LETTER TO THE EDITOR

Author's response

In response to the letter of Aydogan et al. [1] concerning our study entitled "The influence of acute pulmonary embolism on early and delayed prognosis for patients with chronic heart failure" published in *Cardiology Journal* [2] we agree that in order to assess major risk factors for mortality in patients with chronic heart failure (CHF) large--scale prospective randomized studies in this group of patients would be of value. It is clear that not only co-morbidities in CHF but also medication used for treatment of co-morbidities and the patients' lifestyles affect complications and the prognosis in this group of patients [3]. Aydogan et al. [1] suggested that the treatment of acute pulmonary embolism (APE) in CHF patients should be longer than the standard 3-month treatment. Authors also stated that CHF is an irreversible and persistent, chronic risk factor for APE and therefore anticoagulants should be prescribed for life long therapy. However, according to the current quidelines, CHF is only a moderate risk factor for APE, and in patients with the first episode of APE it does not imply a treatment longer than 3 months, unlike in the case of neoplasm or some severe thrombophilias when long-term anticoagulant therapy is justified [4]. We fully agree that CHF patients are at a greater risk of thromboembolic complications. In our study we have also proven that APE is an independent risk factor for an early death in CHF patients; we have additionally suggested that standard secondary prophylaxis following an acute episode of pulmonary embolism maybe insufficient for this group of patients. We think that CHF patients with the first APE episode is not a homogenous group. Most probably it includes high and low risk patients of APE recurrence. Therefore it seems justified to create and define a scale which will be helpful for the assessment of APE recurrence. Such scale could follow the idea of CHADS$_2$-VASC score currently used for risk stratification of thromboembolic complications in patients with atrial fibrillation [5]. We are sure that despite similar degree of left ventricular dysfunction elderly patients in NYHA functional class III with limited mobility are at higher risk of APE recurrence than younger ones with successful CHF therapy and no activity limitations. Perhaps CHF patients with high risk of APE recurrence should be treated with anticoagulant therapy much longer and even more intensely during the first months. Similarly to Aydogan et al. [1], we also have many questions and doubts concerning the treatment of patients with CHF and APE, and that is why we once again stress that large-scale randomized studies assessing these patients are vital.

Conflict of interest: none declared

References

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Leszek Gromadziński[1], Piotr Pruszczyk[2]

[1]*Department of Internal Medicine, Gastroenterology and Hepatology, University Clinical Hospital, University of Warmia and Mazury, ul. Warszawska 30, 10–082, Olsztyn, Poland, tel: +48 89 524 53 89, e-mail: lgol@op.pl*

[2]*Department of Internal Medicine and Cardiology, Warsaw Medical University, Warsaw, Poland*