pregnancy and it is already clearly stated in the methods section of guidelines ‘the use of vasodilators should take into account the contraindication of ACE-inhibitors and angiotensin receptor blockers’. We also agree with the reasons detailed in the letter, which, unfortunately, cannot be developed in a document of guidelines format.

More generally, if possible, patients with left ventricular ejection fraction <=40% should probably be dissuaded from becoming pregnant due to the high risk of complications. 1

References


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Does cardiac resynchronization therapy reduce sudden cardiac deaths?

Rivero-Ayerza et al.1 report a meta-analysis of five trials comparing cardiac resynchronization therapy (CRT) with optimal medical treatment to determine if CRT affects total mortality, heart failure deaths, and sudden cardiac deaths (SCD). In three of the trials, 2–4 the follow-up period was less than 6 months with a total of 30 overall mortality events which together only contributed <9% of statistical weights to the meta-analysis. The meta-analysis is dominated by data from CARE-HF 5 (demonstrating a favourable effect on all-cause mortality [hazard ratio (HR), 0.64; 95% confidence interval (CI), 0.48–0.85; P < 0.002]) and COMPANION 6 (suggestive of a favourable effect on all-cause mortality (HR, 0.76; CI, 0.58–1.01; P = 0.059)). Since these two trials dominate the meta-analysis it is not surprising that it too found a favourable effect on all-cause mortality. CARE-HF alone provides level of evidence B for the efficacy of CRT on all-cause mortality. Do the authors contend that the findings from the meta-analysis raise this to level of evidence A?

The effects on mode of death are also presented. CRT favourably affects death due to progressive heart failure, but again this has been established to level of evidence B by CARE-HF. 5,7 Individually, the five trials considered in the meta-analysis (including the CARE-HF main study) did not provide any evidence for an effect of CRT on SCD nor did the meta-analysis (OR, 1.04; 95% CI, 0.73–1.22). The CARE-HF trial extension phase 2 did, however, find a beneficial effect of CRT on SCD (HR, 0.54; 95% CI, 0.35–0.84; P = 0.005). The fixed effects meta-analysis presented, incorporating the CARE-HF extension study, however did not demonstrate a benefit (OR, 0.86; 95% CI, 0.63–1.19). Although a random effects model is more appropriate (because of the presence of moderate statistical heterogeneity (χ2 = 8.25; df = 4; P = 0.08; I² = 51.5%),) using such a model does not materially affect the result (OR, 1.01; 95% CI, 0.53–1.90; P = 0.99). Thus, the only evidence we have of a beneficial effect of CRT on SCD is derived from the CARE-HF trial extension phase. Given the established symptomatic 2, 4 and mortality 5–7 benefits of CRT in this patient population (with NYHA Class III or IV heart failure symptoms) it would be unethical to conduct further trials of CRT against medical treatment. Thus, it is unlikely that we will ever get a more definitive answer as to whether CRT reduces the risk of SCD when compared with medical treatment alone.

References