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 mainstream for more than two millennium 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 coexist. 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 hospitalization 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 under-

References
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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,3 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, STEMl, 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

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Cardiovascular risk factors in women

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