Suggestions to improve the quality of life in heart failure

We read with interest the study by Hobbs et al. on ‘Impact of heart failure and left ventricular systolic dysfunction on quality of life’. The authors point out that given the poor prognosis of heart failure, quality of life should be a much more important target for management and suggest that enhanced use of ACE inhibitors and β-blockers might improve quality of life; besides, treatment with positively inotropic phosphodiesterase may also be a supplement to the above target, but at the expense of increased mortality. Unfortunately, mention about the use of digoxin which has enjoyed the mainstay for more than two millennia has not been considered. Heart failure is the most expensive medical cause of hospitalization with readmission rate as high as 50% over 3 months. Since the aim of the authors is to improve the quality of life, combination of digoxin with diuretics will serve this purpose by improving the symptoms and decreasing hospitalization despite the absence of any significant effect on mortality.

Chronic heart failure and atrial fibrillation are common and they commonly co-exist. The role of digoxin in these conditions has not been challenged. Even in sinus rhythm, a reasonable approach is to use digoxin in those who remain symptomatic despite diuretic and ACE inhibitor treatment.

Though the authors’ conclusion is that ACE inhibitors significantly reduce progression to clinical heart failure, even with ACE inhibitor therapy, prognosis in heart failure remains grim. In young patients with symptomatic heart failure on ACE inhibitor therapy, 69% of the survived (35% mortality) warranted hospitalized within a span of 3.5 years. Effective new therapies are still desperately needed. Therefore, we feel that exploring the possibility of primary prevention of heart failure could be better targeted. While ischaemic heart disease is the underlying cause in approximately 70% of all newly diagnosed heart failure patients, we suggest that measures to prevent atherosclerotic disease, plaque rupture and thrombosis must be undertaken. Additionally, administration of low dose aspirin as a measure of secondary prevention should be considered.

Concomitant pulmonary infection can also exacerbate or precipitate heart failure. Immunization against influenza annually and Pneumococci once may prevent heart failure and reduce hospitalization.

It is also worth mentioning that carnitine, a neutracelestial has recently been shown to improve cardiac function and quality of life in patients with heart failure. If this finding is substantiated, it may have a role in the future management of heart failure.

References

M. Thulasimani
Department of Medicine
Community Health Centre
Pondicherry 605 501
Mannadipet
India

S. Ramaswamy
Department of Pharmacology
Jawaharlal Institute of Postgraduate Medical Education and Research
605 006 Pondicherry
India

Should we ENACT laws against gambling in RENO?

I enjoyed reading the two back-to-back reports by the investigators on behalf of the RENO1 and ENACT2 registries. However, I was rather disappointed at the lack of explanation of these two acronyms in both articles.

According to the International Committee of Medical Journal Editors, to which your journal belongs, every acronym should be defined when first used. What perplexed me was the fact that the authors defined every other abbreviations in their texts, e.g., ACS, CABG, MACE, PCI, RCT, STEMI, VBT, etc. Perhaps it was just an inadvertent oversight on the part of the authors. Or, did they consider these ‘trade terms’ so well-known that they did not bother to define them? I suggest that you take a poll from your readers to see what percentage did not know.

In order to prevent your office from being flooded with angry letters of protest and your frustrated readers from spending hours in guessing what these two acronyms could possibly mean – like gambling, I would like to come to your rescue. As explained in an updated article on acronyms of cardiologic trials,4 RENO stands for REGistry with NOvoste beta-cath® system, and ENACT stands for European Network for Acute Coronary Treatment.

References

Tsung O. Cheng
George Washington University
Medical Center
Washington DC
USA

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Cardiovascular risk factors in women

The study of coronary atherogenic risk factors and their consequences in women

* Correspondence to: Dr M. Thulasimani, Department of Medicine, Community Health Centre, Department of Medicine, Mannadipet, Pondicherry 605 501, India. Fax: +91 413 2272067
E-mail address: prakram@md4.vsnl.net.in (M. Thulasimani).

* Correspondence to: Prof. T. O. Cheng, George Washington University, Department of Medicine, 2150 Pennsylvania Avenue, Washington, DC 20037, USA. Tel: +1 202 741 2426; fax: +1 202 741 2324
E-mail address: tcheng@mfa.gwu.edu (T.O. Cheng).

* Correspondence to: Prof. Dr H. Kesteloot, Department of Epidemiology, K.U. Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium. Tel: +32 16 336894; Fax: +32 16 336884
E-mail address: Hugo.Kesteloot@med.kuleuven.ac.be (H. Kesteloot).