LETTERS TO THE EDITOR

Scope
Heart welcomes letters commenting on papers published in the journal in the previous six months. Topics not related to papers published earlier in the journal may be introduced as a letter: letters reporting original data may be sent for peer review.

Presentation
Letters should be:
- initially submitted by fax
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(where practicable). Always follow this up by posting the paper copy to us.
- not more than 600 words and six references in length
- typed in double spacing (fax copies and paper copy only)
- all letters can be printed with authors' names and institutions unless they state otherwise. They may contain short tables or a small figure.

Squatting revisited: comparison of haemodynamic responses in normal individuals and heart transplant recipients

Sir—We read with interest the investigation by Hanson et al into the haemodynamic effects of squatting after heart transplantation and were impressed with the elegant demonstration that the effects of a squat on blood pressure and stroke volume are similar in heart transplant recipients and in normal subjects.

We are surprised that Hanson et al consider the transplanted heart to be denervated at a mean of 16 months after operation. There is clear evidence that at least sympathetic reinnervation of the denervated heart occurs. Using injection of tyramine we and others showed sympathetic efferent reinnervation.1 We and others have failed to demonstrate parasympathetic reinnervation using autonomic function testing2 and intraoperative injection of contrast.3 Hanson et al conclude that the differences between normal control recipients and transplant recipients are due to denervation. While this may be true, there are alternative explanations for their findings. Cardiac transplant recipients are survivors of cardiac failure, and the absence of bradycardia in response to hypertension may be partly explained by persisting reduced central baroreflex sensitivity. The response of forearm vascular resistance in the transplant recipients is consistent with this. Thus the absence of bradycardia cannot be taken as evidence of vagal denervation.

The small increase in heart rate of the transplant recipients is also consistent with sympathetic reinnervation in the absence of parasympathetic innervation, and this increase is enhanced by the effort of squatting, in a similar manner to the effect of sustained handgrip, rather than by a volume reflex. Most cardiac sensory nerves lie in the atria, and thus a significant number remain in the recipient atrial cuff. It cannot therefore be concluded that any effect of atrial volume change on heart rate is direct.

We would also like to point out that this manoeuvre might be an excellent non-invasive measure of sino-aortic baroreflex sensitivity, because of the rapid change observed in systolic blood pressure, akin to that observed after the strain phase of Valsalva manoeuvre.4 We suggest that the haemodynamic effects of squatting provide opportunities for the investigation of baroreflexes in other groups of subjects, and may also be useful in measuring reinnervation after cardiac transplantation. All investigations of reflexes in cardiac transplant recipients should take the possibility of reinnervation into account.

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Serum lipids four weeks after acute myocardial infarction are a valid basis for lipid lowering intervention in patients receiving thrombolyis

Sir,—Carlsson et al suggested that serum lipids should be measured 4 weeks after acute myocardial infarction. This is largely because of the high risk of recurrent thrombosis because there were no significant differences between these values and those obtained within 24 hours of onset of symptoms.1 This may in fact not be valid if data are obtained after a long period of time, taken after and not before thrombolysis, because thrombolysis itself may be associated with a small but significant fall in total cholesterol1 and concentrations may not return to baseline values until several months later.2 The danger of course is that some patients with spuriously low concentrations may be overlooked. Given that the 45 study clearly supports active intervention for secondary prevention,3 each hospital should identify their best local practice of targeting patients for intervention. The previously recommended threshold of serum lipids for lipid measurement when intravenous access is secured for thrombolysis is easily applied, yields accurate baseline results, and helps to ensure that no patient with hypercholesterolaemia is missed.

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This letter was shown to the authors, one of whom replies as follows:

Sir,—Dr Bennie refers to a study from Chua et al including 26 male patients. Chua et al reported a 0-4 mmol/l fall in serum cholesterol concentration from a pre-streptokinase treatment concentration of 7-0 mmol/l. The conclusion that serum cholesterol concentrations may be underestimated when they are measured after streptokinase treatment may not be true. Although the clinical importance of this underestimation of the lipid concentration is of less importance than the time lost when patients wait 3-6 months before start-
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