Hypertension treatment is an essential element in primary prevention of cardiovascular disease (CVD). Despite recent guidelines recommending medical therapy at a lower systolic blood pressure (SBP) threshold, these recommendations remain controversial in the elderly because the balance of safety and efficacy is less clear than in younger adults. In this issue of Heart, Jung and colleagues 1 used data from the Korean National Insurance sample, including about 420 thousand participants with no prior history of hypertension or CVD, to examine the relationship between a SBP of 130–139 mm Hg and CVD mortality in three age groups: 40–59 years, 60–69 years and 70–80 years. In all age groups, there was a positive graded association between SBP and CVD over 10 years of follow-up (figure 1). Each 20 mm Hg elevation in SBP was associated with 1.67-fold (95% CI 1.57 to 1.78) elevated risk for overall CVD mortality in those aged 40–59 years, 1.40-fold increase (95% CI 1.33 to 1.48) in those aged 60–69 years and 1.22-fold increase (95% CI 1.16 to 1.29) in those aged 70–80 years.

In the accompanying editorial, Pinho-Gomes and Rahimi 2 discuss the potential limitations of this study and point out that: “harms may outweigh benefits in the elderly or those with multimorbidity, due to higher rates of adverse events and/or because the expected benefit from continuing a preventive medicine is reduced when there is limited life expectancy or high risk of death from competing diseases.” They conclude that “the population-based study by Jung et al 1 provides reassurance about an overall positive association between BP and CVD risk in the elderly in a non-Western population. It further highlights the need for more reliable evidence from randomised trials to assess the balance of safety and efficacy of antihypertensive treatment in elderly patients, in particular when BP is not very high and in the presence of comorbidities. Until such evidence becomes available, ‘clinical judgement’ with its inherent limitations will remain the best standard that guidelines can recommend.”

There is a well-known increased risk of ventricular arrhythmias and sudden cardiac death in adults with mitral valve prolapse (MVP) possibly related to focal or diffuse myocardial fibrosis. Speckle-tracking echocardiography (STE) allows noninvasive measurement of the pattern of ventricular contraction with a heterogeneous pattern defined as ‘myocardial dispersion’. Ermakov and colleagues 3 performed a detailed STE study of 32 patients with MVP and complex ventricular ectopy (A-MVP) compared with 27 patients with MVP but no arrhythmic complications (NA-MVP). Despite similar left ventricular ejection fractions and mitral regurgitation severity, there was greater mechanical dispersion in the A-MVP group compared with the NA-MVP group (52 vs 42 ms, P=0.003) (figure 2).

Marra and Basso 4 conclude: “The current atrial fibrillation risk stratification of patients with MVP identified by 2D echocardiography include a 12-lead ECG and 24-hours ECG Holter monitoring, but the selection of those patients to address to more invasive and expensive tools such as CMR and electrophysiological study remains to be fully defined.”

A study based on the nationwide Danish registers from 2005 to 2014 suggests that peri-partum cardiomyopathy (PPCM) may be familial. 5 The prevalence of heart failure in first-degree relatives of 48 women with PPCM was 23%, compared with 10% in controls (P=0.011). Auger and colleagues 6 review the risk factors for PPCM including pre-eclampsia, advanced maternal age, multiple births, and African and Asian descent. Proposed mechanisms of myocardial fibrosis and mitral-annular disjunction with the current study adding mechanical dispersion to this list of possible risk markers. Interestingly, anatomic features of the mitral leaflet and the severity of mitral regurgitation have not been identified as risk factors for ventricular arrhythmias. Marra and Basso 4 conclude: “The current atrial fibrillation risk stratification of patients with MVP identified by 2D echocardiography include a 12-lead ECG and 24-hours ECG Holter monitoring, but the selection of those patients to address to more invasive and expensive tools such as CMR and electrophysiological study remains to be fully defined.”

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myocardial dysfunction include abnormal endocrine metabolism, oxidative stress, and genetic associations, particularly with the gene that encodes the sarcomere protein titin. They conclude: “Accurately identifying women at risk of PPCM remains the most likely means of offering appropriate interventions at earlier stages of the disease in order to improve outcomes. It appears likely that the development of a screening tool that incorporates both clinical and biochemical risk markers will provide the best discrimination. In the interim, offering cardiovascular disease screening to first-degree relatives of women with PPCM is likely warranted.”

The Education in Heart article in this issue provides a concise overview for the diagnosis, risk stratification and management of arrhythmogenic cardiomyopathies, including indications for placement of an implantable defibrillator and family screening (Figure 3). A second review article provides a simple approach to the standard ECG to identify the anatomic origin of idiopathic ventricular arrhythmias.

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