Letters to the Editor

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Revascularization for everyone?

I read with interest Chris Cannon’s editorial on revascularization in the setting of acute coronary syndrome.1 I was disappointed that Dr Cannon failed to mention that in two of the three major studies of early invasive vs. conservative management for acute coronary syndrome, women not only showed no benefit, but had higher risk of mortality with the early invasive arm. In both FRISC-II2 and RITA-3,4 women in all risk categories had higher risk of mortality with the early invasive vs. conservative management. In both FRISC-II and RITA-3 trials, women not only showed no benefit, but had higher risk of mortality with the early invasive arm. In both FRISC-II and RITA-3,4 women in all risk categories were more likely to die if they underwent early invasive therapy for acute coronary syndrome. It is only in TACTICS-TIMI 18 that women at high risk (elevated troponin T) showed a benefit with early invasive therapy.5 Gender differences in results in acute coronary syndrome have also been shown in the use of glycoprotein IIb/IIIa inhibitors.6 Again, while men show a mortality benefit with use of glycoprotein IIb/IIIa inhibitors, women, in a large meta-analysis of over 30,000 patients from six major trials, show a 15% increase in the primary endpoint, death or myocardial infarction, when treated with the glycoprotein IIb/IIIa inhibitors for acute coronary syndrome.7 It was only in the high-risk category (increased troponin) that women showed a non-significant trend towards benefit, with use of glycoprotein IIb/IIIa agents. It is important to consider results for treatment of acute coronary syndromes in men and women separately, as the risks and benefits differ. It is essential to better understand the pathophysiology in both sexes, so that we can optimally treat every patient with acute coronary syndrome.

References


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Revascularization for everyone?: reply

What Dr Redberg points out is a great area of debate—are there gender differences, over and above risk categories (i.e. by troponin status) that make outcomes different in women? In this acute coronary syndrome (ACS) population, we have differing results as she outlines, but the unifying feature of the studies is that when applying risk stratification, the higher-risk patients (male or female) benefit from the more aggressive therapies (in this case an invasive strategy, or GP IIb/IIIa inhibition). I personally do not use gender to withhold cardiac catheterization or antiplatelet therapy for patients, but I do base my treatment decisions on the patient’s risk—using troponin, the ECG and the overall risk profile. Further research into this topic will certainly be very helpful in sorting this out. For now though, I focus on risk stratification to select therapies for ACS.1

References


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Quality of life in patients with preserved and depressed left ventricular function

Until recently, heart failure (HF) with preserved left ventricular function (PVF) seemed to be an underestimated problem. In the first instance it was assumed that morbidity and mortality among HF patients with PLVF was less serious compared with that among patients with a depressed left ventricular function. Recent insight, however suggests that the picture is more grim than assumed.1 Yet little is known about the quality of life (QoL) of patients with diastolic HF, therefore Lenzen et al. should be commended for addressing this important topic.

The authors described a low QoL in 29% of patients with left ventricular systolic dysfunction (LVSD) and in 23% of patients with PLVF. They also found a difference in QoL between the two groups, suggesting that fewer patients with diastolic HF have a low QoL and therefore experience less impact of their HF on QoL.1 This is the first time such differences in QoL between patients with a preserved and depressed systolic function have been described. From previous research2,3 and our study4 it is known that not only patients with a depressed left ventricular function have impaired QoL but that the QoL of patients with a preserved left ventricle is as bad.

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