

6. Owa M, Aizawa K, Urasawa N, et al. Emotional stress-induced "ampulla cardiomyopathy": discrepancy between the metabolic and sympathetic innervation imaging performed during the recovery course. *Jpn Circ J* 2001;65:349-52.
7. Mori H, Ishikawa S, Kojima S, et al. Increased responsiveness of left ventricular apical myocardium to adrenergic stimuli. *Cardiovasc Res* 1993;27:192-8.
8. Bonnemeier H, Wiegand UK, Friedlbinder J, et al. Reflex cardiac activity in ischemia and reperfusion. Heart rate turbulence in patients undergoing direct percutaneous coronary intervention for acute myocardial infarction. *Circulation* 2003;108:958-64.
9. Abe Y, Kondo M, Matsuoka R, et al. Assessment of clinical features in transient left ventricular apical ballooning. *J Am Coll Cardiol* 2003;41:737-42.

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REFERENCE

1. Scheinert D, Scheinert S, Sax J, et al. Prevalence and clinical impact of stent fractures after femoropopliteal stenting. *J Am Coll Cardiol* 2005;45:312-5.

Letters to the Editor

Impact of Stent Fractures Following Femoropopliteal Stenting

With great interest we read the prospective registry of stent fractures after femoropopliteal stenting in a recent issue of the *Journal* (1). The observed rate of fractures of nitinol stents, which represent an essential progress compared with the use of balloon-expandable stents or wall stents, is astonishingly high in contrast to other studies and our own experience. We therefore regard it as essential to make some critical comments to avoid a too high assessment of the single-center observation.

The described results touch on an observational series in a single center, laid out prospectively and described as a register. However, a registry demands an external monitoring and evaluation of the results. This did not happen. Three types of stents, in varying numbers and of different lengths, were inserted into the vessels.

In 93 patients, 121 extremities were treated interventionaly; 261 stents were implanted. Moreover, the mean length of the stented segments was different in all, with the highest in the Luminexx stent with 168 mm (SD 94 mm). This is remarkably high, because, with a maximum stent length of 120 mm, more than two stents had to be used in various patients. But this is explicitly mentioned under precautions in the instructions for use.

Furthermore, in the publicized pictures of stent fractures of the original study and at different presentations at international congresses, only Luminexx stents are exposed. This is probably explained by the fact that a Luminexx stent, in comparison to a SMART or SelfX stent, is much more visible under X-ray. However, this can lead to a wrong assessment and overestimation of stent fractures. Furthermore, the color-coded duplex sonography was only used for stent patency. Therefore, the visual assessment of the stent has to be checked externally or carried out independently.

Finally, in different illustrations, stent implantations were shown without overlapping and also in the distal third of the superficial femoral artery (SFA) and in the first and second segment of the popliteal artery. In turn, this is obviously listed as a contraindication in the instructions for use. Therefore, the progress of the usage of nitinol stents in the SFA should not be questioned by an observational series done at a single center. Preferably, one should await the results of scientifically relevant prospective controlled and randomized studies.

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Bridging the Resource Gap in Heart Failure Expertise and Management: The Underacknowledged Role of Nurse Specialists

Recent studies in the *Journal* have raised concerns regarding the limited availability of heart failure (HF) specialists. Because HF care now incorporates increasingly complicated strategies and technologies, and because the number of HF patients is burgeoning, capable and specialized providers are in greater demand. The backbone of management must not be forgotten, however, and, as Konstam (1) suggests, "highly specialized clinicians" will clearly be needed to master the evaluation of the HF patient and the timing of HF interventions. The foundation of HF care rests upon the cognitive aspects: identifying and diagnosing the problem, using evidence-based medications, maintaining appropriate intravascular volume status, educating patients about the disease process, and considering device-related and end-of-life issues. Those termed "plumbers" and "electricians" by Naccarelli (2) should not replace, but augment, those who provide the cognitive aspects of HF care.

However, economic remuneration and exciting advances in procedural therapies have led many cardiologists away from the core of HF management, resulting in a shortage of HF providers. Less attention has been paid to the comprehensive strategies provided by specially trained nurses who have shown improved HF outcomes in the past and should not be overlooked as other solutions are posed. When studied in the context of multidisciplinary teams, often led by cardiologists, nurse specialists have been shown to contribute significantly to improving outcomes. The review by McAlister et al. (3) of 29 trials has identified that one of the three "crucial" elements in a successful program is the use of specially trained HF nurses. What role do nurse specialists have in HF management? They are able to monitor patients' intravascular volume status, titrate HF medications, triage and often avert admissions with appropriate telemanagement, and educate patients and families. Additionally, nurse specialists assist with complex levels of care when faced with end-stage strategies of transplant, end-of-life issues, or mechanical support.

Finally, the growing global burden of HF necessitates the investigation into alternative methods of providing coordinated, integrated, and focused care for patients. Though a clear need exists for subspecialized care of HF patients so that all appropriate options can be provided, the role that nurse specialists play in managing patients across the spectrum should be fully acknowledged. Nurse specialists should be part of the solution to the growing HF provider shortage, as multidisciplinary HF team