be fairly common, and a number of similar reports followed. The triple eponym for the condition was adopted almost immediately and has continued to be widely accepted. It is interesting that the relative contributions of the 3 authors are not exactly known, although at least 1 patient had been seen in London, but most of them probably came from Boston, Mass.

Dr Parkinson’s dedication to clinical and research work
in cardiology deservedly won him many honours. Examples include the presidencies of the European Society of Cardiology and of the Association of Physicians of Great Britain and Ireland. He was awarded a knighthood in 1948.

When Sir John died in 1976, a fitting tribute came from his one-time house physician, William Evans, MD, who believed that “Dr Parkinson’s wise leadership in clinical cardiology will be remembered as long as hearts keep beating and an age ahead will rediscover the truths he taught.”

Diana Berry is a medical historian and freelance medical writer.

References
3. Parkinson J. Effort syndrome in soldiers. BMJ. 1941;i:545.

European Meetings Update

May 2007

3–5 May
Annual Meeting of the Norwegian Society of Cardiology
Oslo, Norway
For further information, contact ncs@hjerte.org

4–6 May
Annual meeting of the Working Group on Myocardial Function: “Adverse Cardiac Remodeling: Mechanisms and Repair”
Cracow, Poland
For further information, contact hilfiker.denise@mh-hannover.de

7–9 May
Cardiology and Vascular Medicine: Update and Perspective
Rotterdam, the Netherlands
For further information, contact m.bot@erasmusmc.nl

9–12 May
Annual Scientific Congress of Cardiology of the Hungarian Society of Cardiology
Balatonfüred, Hungary
For further information, contact mkt@axelero.hu

11–13 May
15th Alpe-Adria Cardiology Meeting
Brno, Czech Republic
For further information, contact cks@kardio-cz.cz

17–19 May
IV Congress of Cardiologists and Angiologists
Mostar, Bosnia and Herzegovina
For further information, contact darapovic@yahoo.com

22–25 May
EuroPCR 2007
Barcelona, Spain
For further information, contact europcr@europa-organisation.com

24–26 May
25th Anniversary Meeting of the Slovenian Society of Cardiology
Radenci, Slovenia
For further information, contact sasa.radelj@kclj.si

24–26 May
VI Annual Congress of the Armenian Cardiologists Association
Yerevan, Armenia
For further information, contact niicardio@netsys.am

30 May–2 June
Annual Meeting of the Austrian Society of Cardiology: “Jahrestagung 2007”
Salzburg, Austria
For further information, contact office@atcardio.at

31 May–2 June
Annual Meeting of the Danish Society of Cardiology
Nyborg, Denmark
For further information, contact dcs@daddr.net.dk
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http://circ.ahajournals.org/content/115/16/f73.citation