Importance of Sudden Cardiac Death Risk Stratification in Hypertrophic Cardiomyopathy. Response

La importancia de la estratificación de riesgo de muerte súbita en la miocardiopatía hipertrofica. Respuesta

To the Editor,

We are grateful for the comments of Martínez-Moreno et al in relation to our work on the results of implantable cardioverter-defibrillator (ICD) implantation in hypertrophic cardiomyopathy. Whilst it is true that our study was a small series with a relatively short follow-up, we believe that it was representative of the hypertrophic cardiomyopathy population in non-specialized centers. This non-specialization would explain the low rate of appropriate therapies compared with that in previous studies, which are from large specialized centers attending patients with the most severe disease. The authors’ observations are appropriate, given the recent publication of the new European Society of Cardiology guidelines on hypertrophic cardiomyopathy, which recommend the use of HCM Risk-SCD, a new tool for evaluating sudden cardiac death risk, which naturally was not used in our cohort when the decision was made on ICD implantation. We calculated this risk a posteriori in the 48 primary prevention patients from our cohort, with the following results: 12 patients (25%) would have had a calculated risk of < 4%, and therefore no indication for ICD implantation according to the new guidelines; 7 patients (14.6%) would have had a risk of between 4% and 6% (class IIb ICD indication), and 29 patients (60.4%) would have had a risk > 6% (class IIa indication). Interestingly, the 3 patients in our cohort who received appropriate therapies would have had a risk of > 6%. Had we applied the new guidelines to our cohort, we would have “saved” ICD implantation in 39.6% of the patients, who, in addition, had received no shocks at the time of follow-up. Also, as noted in the original article, secondary prevention patients have a paradoxically low risk profile, and although HCM Risk-SCD is not valid for secondary prevention, in which ICD implantation has a class I indication, we calculated the risk for our cohort patients, using the data available. All patients would have had a theoretical risk of < 6%, and consequently would have had no indication for ICD prior to their episode of ventricular arrhythmia. We agree that HCM Risk-SCD improves patient selection in those with 1 or more risk factors, but it does not solve the problem that many sudden cardiac deaths occur in patients who are theoretically low risk, and so cannot be identified using tools based on classic risk factors. It surprises us that, in the development of HCM Risk-SCD, there was no evaluation of imaging (such as fibrosis on magnetic resonance), electrophysiological, or genetic parameters, which could help to better identify at risk patients in the future.

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Sensitivity and Negative Predictive Value of Treadmill Exercise Stress Testing for the Diagnosis of Catecholaminergic Polymorphic Ventricular Tachycardia

Sensibilidad y valor predictivo negativo de la ergometría para el diagnóstico de la taquicardia ventricular polimórfica catecolaminérgica

To the Editor,

We read with interest the article published by Domingo et al in Revista Española de Cardiología, and would like to congratulate the authors for their work demonstrating the pathogenicity of the RyR2<sup>2420Q2</sup> mutation as the cause of catecholaminergic polymorphic ventricular tachycardia (CPVT), as well as the description of individuals with the RyR2<sup>C2277R</sup> mutation. These are 2 important contributions to our knowledge about this disease.

However, we would like to mention a series of considerations concerning the diagnosis of CPVT, the criteria used, the details of the diagnostic protocol used by the authors and, singularly, the extraordinary diagnostic yield of the exercise stress test (performed on a treadmill according to the Bruce protocol).

The exercise stress test is considered to be the most important and most widely recommended diagnostic test for CPVT, but it is not reproducible and the results can be negative in individuals with the disease. In the context of family screening, the recommendation of international experts representing Europe, the United States, and the Asia-Pacific region is that the observation of ventricular premature beats is sufficient for the test to be considered positive.

The fact is that diagnostic sensitivity is highly problematic in this disease. Up to 30% of the patients in published series who experienced sudden cardiac death had been asymptomatic until that time, and events have been reported in individuals with a negative baseline exercise stress test. Moreover, the sensitivity of the exercise stress test is too low (13%-56% in carriers of RyR2 mutations). The diagnostic criteria are not completely defined. Initial requirements were the documentation of polymorphic or bidirectional ventricular tachycardias or ventricular fibrillation
during exercise stress testing or following catecholamine infusion. Recently, there have been reports of the use of diagnostic thresholds such as more than 10 premature ventricular contractions/minute, bigeminy, or couplets as the “minimum” ventricular arrhythmia, whose presence is indicative of a diagnosis of CPVT. In addition, although catecholamine infusion is not a totally reliable test, it continues to be used to enhance sensitivity in the diagnosis of this disease, especially when dealing with an index case. However, recent studies have reported the limited usefulness of catecholamine infusion because of its very low sensitivity (28%) and specificity for the diagnosis of CPVT. In one study, it was positive in 56 patients with a negative exercise stress test. The reality is that the available tests are insufficiently sensitive, and their negative predictive value is much lower than desired. However, the articles referred to in this letter reports results in terms of sensitivity (89%) and negative predictive value (93%) that do not agree with those reported to date, and convey the message that a negative exercise stress test rules out CPVT. These data probably require an in-depth study of a larger number of members of the family in question and, of course, cannot be extrapolated to other populations with other mutations in what, in our opinion, constitutes a selection bias.

In accordance with the recommendation of the scientific societies, a negative exercise stress test does not rule out CPVT. The disease can be confirmed by the presence of specific ventricular arrhythmias during exercise but, in the context of family screening, just 1 premature ventricular contraction is enough to render the results of the test abnormal, and probably justifies the introduction of preventive treatment with beta-blocker therapy. Moreover, the use of catecholamine infusion should be restricted to selected cases, and should not be included in the protocol to be applied on a general basis.

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The yield of EST varies (ranging from the 25% reported by Ruiz Hernández and Wangüemert Pérez to 100%), and perhaps depends on the point at which the mutation occurs. We had no intention of conveying the idea that a negative EST rules out the disease. A conclusive genetic study supports a positive EST and identifies carriers with a negative EST. In its absence, we perform Holter monitoring and an epinephrine test in relatives with a negative EST (not included in the consensus statement), and if they test negative, these individuals undergo follow-up with periodic EST. There are no studies on the value of epinephrine challenge in family members, but its usefulness has been documented in probands (which is included) and in families with cardiac arrest with preserved left ventricular ejection fraction and may justify its performance in the present context.

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