Dear Editor,

A 67-year-old man had presented 7 months earlier with complaints of flushing, diarrhea and tiredness. Etiologic investigation diagnosed metastatic midgut neuroendocrine carcinoid tumor for which he had trans-arterial embolization and started monthly octreotide. In follow-up, he developed progressive exertional dyspnea and was referred for carcinoid heart screen.

On physical examination there were systolic and early diastolic right-sided murmurs, increased jugular venous pressure with prominent v wave and pitting peripheral edema.

Bidimensional transthoracic echocardiography showed hypomobile fibrotic tricuspid leaflets that resulted in incomplete coaptation and severe regurgitation. The pulmonary valve was not clearly visualized but there was evidence of moderate regurgitation and mild stenosis. Three-dimensional (3D) echocardiography clearly visualized but there was evidence of moderate regurgitation and severe regurgitation of the tricuspid and pulmonary valves in carcinoid heart disease with incremental anatomical detail. Specifically, 3D imaging provides better morphological and functional assessment of right-sided valvular lesions and allows the identification of surrounding structures affected by the pathologic process. Accordingly, this modality may contribute to better recognition of carcinoid heart in clinical practice. Moreover, right ventricular function may be preserved even in the presence of widespread right-sided valvular and subvalvular disease.

Figure 1. A: volume-rendered 3-dimensional echocardiography image showing thickened, retracted and immobile tricuspid leaflets in diastole and systole. B: face volume-rendered image of the pulmonary valve acquired in left parasternal view showing thickened hypomobile cusps in diastole and systole. Ao, aorta; LV, left ventricle; MV, mitral valve; PV, pulmonary valve; TV, tricuspid valve.

Stagnant Cardiovascular Prevention: Professional Barriers
Prevenção cardiovascular estancada: barreras profesionales

To the Editor,

We read with interest the article by Romero et al.1 about trends and socioeconomic barriers in the field of cardiovascular prevention. In fact, the progress made in recent decades has allowed for improved prediction of cardiovascular disease risk. This, furthermore, contributes to reducing associated mortality. However, despite improved identification of cardiovascular risk factors and therapeutic advances to halt their progression, the degree of control that has been achieved is well below target and the residual risk remains high. The authors point to the possible existence of unidentified factors, the possible adverse effect of certain aggressive therapeutic measures and unfavorable lifestyle linked to socioeconomic status. Nevertheless, it is worth mentioning a major obstacle to cardiovascular prevention: “professional bar-

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Response to “Stagnant Cardiovascular Prevention: Professional Barriers”

Respuesta a «Prevención cardiovascular estancada: barreras profesionales»

To the Editor,

We appreciate Dr. Carro’s interest in our article, where we argued that the persistence of unfavorable socioeconomic factors perpetuates harmful behaviors and lifestyles. This has been shown in many studies, in EUROASPIRE II, and indirectly in its three-phase comparison. Carro also proposes the existence of a “professional barrier” that might explain the poor control of cardiovascular risk factors after coronary events. However, the significant increase in the prescription of antihypertensive, lipid-lowering, and cardioprotective drugs shows that there were no major obstacles to scheduled professional care in EUROASPIRE. Factors such as lack of adherence to treatment due to patient unwillingness or denial, side effects, and the cost of medications may have an impact on these unsatisfactory results, in addition to unfavorable socioeconomic factors.

We agree that the time spent by health professionals to educate and motivate their patients is extremely important. This has been demonstrated in cardiac rehabilitation programs, which continue to be underutilized despite their cost effectiveness for secondary prevention and primary prevention in patients with multiple cardiovascular risk factors. Lack of funding has been one of the main causes of underutilization.

As we have stated, many barriers continue to favor the alarming increase in cardiovascular risk factors. Society as a whole, of which health professionals are only a small part, must become more aware, make more resources available, and facilitate the changes that may lead to improved control of these factors.

Note: these opinions do not necessarily reflect those of the institutions to which the authors are affiliated.

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