interventions, much simpler in the periphery than in coronary arteries. The most difficult aspect, one that is paramount to delivering good patient care, is gaining expertise in the discipline of vascular medicine. We advocate continued medical education, attendance at vascular conferences, and the involvement of experienced vascular surgeons and interventionalists in the care and assessment of peripheral vascular patients.

Lavin, a radiologist, notes the issue of "politics and money" as a deterrent for the technology currently being waged by radiologists across the country over who should perform these procedures, rather than being concerned with providing the best care for the patient. Our conviction is that patients are better served when a physician or team of physicians (cardiologists, vascular interventionalists, and surgeons) committed to uniforming and managing peripheral vascular disease view the patient as a whole and make treatment choices based on clinical information as opposed to institution performing procedures in a clinical vacuum.

Lavin's suggestion that radiologists could perform diagnostic coronary angiography is very illustrative. The pioneers of cardiac catheterization and angiography were radiologists, and they don't perform these procedures today. That a radiologist have the technical skills necessary to perform coronary angiography is not the point. Radiologists lack the clinical skills necessary to appropriately select patients for a procedure, narrow the complications that may occur during a procedure, and integrate the anatomic and functional data obtained from catheterization so as to choose the most appropriate medical, percutaneous or surgical therapy for the patient. As a cult of clinicians interventionists from a variety of subspecialty backgrounds becomes available to care for patients with peripheral vascular disease, one must seriously question the future role of noninterventional interventionists performing these potentially dangerous procedures in patients whose lesion severity is limited primarily by coronary artery disease.

REFERENCES

1. Spodick DH. Normal sinus rhythm should define a normal rate of 40 to 100 beats/min, instead of 60 to 100 beats/min. This small change in the rate range may be more descriptive, statistically more normal (in the particular sample under the specific conditions of their study), it is not germane to the nonintervention of sinus rhythm published by the Committee of the New York Heart Association, since it has not been the intention of this publication to define precisely the normal rate of sinus rhythm. Spodick claims that the New York Heart Association definition of normal sinus rhythm has led to inappropriate patient management. There is no evidence to support this assertion.

The adjective "normal" in normal sinus rhythm is clearly ambiguous, since it does not mean normal in the literal sense. Actually, the first 3 editions of the Criteria Committee of the New York Heart Association (1972, 1980 and 1982) listed rates of 60 to 100 beats/min as normal sinus rhythms. Normal sinus rhythm was introduced in the fourth edition (1984) and has been retained in all subsequent editions. Perhaps it would be best to omit the word "normal," "tachycardia," and "bradycardia," as modifiers of sinus rhythm and use a single electrocardiographic readout: "sine rhythm -- rate specified."

REFERENCES

1. Spodick DH. Normal sinus rhythm should define a normal rate of 40 to 100 beats/min, instead of 60 to 100 beats/min. The American Journal of Cardiology 58: 1060, 1986.

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