LETTERS TO THE EDITOR

The British Heart Journal welcomes letters
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within the past six months.

All letters must be typed with double
spacing and signed by all authors.

No letter should be more than
600 words.

In general, no letter should contain more
than six references (also typed with double
spacing).

Asymptomatic ischaemia during daily life in
stable coronary artery disease: relevant or
redundant

SIR,—In their interesting review on the
prognostic implications of silent myocardial
ischaemia1 Mulcahy et al, referring to our
paper on silent ischaemia after myocardial
infarction,2 wrote: "Silolaine et al performed
ambulatory ST segment monitoring in 40
patients eight weeks after a first myocardial
infarction and followed them for two
years. Six patients had asymptomatic
ischaemia during ambulatory monitoring.
No events occurred in them: there was
one cardiac death in a patient without
ischaemia." There was some misinterpreta-
tion of our data. In fact, our investigation
showed that 11 (27.5%) out of 40 patients
had silent ischaemia after infarction: five
only on exercise testing, five on exercise
testing and Holter monitoring, and one on
Holter monitoring. Of those 11 patients,
four (36%) had a non-fatal cardiac event
whereas only one (3.6%) of 29 patients
without silent ischaemia had a cardiac event
(fatal reinfarction) during this two year fol-
low up. Kaplan-Meier analysis showed that
during this period patients without silent
ischaemia were much less likely to experience
a cardiac event than patients with
ischaemia (62.3%) (P < 0.007). We
concluded that silent myocardial ischaemia
after myocardial infarction is of considerable
prognostic significance—a somewhat
different conclusion from that reached by
Mulcahy et al.

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1 Mulcahy D, Purcell H, Patel D, Fox K. Asymptomatic ischaemia during daily life in
stable coronary disease: relevant or redun-
2 Solimene MC, Kamires JAF, Gruppi CJ et al. Prognostic significance of silent myocardial
ischaemia during ambulatory monitoring in

This letter was shown to the authors, who reply as follows:

SIR—Thank Dr Solimene for her letter.
Our review was about the prognostic signifi-
cance of transient myocardial ischaemia
detected on ambulatory ST segment moni-
toring and not exercise testing or any other
investigation. In her letter Solimene con-
firms the figure noted, in six patients with
transient ischaemia on ambulatory monitoring
after myocardial infarction.

In their study of 40 patients Solimene et al related silent ischaemia after myocardial
infarction during ambulatory monitoring (that is, exercise testing, n = 10; ambulatory
monitoring, n = 6; one or the other, n = 11) to events, and not to a straight assessment
of ambulatory ischaemia as such. Outcome.
Only one "hard" coronary event (acute
myocardial infarction or sudden coronary
death) was reported by Solimene et al (car-
diac death), and this occurred in a patient
who did not have transient ischaemia on ST
segment monitoring. We reported this in
our review which focused on the relation
between transient ischaemia and subse-
quent death or non-fatal myocardial infarc-
tion. Recurrence of angina (referred to as
a non-fatal cardiac event by Solimene et al)
was reported to occur in four patients with
silent ischaemia during exercise testing or
ambulatory monitoring—Solimene et al do
not state which. To reply to Solimene's let-
ter in the context of our review, and to
establish whether "soft" end points occurred
in those with transient ischaemia during daily
life, we would need to know how many of
these four recurrences of angina occurred in
those with only a posi-
tive exercise test and
whether anything
further happened to them.

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Issues in cardiac pacing: can asigm be justified?

SIR,—The continuing debate surrounding
the cost effectiveness of rate adaptive pacing
in the elderly remains, handicapped by a
lack of reliable data.1 The antagonists would
point to the absence of hard clinical evi-
dence to support the use of sophisticated
pacing technology in the elderly. Recent
trends, however, which specifically included
elderly subjects, have confirmed the
clinical impression that the elderly stand
to gain as much from physiological pacing
as younger patients.2 4 However, the biggest
stick with which to beat the enthusiasts is
that of cost. In a retrospective analysis, de
Belder et al estimated that implantation of
dual chamber pacemakers in all suitable
patients (that is, those with advanced
ventricular block and sinus rhythm) aged
over 75 years would have added an extra
£264 357 to the regional pacing budget (an
increase of 57%)4 quoted in figures it is little
wonder that there is some reluctance
to implement the BPEG guidelines in the
elderly.6 It is important to realise, however,
that these figures were based on the
assumption that all electrophysiologically
suitable patients aged over 75 would have
been given DDD pacemakers.

Patients aged over 75 years may con-
stitute a selected group in whom the
presence of advanced conduction disease
may be a marker of an advanced aging
process. Limiting, non-cardiac disease or
cognitive impairment for example, pre-
vious stroke—is not uncommon in this
group and such patients would not normally
be considered for a dual chamber system.
We do not know how many of these patients
are offered VVI systems on the
grounds of limiting, non-cardiac disease or
cognitive impairment. Nevertheless, it is
clear that available estimates of the financial
impact of the BPEG guidelines are likely to be
exaggerated and serve only to foster
inappropriate implantation policies.

In addition to further clinical trials, which
are likely to confirm the overall bene-
fits of physiological pacing in the elderly,
we need reliable information on the costs of
implementing these research findings.

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ing: can asigm be justified? Br Heart J 1994;
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Arrhythmia, Sup Heart J 1998;20:35-44.
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5 de Belder MA, Linker NJ, Jones S, Camm AJ,
Ward DE. Cost implications of the British
Pacing and Electrophysiology Group's
recommendations for pacing. Br Heart J
6 British Pacing and Electrophysiology Group.
Recommendations for pacemaker pro-
scription for symptomatic bradycardia.

The British Pacing and Electrophysiology
Group Guidelines on pacemaker group
prescrip-
tion, published in 1991, have generated much
controversy. It is clear that universal implen-
tation of the BPEG guidelines will be very
expensive. We need to know whether this
expense is justified in terms of longevity, quality
of life, reduction in stroke and effect on heart
failure. We cannot know until we have the
results of planned trials. Let us have a moratu-
mium until then.—EDITOR

Detection of left ventricular dysfunction after
myocardial infarction: comparison of clinical,
echocardiographic, and neurohormonal methods.

SIR—A major limitation of the Peal index,
even in its modified form1 is that it does not
take into account the adverse prognostic
significance of the association between
depression and ST segment depression.
In thrombolytic trials such patients con-
tinue to have a high mortality despite
treatment.2—3 not only because ST segment
depression is an independent predictor of
poor prognosis1 but also because it some-
times signifies structural damage caused
by previous myocardial infarction.3

Furthermore, even when patients with ST
segment depression prove to have smaller
infarcts than their counterparts with ST
deficit elevation, they still have more
severe impairment of left ventricular systolic
function.4 These patients should, therefore,
Asymptomatic ischaemia during daily life in stable coronary artery disease: relevant or redundant

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