We share Baena-Díez et al’s concern to determine the risk attributable to high blood pressure is greater in antihypertensive treatments and possibly–statins or antiplatelet agents. In fact, risk attributable to high blood pressure is greater in patients with diabetes, we do not believe this constitutes an important limitation. The same could be said about the inclusion of patients with high blood pressure who, due to their higher cardiovascular risk, would also more frequently receive antihypertensive treatments and possibly–statins or antiplatelet agents. In fact, risk attributable to high blood pressure is greater than that of diabetes, as the magnitude of the effect does not differ excessively but prevalence is greater. 

We agree that ankle-brachial index (ABI) measurement is of less clinical interest in low-risk than in intermediate-risk patients. Fortunately, there is a tool (REASON) that prioritizes ABI use, developed by the HERMES group and our own ARTPER group. To date, the Inter-society Consensus (TASC II) recommended measuring ABI in asymptomatic patients aged 50-69 years with diabetes or a history of smoking, at 70 years and older, and when cardiovascular risk is 10% to 20%. This will require cohort follow-up studies and the consensus of groups of experts.

REFERENCES

8. Available online 17 June 2011

Vascular Risk, Diabetes, and the Ankle-Brachial Index

Riesgo vascular, diabetes e índice tobillo-brazo

To the Editor,

We would like to thank Valdivieso et al.1 for their interesting comments on the article by our ARTPER research group published in Revista Española de Cardiología. With regard to a possible distortion of results caused by including patients with diabetes, we do not believe this constitutes an important limitation. The same could be said about the inclusion of patients with high blood pressure who, due to their higher cardiovascular risk, would also more frequently receive antihypertensive treatments and possibly–statins or antiplatelet agents. In fact, risk attributable to high blood pressure is greater than that of diabetes, as the magnitude of the effect does not differ excessively but prevalence is greater.

We agree that ankle-brachial index (ABI) measurement is of less clinical interest in low-risk than in intermediate-risk patients. Fortunately, there is a tool (REASON) that prioritizes ABI use, developed by the HERMES group and our own ARTPER group. To date, the Inter-society Consensus (TASC II) recommended measuring ABI in asymptomatic patients aged 50-69 years with diabetes or a history of smoking, at 70 years and older, and when cardiovascular risk is 10% to 20%. The REASON tool—which has been constructed and validated—establishes a score as a function of the risk factor profile to identify patients with a high probability of having ABI <0.9; it has 85.2% sensitivity, similar to TASC II, and 47.2% specificity, greater than TASC II (38.3%). How often ABI should be measured and/or repeated remains to be determined. This will require cohort follow-up studies and the consensus of groups of experts.
Inequalities for Which We Have No Explanation, a Reproducible Phenomenon in Different Local Health Districts

To the Editor,

We read with attention the article by Riesgo et al. about sex-related differences in the treatment of patients with atrial fibrillation in which the authors convincingly demonstrate that the management of said disease is different in women. Our opinion is that this phenomenon has long been reproducible in any cardiovascular disease.

Riesgo et al. point to these differences as the reason for more conservative management, which they attribute to the longer time course between presentation and diagnosis of the arrhythmia in women. On the other hand, the authors maintain that, by broadening the evaluation to cover a health district, their study design avoided the selection biases of other studies focused more specifically on tertiary care or referral centers for the treatment of atrial fibrillation, a circumstance that some-

A recent atrial fibrillation registry of 798 patients, with the participation of general practitioners in a region of Galicia in northwestern Spain, presents data that are fully reproducible in any cardiovascular district. The authors intuit certain inequalities for which they have no explanation.

A recent atrial fibrillation registry of 798 patients, with the participation of general practitioners in a region of Galicia in northwestern Spain, presents data that are fully reproducible since, despite their having a significantly shorter disease course than the men in the registry, fewer women had undergone electrical cardioversion (5% vs 10%) and more of them were being treated with digoxin (41% vs 30%). These results may again reflect the trend toward a sex-related conservative management, as occurs in other cardiovascular diseases, except that, in addition to failing to provide them with a beneficial treatment, in this case a higher proportion of women receives a treatment that is customarily associated with a worse adaptation to exercise, the major indication for which in the latest guidelines for atrial fibrillation is an inactive lifestyle, and that “may cause (life-threatening) adverse effects and should therefore be instituted cautiously."

REFERENCES


SEE RELATED ARTICLE:
DOI: 10.1016/j.rec.2011.04.006

SEE RELATED ARTICLE:
DOI: 10.1016/j.rec.2011.04.003

SEE RELATED ARTICLE:
DOI: 10.1016/j.rec.2010.04.002

SEE RELATED ARTICLE:
DOI: 10.1016/j.rec.2011.03.029

SEE RELATED ARTICLE:
 DOI: 10.1016/j.rec.2011.03.026