Function and RV systolic function in the population investigated in the article by Lindqvist et al. What was the detailed therapeutic regimen? Did they explore patients with very recent manifestations of SSc, indicating that RV diastolic function is an early marker of heart involvement; one may therefore question the definition of disease duration (first symptom of Raynaud syndrome?).Were some patients with undifferentiated connective tissue disorder included in the study? Or does the study reflect the lack of sensitivity of their method of assessment?

Concerning this issue, while the authors evaluated RV function using tissue-Doppler echocardiography, one may wonder why they did not use myocardial velocities and strain rates determined by tissue-Doppler echocardiography to assess LV function. In conclusion, the study by Lindqvist et al does not support the absence of primary myocardial involvement in patients with SSc but raises fewer concerns about the methods of selection and investigation that were used.

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Correspondence to: Christophe Meune, MD
Yannick Allanoire, MD, PhD
René Descartes University, Cochin Hospital
Paris, France

REFERENCES

Anticoagulant Therapy and Idiopathic Pulmonary Fibrosis

To the Editor:

We read with interest the report by Kubo and colleagues of a randomized controlled trial of anticoagulation and corticosteroids vs corticosteroids alone in 56 Japanese patients with idiopathic pulmonary fibrosis (IPF). The authors should be commended for applying sound biological rationale in developing a promising hypothesis, and the results provide hope that anticoagulation may benefit patients with IPF. However, there are three substantial methodologic issues in this study, and physicians should not rush to adopt this treatment as a new standard of care.

First, this cohort is not representative of the general IPF population. The study population was significantly younger than the patients included in the previous randomized trials of corticosteroids. It is not clear why the overall survival was not different between the groups.

Second, the treatment strategy was not consistent with the current guidelines for IPF. The patients were treated with oral anticoagulants for 12 months, followed by a 6-month period of observation. This is in contrast to the current guidelines, which recommend a shorter period of anticoagulation (3–6 months) and a follow-up period of 12 months.

Third, the study did not include a placebo group, which is a limitation of the study. This is important because it is not clear whether the observed differences are due to the anticoagulation or the corticosteroids. Including a placebo group would have provided a better comparison of the two treatments.

In conclusion, the study by Kubo and colleagues provides valuable information on the potential benefits of anticoagulation in IPF. However, the study has important limitations that need to be considered before adopting this treatment as a new standard of care.

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Correspondence to: Christophe Meune, MD
Yannick Allanoire, MD, PhD
René Descartes University, Cochin Hospital
Paris, France

REFERENCES

Abnormal Right Ventricular Diastolic Function May Not Be the Only Early Marker of Myocardial Involvement in Systemic Sclerosis

To the Editor:

We read with great interest the study of Lindqvist et al (August 2005) concerning 26 patients with systemic sclerosis (SSc) and matched control subjects. In their population of patients with SSc (mean ± SD age, 56 ± 15 years; mean disease duration, 11.8 ± 8.7 years), they found no alterations in left ventricular (LV) systolic or diastolic function and also in right ventricular (RV) systolic function. In contrast, they demonstrated abnormal RV diastolic function. As they evaluated age-matched control subjects and investigated patients using both conventional and tissue-Doppler echocardiography, which is a modern and accurate method, their findings of alteration in RV diastolic function may be considered to be robust.

As discussed in their article, RV involvement may have a different origin, including primary myocardial involvement, lung fibrosis, and/or pulmonary artery hypertension. Based on the absence of LV or RV systolic abnormalities and extensive lung fibrosis, they assumed that RV diastolic abnormalities are consistent solely with pulmonary artery hypertension; they also addressed a few limitations concerning the assessment of pulmonary artery pressure by resting echocardiography. However, to our knowledge, the absence of systolic abnormalities using conventional techniques does not rule out primary myocardial involvement. Moreover, diastolic function may be altered very early in the course of SSc, and may be consistent with primary myocardial involvement. Even more intriguing may be the absence of LV systolic, LV diastolic, and RV systolic abnormalities. In fact, we and others have previously highlighted that patients with SSc often exhibit myocardium perfusion abnormalities in up to 100% together with LV diastolic dysfunction, and also RV systolic dysfunction; moreover, these alterations were demonstrated in both cutaneous subtypes of the disease and in patients with normal pulmonary artery pressure and early manifestations of SSc (duration of disease, <5 years). The question is how to explain the absence of any alterations in both LV functions in up to 100% together with LV diastolic dysfunction, and also RV systolic dysfunction. Moreover, these alterations were demonstrated in both cutaneous subtypes of the disease and in patients with normal pulmonary artery pressure and early manifestations of SSc (duration of disease, <5 years). The question is how to explain the absence of any alterations in both LV function and RV systolic function.