Alike the metabolic syndrome, hypertension is more than just increased blood pressure.

I strongly believe that the primary objective of the metabolic syndrome criteria, advocated by the National Cholesterol Education Program’s Adult Treatment Panel III report (NCEP-ATPIII), is indeed to draw the attention of physicians, mainly cardiologists and other specialists who are bound up with the universal problems of the metabolic and cardiovascular complications generated by obesity, hyperglycaemia, dyslipidaemia, and frank diabetes, as all these are present in the insulin resistance syndrome. In their editorial, Sattar and Forouhi stated clearly that specialists must give thoroughgoing assistance to their patients. In the case of hypertensive patients, the disease should not be seen just as a condition that has increased levels of blood pressure, but it also happens, most of the time, with metabolic changes (the metabolic syndrome criteria), as well as vascular and left ventricular hypertrophy. As they wrote, neither the National Cholesterol Program (NCEP-ATPIII) nor the World Health Organization metabolic syndrome criteria can be better predictors of cardiovascular risk than the Framingham score. However, when those are present, physicians get to have different view about the problem because they know the evolution and consequently the least appropriate prognostic.

The results of simple tests, such as glycaemia, high density lipoprotein cholesterol, triglyceride, and waist circumference, can aid the physician who assists such patient for both the insulin resistance and their complications, more than a table filled in for estimating the risk within the following decade. These conclusions can improve the doctor–patient relationship, the treatment, and obviously its progress, which are the aims at the clinical practice.

Reference


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do:10.1093/eurheartj/eht787

Psychological distress and cardiovascular disease

With interest, we read the article by Ferketich and Binkley in which they examined psychological distress; depressive symptoms, and anxiety are among individuals with heart disease. Psychological distress was measured with an uncomplicated six-item questionnaire that was developed for this study. The results showed that the greatest proportion of psychological distress (10%) was estimated among participants with self-reported chronic heart failure (CHF). Self-reported CHF was associated with three-fold increased odds of having psychological distress. The authors also state that perhaps most alarming is the very low number of patients who saw a mental health professional within the past year, which was only 35%, even in those heart failure (HF) patients with psychological distress.

We feel that these data are important as they support earlier data² that have shown that this problem is underestimated and undertreated in HF patients. We would like to confirm and elaborate on this finding. We recently completed baseline data of 1050 elderly hospitalized patients with a confirmed diagnosis of HF.³ Mean age of the sample was 72 years and 40% was female. When compared with Ferketich and Binkley,¹ we used a more extensive tool to measure depressive symptoms in CHF patients: the Center for Epidemiological Studies Depression Scale (CES-D).³,4 A cut-off value of 16 was used to define patients at risk for clinical depression. Almost 40% of the participants reported depressive symptoms. Not more than 8% of these 388 HF patients with depressive symptoms had anti-depressive medication described at discharge from the hospital.

In his editorial, Belardinelli recommends that clinicians make screening for psychological distress a routine evaluation of the patient with cardiovascular disease. The screening should be used as a means to alert the clinician that the patient may have need for psychological care and serve as a basis for referral to mental health professionals. We agree with Belardinelli and Ferketich to adjust more attention to psychosocial problems and find appropriate strategies to help patients deal with distress after cardiac disease.⁶

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