Their response is biventricular pacing or cardiac resynchrony and its relation to outcome after editorial on the question of detecting dysynchrony: global or regional function? 1 The costs, unlike medical therapy that can be stopped at any time removing any further risks and saving money. Thus, for a device therapy identifying patients who will not respond is vitally important. Dismissing all echocardiographic techniques that appear to do this because they were not part of the inclusion criteria in the major clinical trials is pedantic. Many studies have shown that the degree of mechanical dysynchrony by Doppler-echocardiography is related to the success of CRT whether that is assessed by symptoms or the degree of reverse remodelling. 2 Remodelling is a major process in heart failure and all treatments that have been shown to reduce mortality and improve quality of life prevent or reduce remodelling. 3 And, after CRT, Yu et al.4 have shown that reverse remodelling (a reduction of end-systolic volume of 10%) predicts long-term survival. It is true that a number of indices of dysynchrony have been proposed but in a thorough analysis of regional functional indices. Yu et al. have shown that those based on a 12-segment model appear to be most reliable.5 Using a global functional measurement, Duncan et al.6 were able to gain good separation of responders from non-responders defined by clinical criteria (not volumes alone).7 As suggested in my editorial, a combination of both regional and global indices would probably be the best.1 Obviously, these new methods for selection need to be tested in larger trials, which was also stated in the editorial. In particular, we need to know if CRT can produce benefit in those who do not have mechanical dysynchrony despite a widened QRS (which occurs in 30%),6 or in those with a normal QRS duration and dysynchrony who have been excluded from previous trials. After all, the QRS duration criteria are just a historical accident because it was the only available measure of abnormal activation at the time. Finally, no one is against guidelines but they are just that, guidelines; they are not immutable. They can change quickly with new information and progress is often made when guidelines are challenged. The history of medicine is littered with examples of erroneous guidelines.

References


John E. Sanderson  
Department of Cardiology  
University Hospital of North Staffordshire  
Keele University School of Medicine  
Stoke-on-Trent ST4 6QG  
UK  
E-mail address:  
John.Sanderson@uhns.nhs.uk  
doi:10.1093/eurheartj/ehl408  
Online publish-ahead-of-print 24 November 2006