Correspondence

References


This letter was shown to the author, who replies as follows:

Sir,
I am grateful to Professor Wagenvoort for his semantic correction. “Plexogenic” presumably means giving rise to “plexiform”. If only the arteriopathy were “plexogenic” rather than “plexiform” when these patients are referred then we might produce some therapeutic benefit with vasodilator drugs. Very occasionally death from primary pulmonary hypertension occurs when the arteriopathy is still only “plexogenic” and one feels that in these rare patients the disease might have been amenable to treatment. We need to see patients when their arteriopathy although apparently “plexogenic” is not yet “plexiform”.

Celia M Oakley,
Royal Postgraduate Medical School,
Hammersmith Hospital,
Ducane Road,
London W12 0HS.

Cardiac transplantation

Sir,
I was interested to read the letter in which Dr Evans (1985; 53: 472) compared the survival statistics of the Stanford University Coronary Transplantation Program with the survival rates of medically treated patients with dilated cardiomyopathy in the United Kingdom. Dr Evans states that medical treatment of dilated cardiomyopathy carries a one year mortality rate of 34.7% and five year mortality rate of 59.4%. He compares this with the 37% one year mortality rate and a 61% five year mortality rate at Stanford. He then takes exception to the statement “that cardiac transplantation prolongs life”. Fortunately, the current data upon which we base our justification for cardiac transplantation in the United States do not agree with Dr Evans’s contention for several reasons.

The first and foremost criterion for cardiac transplantation in the United States is the presence of New York Heart Association class IV heart failure. In patients with class IV congestive heart failure, including those with coronary artery disease, one year mortality is 50% and three year mortality is 80%.

Since the quoted Stanford data include both patients with ischaemic heart disease and primary dilated cardiomyopathy the data do indeed appear promising. The Stanford statistics quoted comprise data accumulated before the introduction of cyclosporin immunosuppression. Comparison of one year and three year mortality rates in the registry maintained by the International Society for Heart Transplantation,² shows a 15% one year mortality rate and a 25% three year mortality rate in patients who have had cardiac transplantation and immunosuppression with cyclosporin. Therefore, the most recent data indicate that cardiac transplantation does indeed prolong survival in those patients with New York Heart Association class IV heart failure. The problem in 1985 is not one of the therapeutic efficacy or of satisfactory long term immunosuppression but rather that of donor heart availability. The efforts of the medical community must be directed towards reducing the high early mortality rate of patients who presently are not surviving long enough to undergo cardiac transplantation.

Michael L Hess,
Director of Cardiac Transplantation,
Medical College of Virginia,
Richmond, VA 23298,
USA.

References