Who is responsible for the preoperative evaluation of patients who are going to have an extracardiac operation, the cardiologist or the anaesthetist? Recommendation III/ D/ 5/82 of the European Advisory Committee for Medical Training is clear that the boundaries between specialties are not fixed. Consequently the real problem should be medical rather than occupational. In Greece the anaesthetist trains in cardiology for 6 months after which he can obviously not be compared to a fully trained cardiologist, as far as cardiological knowledge is concerned. On the other hand, the cardiologist has no training whatsoever in either anaesthesiology or surgery, thus, to a large degree, ignoring the problems of these specialties. The cardiac risk of the surgical patient during anaesthesia and the surgery itself, must be evaluated both pre- and post-operatively.

The knowledge required for this purpose is exactly the subject covered by the textbook “Anaesthesia and the Cardiac Patient in Extracardiac Surgery” by P.T. Michelakos and J.B. Vasilides (Parisianos Edition, Athens 2001).

This 741 page textbook systematically examines all those cardiological and anaesthesiological aspects that are necessary for the evaluation and management of the surgical patient before, during and after the operation, as far as the circulatory system is concerned. It begins with the anatomy and physiology of the circulation, proceeds to pathophysiology and the clinical and practical aspects of the problems. Both aspects are tackled in this book, written by two authors, one an anaesthesiologist and the other a cardiologist. The book is rich in figures, tables and references and attempts to clarify the most difficult concepts for both the anaesthetist and the cardiologist. The frequent use of algorithms facilitates the practical scope of the textbook. In studying the book the anaesthetist will be informed...
about the anatomy, physiology and pathophysiology of the circulatory system, while the cardiologist will renew his knowledge on this essentially scientific part of his specialty. The discussion about the strain on the cardiovascular system during an operation of which the cardiologist may not be fully aware follows. The fourth part of the textbook is devoted to the important practical aspects of the perioperative management of cardiac diseases during general surgery, a chapter equally useful for both the cardiologist and the anaesthetist. The fifth chapter concerns the anaesthesia of cardiac patients during extracardiac operations. Although the chapter refers to the cardiac patients, the cardiologist will learn, probably for the first time, something about anaesthesiology, the properties of the anaesthesiological agents, as well as how to manage other practical problems, like the perioperative management of patients receiving anticoagulants etc. The last part deals with anaesthesia in vascular surgery, where the risks during the operation originate primarily from the heart and more generally from the circulatory system.

This informative book, enriched with the personal experience of the authors, is clearly written and easy to read. I am certain it will prove very useful to trainees, cardiologists, anaesthetists, surgeons and physicians dealing with intensive care.
The incidence of cardiac morbidity after surgery depends on the definition, which ranges from elevated cardiac biomarkers alone to the more classic definition with other signs of ischemia (37–39). In a study of 15,133 patients who were >50 years of age and had noncardiac surgery requiring an overnight admission, an isolated peak troponin T value of ≥0.02 ng/mL occurred in 11.6% of patients. The 30-day mortality rate in this cohort with elevated troponin T values was 1.9% (95% confidence interval [CI]: 1.7% to 2.1%) (40). See Online Data Supplements 1 and 2 for additional information on CAD and the influence of age and sex. An extensive consideration of CAD in the context of noncardiac surgery, including assessment for ischemia and other aspects, follows later in this document. In patients with cardiovascular disease, regional anesthesia techniques (either alone or in conjunction with general anesthesia) can offer the potential perioperative benefits of stress response attenuation, cardiac sympathectomy, earlier extubation, shorter hospital stay, and intense postoperative analgesia. However, the decision to utilize regional anesthesia should be made with caution in some circumstances. Patient characteristics, the type of surgery proposed, and the potential anesthetic risks will all have an impact on anesthetic choice and perioperative management. High thoracic epidural anesthesia (TEA) from T1–T5 blocks the cardiac afferent and efferent