double anti-aggregation therapy. The clinical follow-up at 4 months was satisfactory.

The prevalence of PFO in patients with a history of stroke ranges between 20% and 40%, and the estimated annual rate of recurrent ictus among PFO patients ranges between 1.5% and 12%, depending on the population studied. The optimal treatment for preventing strokes in PFO patients has not been identified. The international clinical practice guidelines recommend antiplatelet aggregation treatment for patients with transient ischemic attack and PFO, although it also could be indicated as an anticoagulant in other situations, such as atrial fibrillation: "[...] insufficient data exists [...] regarding the use of percutaneous closing devices for PFO in patients with their first ictus; this strategy could be considered for those patients who have suffered repeated cryptogenic strokes in spite of medical treatment."^2,3

During the percutaneous closure of a PFO, the total incidence of device thrombosis is small, varies according to the study, and also depends on the type of occluder used. In the Krumsdorf series (with 1000 patients [593 PFO and 407 with atrial septal defects] and TEE used during the procedure and at 4-week follow-up), the total rate was 6%. In the TEE study after 4 weeks, no thrombi were found in the 292 cases involving an Amplatz occluder, 1 (1%) in 161 Helex devices, 3 (7%) in 127 PFO-Star devices, and 7 (7%) in 100 CardioSEALs. Although the incidence was low, the best predictors for the thrombi formation were the presence of persistent atrial fibrillation and ASA. No increased benefit was observed when treating patients with a combination of aspirin and clopidogrel with respect to the group that received only aspirin as a thrombosis prophylaxis treatment. In general, thrombus was resolved through medical treatment in 17 of 20 patients within 4 weeks to 6 months (warfarin and/or heparin); in 3, a surgical extraction of the thrombus was required.

This case illustrates the usefulness of TEE during percutaneous structural procedures, as well as the need for intensive anti-aggregant and anti-coagulant treatment in order to avoid complications in patients with thrombi.

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was 88% in our study (95% CI: 83.8%-93.7%),7 which is very different from that found in Escrivanó et al.'s article.

The authors reported a relationship between obesity (mainly abdominal) and the presence of other CVRF in the adult population, which is a phenomenon that we also found in our study.7

To make it easier to define obesity in early life stages, which are subject to growth, we have validated the waist-to-height ratio, estimating 0.5 as the cut-off point for establishing the prevalence of abdominal obesity.7 As such, this method has an advantage over using absolute WC and BMI values, as complicated percentile charts for age and sex can be avoided. This new anthropometric index should be validated externally in the child and adolescent population.

We would like to conclude our letter by congratulating Escrivanó et al. for their study, which serves as a national reference point, and the editorial team for accepting epidemiological studies of this type in their prestigious clinical journal.

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Usefulness of Coronary Computed Tomography in Real Practice

Valor, en la práctica clínica real, de la angiografía coronaria por tomografía computarizada

To the Editor,

Patients frequently seek medical advice in our hospital emergency department due to chest pain. It is for that reason that we read the editorial that recently appeared in Revista Española de Cardiología with interest.1 This article reviewed how certain non-invasive image tests contribute to assessing patients with chest pain, as reported in other studies.2,3 Coronary computed tomography (CT) is especially reaching a notable peak, given the machine resolution increases. This is a second important reason for finding that coronary TC has to be used along with other noninvasive methods to correctly assess chest pain and it increases the percentage of cardiac catheterization. We believe that these findings can improve over time as doctors gain more experience and machine resolution increases. This is a second important reason for questioning the current usefulness of coronary CT in real practice.

However, we are positive about the future usefulness of coronary CT. The results from the controlled studies are outstanding and encouraging for emergency room doctors, who are often under extreme pressure. The only way that we are able to safely and cheaply shorten the waiting hours that these patients spend in the emergency department is by encouraging future studies that delve deeper into which subgroup of patients to consider and how coronary CT can be implemented in assessment protocols for patients with chest pain in hospital emergency departments.

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