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 coupled 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%)9 and specificity9 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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