symptoms ($P = .45$). 1 Although patients with COPD and MCI had a slightly higher ESS total score (8.42) compared with patients with COPD without MCI (6.28), the difference did not reach significance ($P = .62$). 2 Furthermore, no significant difference was found in the proportion of subjects with excessive daytime sleepiness (ESS $\geq 10$) between patients with COPD and control subjects (20% vs 18%; $\chi^{2}$ test = 0.02; $P = .90$) or between patients with COPD with and without MCI (29% vs 15%; Fischer exact test, $P = .41$). Therefore, although we could not determine the proportion of subjects with objectively confirmed OSA in our sample, our results on the ESS suggest that daytime sleepiness, which is a central symptom in OSA diagnosis, is probably not a major factor explaining the high frequency of MCI in the COPD cohort.

Nevertheless, as mentioned by Dr Damiani and colleagues, the coexistence of OSA and COPD (overlap syndrome) 3, 4 may cause more severe cognitive impairment, increasing the risk of cognitive decline in this subgroup of patients. This would have important implications for the clinical support and follow-up of patients with COPD. Thus, further longitudinal studies in larger samples are needed to better assess the impact of OSA on cognition in COPD.

Jillene Villeneuve, PhD
Berkeley, CA
Véronique Pepin, PhD
Nadia Gosselin, PhD
Katia Gagnon, BSc
Jean-François Gagnon, PhD
Montreal, QC, Canada

Affiliations: From Helen Wills Neuroscience Institute (Dr Villeneuve), University of California, Berkeley; Centre de recherche (Drs Pepin, Gosselin, and Gagnon and Ms Gagnon), Hôpital du Sacré-Cœur de Montréal; the Department of Exercise Science (Dr Pepin), Concordia University; the Department of Psychiatry (Dr Gosselin), Université de Montréal; and the Department of Psychology (Dr Gagnon and Ms Gagnon), Université du Québec à Montréal.

Financial/nonfinancial disclosures: The authors have reported to CHEST the following conflicts of interest: Dr Pepin has received honoraria from GlaxoSmithKline for serving on the ADC113877 steering committee. Ms Gagnon and Drs Villeneuve, Gosselin, and Gagnon have reported that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

Correspondence to: Jean-François Gagnon, PhD, Centre d’Études Avancées en Médecine du Sommeil, Hôpital du Sacré-Cœur de Montréal, 5400 boul. Gouin ouest, Montréal, QC, H4J 1C5, Canada; e-mail: gagnon.jean-francois@ uqam.ca

© 2013 American College of Chest Physicians. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians. See online for more details.

DOI: 10.1378/chest.13-0094

References

Antithrombotic and Thrombolytic Therapy for Valvular Disease
Can This Guideline Apply to Chinese?

To the Editor:

We were pleased to read the article by Whitlock et al 1 in the February 2012 supplement issue of CHEST. They concluded, “In patients with a mechanical mitral valve (both the aortic and mitral position), we suggest [vitamin K antagonist] therapy with a target [international normalized ratio (INR)] of 3.0 (range, 2.5-3.5).” 2 However, we have several concerns about their conclusion.

First, thromboembolism and bleeding while receiving anticoagulants continues to account for 75% of all complications following mechanical heart valve replacement. 3 A significant trend toward a higher frequency of thromboembolism events was observed in the group of non-Chinese patients in Western countries, while the trend in Chinese patients was a higher frequency of bleeding. Hence, there was always doubt as to whether the guideline was appropriate for Chinese patients. This high-intensity strategy is relatively more effective for races other than Chinese. INR levels between 1.5 and 2.0 are recommended for Chinese patients with anticoagulation treatment after mechanical heart valve replacement. 3

Second, West China Hospital, in Chengdu, has developed a national, multicenter database (Anticoagulation Therapy Database of Chinese Patients After Heart Valve Replacement, unpublished data, January 2011-December 2012) of patients who have undergone heart valve replacement since 2011. The database is part of the Low-intensity Anticoagulation Study. The database is now one of the largest of its kind in China, with 45 centers from 15 provinces participating in the project. To date, detailed information has been collected from >8,000 patients. The preliminary research demonstrates that when INR values are between 1.5 and 2.0, the incidence of both thromboembolic and bleeding complications is the lowest.

Patients in the study need rigorous follow-up. We embarked on this study to establish an anticoagulant guideline that is in accordance with the characteristics of Chinese following heart valve replacement, as well as to provide a potential clinical research tool for the future.

Bo Fu, MD
Huaidong Chen, MD
Li Dong, MD
Chengdu, China

Affiliations: From the Department of Cardiac Surgery, West China Hospital, Sichuan University. All authors contributed equally to this work.

Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

Correspondence to: Li Dong, MD, Department of Cardiac Surgery, West China Hospital, Sichuan University, No. 37, Guoxue Alley, Chengdu, Sichuan Province, 610041, China; e-mail: dongli1990@163.com

© 2013 American College of Chest Physicians. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians. See online for more details.

DOI: 10.1378/chest.13-0094
REFERENCES


Response

To the Editor:

We thank Drs Fu and colleagues for their letter regarding the applicability of the American College of Chest Physicians guidelines on antithrombotic and thrombolytic therapy for valvular disease to Chinese patients. To clarify, the guidelines on mechanical valves recommend the following:

1. In patients with a mechanical aortic valve, we recommend VKA (vitamin K antagonist) therapy with a target of 2.5 (range, 2.0-3.0) over higher targets (Grade 1B).

2. In patients with a mechanical mitral valve, we suggest VKA therapy with a target of 3.0 (range, 2.5-3.5) over lower international normalized ratio (INR) targets (Grade 2C).

3. In patients with mechanical heart valves in both the aortic and the mitral positions, we suggest target INR 3.0 (range, 2.5-3.5) over target INR 2.5 (range, 2.0-3.0) (Grade 2C).

However, the gist of the letter from West China Hospital is valid. INR targets in Chinese patients, and indeed in all patients, need higher-quality evidence than what currently exists. Differing INR targets based on thromboembolic risk is unique to heart valve disease; antithrombotic therapy and prevention of thrombosis, 9th ed: American College of Chest Physicians evidence-based clinical practice guidelines. Chest. 2012;141(2)(suppl):e576S-e600S.


The Predictive Value of Interferon-γ Release Assays and Tuberculin Skin Test

What About Those Not Vaccinated With Bacillus Calmette-Guérin?

To the Editor,

In a recent meta-analysis in CHEST (July 2012), Diei et al. concluded that interferon-γ release assays (IGRAs), including QuantiFERON-TB Gold (QFT-G) (Cellestis, a company of Qiagen GmBH), QuantiFERON-TB Gold In-Tube (QFT-GIT) (Cellestis, a company of Qiagen GmBH), and the T-SPOT.TB ELISPOT (Oxford Immunotec Ltd), have a higher positive predictive value (PPV) and negative predictive value (NPV) for progression to active TB compared with those of the tuberculin skin test (TST). The PPV and NPV in those not vaccinated with bacille Calmette-Guérin (BCG) was not shown because the majority of the study participants had a history of BCG vaccination. Therefore, the results should apply mostly to the BCG-vaccinated and not be generalized.

A previous study in contacts of patients with TB by the same authors disregarded the analysis in the population at the highest risk of disease, that is, BCG-unvaccinated close contacts exposed to patients who tested positive on smear with pulmonary disease. But further analysis found that the PPVs of QFT-GIT and TST were not statistically different. This indicates that both tests may predict TB disease similarly in this population. This is probably one of the reasons why the use of TST continues in most low-burden settings where the BCG vaccine has been discontinued.