The authors' reply:
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*Heart* 2010 96: 73-74
doi: 10.1136/hrt.2009.182097

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Society of Cardiology guidelines. Should the slate now be wiped clean regarding the management of this condition until universally accepted diagnostic criteria are established?

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Competing interests: None.

Provenance and peer review: Not commissioned; not externally peer reviewed.

Heart 2010;96:72–73. doi:10.1136/hrt.2009.182121

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The authors’ reply: We thank Drs Dalzell and Jackson1 for their comments on our editorial on “Heart failure with a normal ejection fraction: new developments”, recently published in Heart.2 Their comments are appreciated, and we would agree with them that a major problem in this field is providing exact diagnostic criteria for those patients who have symptoms of heart failure but have a normal ejection fraction. This is partly due to the difficulty in finding agreement on how to define diastolic dysfunction and the lack of any accepted “gold standard”.2 The entry criteria for most of the previous trials on heart failure with normal ejection fraction were based on clinical assessment with documented preserved left ventricular ejection fraction without any clear criteria for diastolic dysfunction. It is likely therefore that the recent large-scale trials may have included many patients with other non-cardiac causes for dyspnoea. On the other hand, even using the new European Cardiac Society guidelines many patients who have exertional dyspnoea due to occult heart failure with normal ejection fraction may be excluded because the resting echoangiogram appears normal. As mentioned in our editorial, these patients have dyspnoea on exertion rather than at rest. With newer echocardiographic techniques, such as tissue Doppler and strain echocardiography, impaired systolic and diastolic function can be detected on exertion, which correlates with the degree of symptoms and exercise limitation.3 The situation is therefore complicated, but at least any new trials on this disease entity should perhaps require documented proof that the dyspnoea is of cardiac origin using cardiologynamic exercise testing and also exercise echocardiography for a full assessment of systolic and diastolic function on exercise.

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Competing interests: None.

Provenance and peer review: Not commissioned; not externally peer reviewed.

Heart 2010;96:73. doi:10.1136/hrt.2009.182147

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Triple antithrombotic management after stent implantation: when and how?

To the editor: We read the article by Schöömag et al1 with great interest. We learnt when and how doctors should prescribe triple antithrombotic therapy after stent implantation. Schöömag states that further prospective clinical trials are needed in order to evaluate the best treatment strategy for patients receiving oral anticoagulation (OAC) who undergo percutaneous coronary interventions (PCI). Unfortunately, all present recommendations are based on expert opinion and not on randomised trials. In patients with indication for chronic oral anticoagulation who need to undergo PCI, there are theoretically four possibilities: the combinations of OAC + aspirin and aspirin + clopidogrel are unsafe because of increased risk of stent thrombosis and stroke, respectively.1 2 The combination of triple therapy, which is currently recommended, is known to increase bleeding risk. A last possibility is the combination of OAC and clopidogrel, and this seems to be promising.2 Therefore a first prospective randomised international, multicentre, open-label trial was started on 1 December 2008. This will assess the hypothesis that after PCI with stent implantation in patients receiving OAC, the combination of OAC and clopidogrel 75 mg/day is safe and not inferior to triple therapy for the prevention of thrombotic complications while reducing the risk of bleeding. The primary outcome is the combination of TIMI and GUSTO minor and major bleeding up to 30 days and 1 year. The secondary outcome is major adverse cardiac and cerebrovascular events. The sample size is 496. Given that, to date, no prospective randomised study has yet examined this topic, the WOEST (What is the Optimal antiplatelet and anticoagulant therapy in patients with oral anticoagulation and coronary StenTing) clinical trials. gov:CNT00769938) trial will help to define new guidelines for patients with chronic indication for chronic anticoagulation who need coronary stenting.

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Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

Heart 2010;96:73. doi:10.1136/hrt.2009.182099

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The authors’ reply: We agree with Dr Dewilde and Dr Ten Berg that current recommendations for coronary stenting in patients on oral anticoagulation (OAC) are not based on randomised controlled trials (RCTs) and congratulate them for dealing with this important topic by initiating this
WOEST trial (NCT00769938). While the WOEST trial compares a triple therapy with treatment comprising OAC + clopidogrel, a second RCT is ongoing (ISAR-TRIPLE, NCT00776633) which evaluates the duration of clopidogrel therapy (6 weeks vs 6 months) after drug-eluting stent placement in patients receiving OAC + aspirin.

These randomised trials will answer unresolved questions about ischaemic and bleeding complications in this high-risk population. In the future, we hope that recommendations can be based on the results of these RCTs.

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Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

Heart 2010;96:73–74. doi:10.1136/hrt.2009.182097

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