failure or pulmonary oedema (probably due to, or favoured by the occurrence of atrial arrhythmia), we thought it unethical to administer a placebo treatment to these patients. Patients with decompensated heart disease and for whom conversion may be crucial, are probably more resistant to spontaneous or chemically induced sinus conversion. Such patients are almost systematically excluded from clinical studies, notably those which randomly assign patients to effective therapy or placebo\(^{[23]}\). In these latter studies, rates of spontaneous conversion to sinus rhythm were 48% within 8 h\(^{[0]}\), and 44% within 18 h\(^{[0]}\), respectively. Because the mean delay to spontaneous sinus conversion has been found to range from 3-3 h\(^{[5]}\) to 3-9 h\(^{[0]}\), late conversions are unlikely to occur frequently, and the rate for spontaneous conversion within 24 h is thus, at best, 15% lower than that observed in our report (64-4%). In addition, we are aware of no study showing spontaneous conversion rates as high as 60% at 24 h. Neither Borgeat et al.\(^{[5]}\) nor Pilati et al.\(^{[5]}\) could report such rates, since they used a quinidine-controlled group but no placebo-controlled group. Similarly, most of the studies mentioned in our report (references 3-12, 14, 16) used no placebo-controlled group. This is the second reason why we stated that a placebo group was not thought essential to evaluate the efficacy of this high-loading oral amiodarone regimen. Efficacy of such a regimen, whether it was considered excellent, good or poor, can be most easily evaluated by every physician, according to his or her personal judgement and clinical experience. Our results are what they are, but we cannot agree with the assumption that they are completely unreliable and totally inconclusive.

(5) The fact the i.v. amiodarone gives a conversion rate similar to that observed with placebo at 8 h\(^{[0]}\) does not imply that amiodarone is not of therapeutic value in atrial tachyarrhythmias; indeed, the placebo group was not followed beyond this delay of 8 h in this study (was sinus rhythm always maintained at 24 h?), and amiodarone produced a conversion rate of 89% at 24 h, no different from that observed with flecainide (95%). Besides, the fact that sinus conversion of patients, hospitalized for atrial arrhythmia but otherwise healthy\(^{[0]}\), could occur a few hours sooner or later with such and such antiarrhythmic agent seems to us as a minor point of interest.

(6) We apologize for having omitted to mention the studies from Dr Capucci’s group. The purpose of this clinical study was not to offer an exhaustive review on the pharmacological treatment of atrial tachyarrhythmias, but was limited to evaluating efficacy and safety of a widely used but still incompletely described therapy.

In summary, controlled studies in the field of pharmacological management of atrial arrhythmias, although methodologically desirable, are not always feasible for various ethical reasons. Provided limitations of uncontrolled studies are properly underlined, there is still a place for such reports which can help to shed light on unresolved issues, while awaiting confirmation with wider-scale randomized protocols.

Heart disease and mortality in a Mediterranean population

In their paper, Tomás-Abadal et al.\(^{[1]}\) found a low incidence of ischaemic heart disease in a Mediterranean population in spite of a high frequency of smoking and relatively high cholesterol levels. This fact had already been noted by Keys et al. in 1954\(^{[22]}\) while conducting a study in the population of Madrid where they found similar cholesterol values in subjects of high socio-economic groups. The surprising element in this and Keys’ work is that in spite of having similar cholesterol levels to those found in the Minnesota population but higher smoking levels, the incidence of ischaemic heart diseases (IHD) remains low. The situation is not restricted to Spain, since a similar phenomenon exists in France known as the ‘French paradox’\(^{[23]}\), and in Greece, another country with very low incidence of IHD, but with very high tobacco consumption.

In the study by Gey et al.\(^{[6]}\), France and Spain systematically behaved as outliers when a regression of IHD against cholesterol blood levels was made. The association became negative and the distance to the regression line decreased when the incidence of IHD was related to retinol consumption, and disappeared when

References

the regression was carried out against vitamin E. These facts lead one to think that not only are risk factors important, but that there must also be some protection in certain Mediterranean diets. Stampfer et al.\(^6\) demonstrated that vitamin E protects women against IHD development only when it is taken as a supplement, but consumption of vitamin E by the Spanish population is five times higher than that in American patients.\(^6\) The antioxidant hypothesis here reaches distinctive relevance since consumption of fruit, fresh and lightly cooked vegetables is common in Mediterranean diets and is a significant source of both vitamins A and E as well as other antioxidants such as carotenoids, tocopherol and phenol compounds. The antioxidant effect of these substances can be potentiated with the consumption of oleic acid, more resistant to oxidation than other fatty acids with higher unsaturation levels and thus more vulnerable to oxidizing stress. We believe that the study of Tomas-Abadal et al.\(^6\) increases the strength of the evidence for the protection of factors as regards the development of IHD in the Mediterranean diet. Until more attractive hypotheses become available, LDL oxidizing protection through a high consumption of natural antioxidants and oleic acids offers a reasonable explanation and warrants further investigation in the causative chain of this disease.\(^6\)

F. RUIZ-REJÓN
G. MARTÍN-PESA
J. PERIANES-MATESANZ
E. CANALEJO-CASTRILLERO
J. RUIZ-GALIANA

Sección de Cardiología y Unidad de Nutrición
Servicio de Medicina Interna
Hospital de Móstoles
Madrid
Spain

References


Clinical electrocardiography

In 1987 Antonio Bayés de Luna published A Textbook of Clinical Electrocardiography\(^1\) (Martinus Nijhoff Publishers, Dordrecht, The Netherlands). His new book, Clinical Electrocardiography: A Textbook should not be regarded as an update of the former. It is a totally new book which, for the most part, is devoted to the clinical 12-lead electrocardiogram. A considerable number of pages deal with the fundamentals of electrocardiography and with the genesis and features of the normal PQRST tracing. Each chapter related to the abnormal electrocardiogram first introduces the reader to the most simple electrocardiographic features of a given cardiac pathology and then, in a stepwise, intelligent, and most didactic manner, conducts him/her to more detailed and specific information on the electric manifestations of the cardiac disease.

This book also contains a chapter on electrocardiologic techniques other than the 12-lead ECG (vectocardiography, Holter monitoring, exercise testing, wave averaging, recording of late potentials, intracavitary electrophysiology, etc.). It ends with a chapter on the clinical value of the electrocardiogram. These pages should be read with attention by anyone who has an interest in clinical cardiology.

Antonio Bayés de Luna is a gifted, learned and enthusiastic teacher. His text, although complete and accurate, has none of the dryness of most medical textbooks. It has a colloquial flavour which makes it very easy and pleasant to read. The book will be of value for many different categories of readers: medical students, general practitioners, doctors in training in internal medicine, cardiology, anaesthesiology, emergency medicine, etc. Those who have no prior knowledge of electrocardiography will, after a thorough reading, be able to use the technique with ability. Those who already know the method will learn to use it in a more appropriate manner and to derive from this simple, inexpensive investigational technique a great deal of information that is often sought for by the use of more sophisticated and expensive exploratory systems.

H. KULBERTUS

Centre Hospitalier Universitaire de Liége

Liége
Belgium