Importance of Definition and Technique When Using Noninvasive Coronary Angiography to Diagnose Myocardial Bridging. Response

José Alberto de Agustín,* Pedro Marcos-Alberca, José Juan Gómez de Diego, and Leopoldo Pérez de Isla

Unidad de Imagen Cardiaca, Instituto Cardiovascular, Hospital Universitario San Carlos, Madrid, Spain

*Corresponding author:
E-mail address: albertutor@hotmail.com (J.A. de Agustín).

Available online 14 February 2013

REFERENCES


Carotid Intima-media Thickness and Morbidity and Mortality in Spain: A Definitive Prospective Study Is Needed

El grosor íntima-media carotídeo requiere un estudio prospectivo de morbil mortalidad en España definitivo

To the Editor,

We have read with interest the article entitled “Carotid Intima-media Thickness in the Spanish Population: Reference Ranges and Association With Cardiovascular Risk Factors” published in the Revista Española de Cardiología, and consider that the questionable aspects of this determination continue to outweigh its utility in cardiovascular prevention. The authors demonstrate a very weak correlation with cardiovascular risk factors, which is strongest for age, followed by high-density lipoprotein cholesterol. We feel that the results of this study warrant several considerations. First, that the European Society of Cardiology’s guidelines for cardiovascular disease prevention specify that the detection of subclinical vascular disease helps to improve estimation of cardiovascular risk in intermediate risk patients. Moreover, these results are not substantiated by specifically designed, randomized, prospective trials, and thus do not reach a level A recommendation, although they do attain level B. The only two techniques that receive a class Ila recommendation are assessment of carotid intima-media thickness (IMT) and the ankle-brachial index.

Secondly, measurement of carotid IMT has 3 key limitations. Firstly, its independent predictive value is fairly low and this technique is practically useless in the reclassification of individual risk; secondly, progression of IMT does not correlate with an increase in the incidence of cardiovascular events. Thirdly, drug-induced regression or stabilization is not associated with reductions in the complications rate. Some of these aspects are shared with the ankle-brachial index, although the latter has some strong points, such as its independent predictive value when its values are abnormal, even in the absence of clinical evidence of claudication, and its additive role in the presence of other vascular lesions or even in combination with advanced age. Moreover, these findings were reported in a Spanish population.

A final question is to consider what carotid IMT assesses: cerebrovascular involvement or the total atherosclerotic burden? Risk factors have a differential effect on the development of complications in distinct areas, given that hypertension and smoking confer a greater risk of stroke, whereas dyslipidemia and diabetes mellitus are associated with a higher risk of ischemic heart disease. The results of Grau et al.1 appear to indicate that carotid IMT reflects the total atherosclerotic burden because of its association with age and high-density lipoprotein cholesterol, one of the major determinants of acute coronary syndrome in our patient.
population. This study provides relevant data, but we feel that a prospective study in Spain is still required to clarify the true value of carotid IMT measurement in the field of cardiovascular prevention in our general population.

Alberto Cordero,a,* Lorenzo Fálica,b Eduardo Alegria,c and Enrique Galvvad
aDepartamento de Cardiología, Hospital Universitario de San Juan, San Juan de Alicante, Alicante, Spain
bDepartamento de Cardiología, Hospital General de Valencia, Valencia, Spain
cDepartamento de Cardiología, Policlinica Guipuzcoa, San Sebastián, Guipuzcoa, Spain
dDepartamento de Cardiología, Hospital de la Vall d’Hebron, Barcelona, Spain

*Corresponding author: E-mail address: acorderofort@gmail.com (A. Cordero).
Available online 14 February 2013

REFERENCES

SEE RELATED ARTICLE:
http://dx.doi.org/10.1016/j.ijjrec.2012.04.019
http://dx.doi.org/10.1016/j.ijjrec.2012.12.003

Predictors of Carotid Intima-media Thickness

**Predicadores del grosor intima-media carotídeo**

To the Editor,

We have read the interesting report of Grau et al. on reference values for carotid intima-media thickness in the Spanish population and their association with cardiovascular risk factors. In their study, involving 3161 patients of both sexes, the authors found that the major predictors of carotid intima-media thickness were age and pulse pressure, as well as smoking in men and high-density lipoprotein cholesterol in women.

Aging is accompanied by atherosclerosis, which explains why age is predictive of the carotid intima-media thickness: as the authors point out, the association of smoking in men is explained by the higher prevalence of this habit in male patients (24.2%).

The predictive nature of high-density lipoprotein cholesterol exclusively in women can be explained by the effect of 2 confounding variables that are not considered in the study: abdominal obesity and menopausal status. In men, fat is most commonly deposited in the abdominal region, a phenomenon referred to as android obesity, which is associated with increased insulin resistance.

In insulin resistance, the flow of fatty acids from the visceral fat to the liver is enhanced, resulting in triglyceride accumulation (hepatic steatosis) and an increase in very-low-density lipoprotein synthesis. The increase in plasma lipoproteins due to their enhanced formation in the liver raises serum triglyceride levels, a process favored by the reduced activity of lipoprotein lipase, an insulin-dependent endothelial enzyme. Hypertriglyceridermia affects the pattern of other lipoproteins by increasing the activity of cholesteryl ester transfer protein, which augments the triglyceride content of high-density lipoproteins particles and the cholesterol ester concentration in very-low-density lipoprotein particles. Ultimately, low-density lipoproteins become small and dense, allowing them to pass through the vascular endothelium and form atheromatous plaques; in addition, these lipoproteins are taken up preferentially by macrophage scavenger receptors, enabling them to evade the normal mechanisms for their elimination by means of low-density lipoproteins receptors. Triglyceride-rich high-density lipoproteins particles are more easily eliminated by hepatic lipase, which reduces serum high-density lipoprotein cholesterol concentrations.

Another factor that could influence the negative association between high-density lipoprotein cholesterol and carotid intima-media thickness in women is menopausal status. During menopause, there are profound metabolic and hormonal changes due to a loss of ovarian function and a reduction in circulating estrogen levels. These changes contribute, among other effects, to fat distribution in the abdominal region, increased insulin resistance, and the resulting dyslipidemia. If the prevalence of menopause in the sample analyzed had not been high, the presence of these disorders would have been less marked, which partially explains the higher high-density lipoprotein cholesterol concentrations in women and the negative association with the carotid intima-media thickness observed in this group.

Another factor that could contribute to dyslipidemia and favor atherosclerosis is the chronic low-grade inflammation that accompanies abdominal obesity. Visceral adipose tissue is an important source of proinflammatory cytokines, such as interleukin-6 and tumor necrosis factor-alpha, and high blood