Pathophysiology and time course of silent myocardial ischaemia during mental stress

Sir,—Most patients in the study by Legault et al did not develop anginal chest pain when the ejection fraction decreased during periods of mental stress.1 The authors, however, did not comment on this finding. The precise mechanism responsible for the lack of symptoms associated with the ischaemic episode induced by mental stress in the laboratory and evaluations made by ambulatory electrocardiographic monitoring performed for 24-48 h in the patient's own environment is a recent study has provided clinically meaningful information on this aspect. Gottdienner et al evaluated the relationship between myocardial ischaemia induced by mental stress and the functional severity of ischaemia during exercise stress testing and triggers of ischaemia during daily life. They showed that in patients with confirmed coronary artery disease, the induction of myocardial ischaemia by mental stress was predictive of an increased risk of myocardial ischaemia during routine daily life. However, most ischaemic episodes during daily life occurred without mental stress. These results suggest that findings observed during psychological stress testing in the laboratory might not correlate well with the magnitude of stress perceived by patients during daily life.

Legault et al failed to prove the clinical significance and prognostic importance of their findings. Information about the clinical impact of ischaemia induced during mental stress in the laboratory has been lacking because most studies, including the present one, have not correlated their findings with the risk of ischaemia encountered during daily life or provided longitudinal follow up data on the patient evaluated. Clearly, more work is needed in this area especially to document the significance of findings observed in the laboratory by correlation with evaluations made in the patient’s own environments.

The dynamic decrease in coronary supply induced by mental stress may have secondary to an increase in α-adrenergic activity produced by mental stress.2 This hypothesis carries important therapeutic implications. Treatment with α-adrenergic blocking agents alone or in combination with β receptor blocking agents might be the most effective regimen. However, if coro-

tary vasoconstriction seems to play a dominant role, it is possible that treatment with calcium channel blockers would be appropriate. At present, there is little if any information available to establish the super-
ority of one anti-ischaemic regimen over another as a treatment for myocardial ischaemia induced by mental stress.

SUSHIL K AHALWAT
9405 58th Avenue
Elmhurst NY 11373, USA

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

Sir,—As Dr Ahlawat correctly points out, the mechanisms responsible for pain during myocardial ischaemia are not fully elucidated. Our finding that ischaemia induced by mental stress was usually painless is consistent with the findings of Rozanski et al and Gottdienner et al.1 The pathophysiology of ischaemia may be important in causing pain. Ischaemia may be more likely to be asymptomatic when increases in heart rate or blood pressure are modest. We and others have shown that the pain threshold is higher in patients with silent rather than symptomatic myocardial ischaemia.

The aim of our study was to gain insight into the pathophysiology of ischaemia induced by mental stress, which did not set out to assess possible correlations between ischaemia induced by mental stress in the laboratory and during daily life. However, in another study we found that the ischaemic response to mental stress predicted the fre-

quency of ambulatory ischaemia independently of the left ventricular response to exercise. Moreover, patients with ischaemia induced by mental stress may have had more frequent episodes and longer total duration of ambulatory ischaemia. These findings suggest that the ischaemic response to mental stress may be a clinically relevant finding.

Gottdienner et al found that patients with ischaemia induced by mental stress had more ischaemia (detected by ambulatory monitoring) during sedentary activities but did not differ in terms of magnitude or duration of episodes of ambulatory ischaemia.2 Only 26% of episodes of "sedentary ischaemia" during ambulatory monitoring were accompanied by high mental or emotional arousal. It is possible that a better understanding of the role of "sedentary ischaemia" in the daily life of patients with ischaemia is needed.

We agree that a longitudinal study to examine the clinical significance and prognostic importance of ischaemia induced by mental stress is clearly desirable but this was beyond the scope of the present study. However, a more detailed understanding of the pathophysiology of ischaemia induced by mental stress, as provided by this study, may have important therapeutic implications. A treatment study of pharmacological and non-pharmacological approaches to treat-
ment would be of interest.

Novel and clinically relevant findings of our study include: (a) data on the time course and left ventricular volume changes that accompany myocardial ischaemia induced by mental stress; (b) the trend for more severe ischaemic disease in patients with ischaemia induced by mental stress, which became statistically significant in the subgroup of patients not on β blockers; (c) evidence that β blockers may protect against stress induced ischaemia; (d) the finding that ischaemia is consistent with a study by Bayes et al which showed that β blockers may be effective in suppressing ischaemia caused by mental stress.

SUZANNE E LEGAULT
Program in Medical Psychiatry, Department of Psychiatry, The Toronto Hospital, University of Toronto, 8 EN 212, 200 Elizabeth Street, Toronto, Ontario M5G 2C4, Canada

1 Rozanski A, Bairey CN, Krantz DS, et al. Mental stress and the induction of silent myocardial ischaemia in patients with coro-


