EDITOR'S PAGE

Congratulations to All of You

The end of June brought a great deal of excitement to those who have worked so hard on this journal. The impact factor that we have been waiting for since the journal began was 5.862, an unheard of initial impact factor for a new medical journal. Even though we frequently assert that the impact factor (the average number of citations per published paper) is only one measure of quality, it was impossible for us not to be proud of this accomplishment. Many people have made this journal what it is today. We owe a great deal of gratitude to the highly professional staff at the American College of Cardiology (ACC) and at the journal office in San Diego, California. We especially thank Elizabeth Wilson of the ACC and Justin Byrne, Glenn Collins, and their staff, who have brought their expertise from JACC seamlessly to JACC: Cardiovascular Interventions and JACC: Cardiovascular Imaging. But, this thank-you note from us, the editors, is for all of you who have given so generously of your time and intellect to review papers and provide not only expert judgment but also enlightened constructive criticism for improving manuscripts. Finally, we thank the authors who have chosen to send outstanding papers to the journal. Without the quality submissions you send, there would be no chance of such extensive citations by others. Are we having fun? Yes, every day, but we had extra fun at the end of June. However, enough about us—on to other things.

I have previously emphasized the international reach of the journal because of its broad source of submissions from around the world. Indeed, interventional cardiology has captured the imagination of not only the so-called developed world but also countries with emerging markets. The use of the term “market” is troubling to me, but, in fact, the incentive to apply these effective high-tech methods gains in strength as economies strengthen. Also, since the application of the core coronary interventions has become stable in the Western countries, the greatest growth for these methods is in developing countries. As interventional cardiologists, we should be proud of the growth of our specialty. It is a good thing that interruption of an evolving ST-segment elevation myocardial infarction can be performed properly in scores of cities in China or that a patient with angina can have his lifestyle improved with multivessel stenting in Malaysia. As exciting as it is to see high-quality interventions applied in places that did not even have catheterization laboratories several years ago, some recent experiences have caused me to wonder if we are not “closing the door after the horse is out of the barn.”

Unfortunately, the growth of cardiovascular interventions is accompanied by the growth of cardiovascular disease in many countries. In Egypt, for the CardioAlex meeting, I learned that not only has there been a political revolution, but also the leading cause of death for some time now has been cardiovascular disease. At a conference of physicians of Indian origin in New York, I learned that India will soon have the largest population of patients with diabetes and cardiovascular disease in the world. These are great “markets” for interventional cardiology, right? Although the proliferation of catheterization laboratories and imaging systems for diagnosing and treating advanced cardiovascular disease is greatly needed and vigorously promoted by industry, and although the training of legions of interventional cardiologists is necessary, is this all we should be doing?

It seems to me that if the worldwide epidemic of cardiovascular disease was instead an epidemic of infectious disease, the approach would be different. Instead of aiming all of the resources at the fully developed disease, the emphasis would be on attacking the cause. A friend’s daughter interested in a career in public health was recently discussing her options with me. We were reflecting on the great success of public health in the extension of life and
on the quality of life. These advances have made infectious disease a minor player in much of the world, but unfortunately not all. On the other hand, cardiovascular disease is becoming the major public health issue in the world. Should it be approached as a public health issue? We are not accustomed to this approach, and we would rather think of the prevention of cardiovascular disease as the responsibility of the individual. Our recent interest in “personalized medicine,” which may become optimal for the individual, may not be adequate for changing the curve of death, disability, and economic disaster facing countries with developing economies. Public health solutions will be necessary.

In some parts of the world, atherothrombotic disease has become a status symbol, but one that the individual and the society can ill-afford. Public health measures to cope with this epidemic will probably be implemented in developing countries, and if successful, may provide lessons for the rest of us. I advised my friend’s daughter. “When you think of public health, think not of infectious disease but think of what can be done for the epidemic of cardiovascular disease.” And, by the way, no group of physicians understands cardiovascular disease and its consequences better than interventional cardiologists. Cardiology would be a great place to start a career in public health.”

Address correspondence to:
Spencer B. King III, MD, MACC
Editor-in-Chief, JACC: Cardiovascular Interventions
Saint Joseph’s Heart and Vascular Institute
5665 Peachtree Dunwoody Road, NE
Atlanta, Georgia 30342
sbking@sjha.org