



**Figure 1** Survival of patients with atrial fibrillation (AF) and sinus rhythm (SR) after admission to hospital for a major cardiovascular event.

outcome in patients classified as having AF. We can confirm that, in a further analysis, exclusion of patients with paroxysmal AF had no effect on the clinical end points: over a follow-up period of up to 6.8 years, no differences emerged between patients with chronic AF (n = 66) or sinus rhythm (SR; n = 209) in the composite end points of cardiovascular death or unplanned hospitalisation for major cardiovascular events (fig 1), the composite end point of cardiovascular death or hospitalisation for worsening heart failure, cardiovascular mortality or total mortality. The groups with chronic AF and SR derived similar improvements in NYHA class, 6-min walking distance and quality of life scores (all p < 0.001). Reductions in left ventricular end-systolic (p < 0.001) and end-diastolic (p < 0.001) volumes and improvements in left ventricular ejection fraction (p < 0.001) were comparable in the groups with chronic AF and SR.

Third, we agree with Gasparini and Regoli that the percentage biventricular pacing

achieved in the AF group was high, particularly in view of the relatively low uptake of rate-slowing drugs. In a reanalysis, the percentage biventricular pacing was 86.7% in the chronic AF group and 95.2% in the SR group (p < 0.001). This not only raises questions about the patients' intrinsic heart rate in our study, but in others as well. Arguably, patients with heart failure and AF referred to an electrophysiology unit may have different ventricular rates from those referred to a general heart failure service, as was the case in our study. Selection bias and differences in heart rate at rest and during exercise might contribute to the different percentage of biventricular pacing seen in these studies.

There are many questions to be answered with respect to CRT in patients with AF. Prominent among these is the role of ventricular triggered pacing, which has been dismissed by some as not beneficial, because it causes fusion beats. Nevertheless, no studies have shown that fusion beats are

haemodynamically inferior to conventional biventricular pacing.

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**CORRECTIONS**

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J T Parissis, S Adamopoulos, D Farmakis, et al. *Heart* 2006;**92**:1768–72. Effects of serial levosimendan infusions on left ventricular performance and plasma biomarkers of myocardial injury and neurohormonal and immune activation in patients with advanced heart failure. This article was originally published with an incorrect digital object identifier (doi). It has been updated with the correct doi: 10.1136/hrt.2005.079707. We apologise for any inconvenience caused.

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Donald C Oxorn. Intraoperative echocardiography. *Heart* 2008;**94**:1236–43. On page 1237 of this article (first paragraph of the second column) the last sentence should read: The presence of multiple jets will require additional tests to quantitate regurgitation severity; the presence of systolic reversal in pulmonary veins indicates severe MR and the presence of pan **diastolic** flow reversal in the descending aorta indicates severe AR.

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