

REFERENCES

1. Jasti V, Ivan E, Yalamanchili V, Wongpraparot N, Leeser MA. Correlations between fractional flow reserve and intravascular ultrasound in patients with an ambiguous left main coronary artery stenosis. *Circulation* 2004;110:2831-6.
2. Fassa AA, Wagatsuma K, Higano ST, et al. Intravascular ultrasound-guided treatment for angiographically indeterminate left main coronary artery disease. *J Am Coll Cardiol* 2005;45:204-11.

Treating Hypertrophic Cardiomyopathy: Two Views

I am writing in response to the published views in *JACC* regarding treatment of hypertrophic cardiomyopathy (1). I am the president of the Hypertrophic Cardiomyopathy Association (HCMA), a nonprofit organization providing information, advocacy, and support to patients with this often misunderstood genetic cardiac disease, and to their families and the medical community. As such, I have the responsibility to speak on behalf of the over 2,500 HCM families represented by the HCMA.

The case for surgical septal myectomy presented by Maron et al. defends and promotes a time-honored treatment strategy with a balanced, well-referenced discussion, which is consistent with the recent 2003 American College of Cardiology/European Society of Cardiology (ACC/ESC) expert consensus panel on the management of hypertrophic cardiomyopathy (2). That document promotes surgical myectomy as the primary “gold standard” treatment for patients with severe heart failure and outflow obstruction refractory to medical treatment.

The “counterpoint” authored by Drs. Otto Hess and Ulrich Sigwart (3) was, in contrast, brief and incomplete. Specifically, the researchers chose to omit the surgical option from their HCM treatment algorithm. This arbitrary exclusion of surgical myectomy is contraproductive to providing clinicians and HCM patients with all the necessary information to understand the treatment options in this complex disease. The researchers have, therefore, omitted a treatment strategy from their Figure 1 (pg. 2055) (i.e., septal myectomy), which has, in fact, provided symptomatic benefits and enhanced longevity to thousands of HCM patients worldwide for over 45 years.

It is the role of the HCMA to provide information to our patients and families, which is accurate and consistent with the entire body of literature on HCM. Patients have a right to know all about treatment options available; therefore, it is a disservice to the patient population for Drs. Hess and Sigwart to arbitrarily withdraw the “gold standard” treatment of surgical septal myectomy from severely symptomatic obstructive HCM. These comments are presented in the best interests of the HCM patient population.

*Lisa Salberg

*Hypertrophic Cardiomyopathy Association (HCMA)
P.O. Box 306
Hibernia, NJ 07842
E-mail: support@4hcm.org

doi:10.1016/j.jacc.2005.09.011

REFERENCES

1. Maron BJ, Dearani JA, Ommen SR, et al. The case for surgery in obstructive hypertrophic cardiomyopathy. *J Am Coll Cardiol* 2004;44:2044-53.
2. Maron BJ, McKenna WJ, Danielson GK, et al. American College of Cardiology/European Society of Cardiology clinical expert consensus document on hypertrophic cardiomyopathy. A report of the American College of Cardiology Foundation Task Force on Clinical Expert Consensus Documents and the European Society of Cardiology Committee for Practice Guidelines. *J Am Coll Cardiol* 2003;42:1687-713.
3. Hess OM, Sigwart U. New treatment strategies for hypertrophic cardiomyopathy: alcohol ablation of the septum: the new gold standard? *J Am Coll Cardiol* 2004;44:2054-5.

REPLY

We agree completely with Ms. Salberg's views regarding the recently published point-counterpoint comparing surgical septal myectomy and alcohol septal ablation in the management of obstructive hypertrophic cardiomyopathy (HCM) (1,2). Ms. Salberg asserts that Drs. Hess and Sigwart have been unfair and misleading by arbitrarily expunging surgery from their HCM treatment algorithm. Surely, a debate on this important controversy is both warranted and timely, but it is incumbent on all clinicians to approach the problem with measured judgment and prudence—for there is much at stake. The central issue is simply the optimal therapy for the individual patient with obstructive HCM.

We believe that we have met this threshold honorably in presenting the case for surgery (1). Conversely, we share Ms. Salberg's substantial reservations regarding the brief counterpoint (2) in which Drs. Hess and Sigwart chose to literally obliterate surgery from consideration as a treatment option, as clearly evident in their prominent Figure 1. In the recent American College of Cardiology/European Society of Cardiology (ACC/ESC) expert consensus panel recommendations for HCM (3), septal myectomy is stipulated as the primary and “gold standard” treatment option for HCM patients with outflow obstruction and severe drug-refractory symptoms.

Publication of a point-counterpoint on the management of obstructive HCM was intended to be a fair presentation of divergent views—that is, pro and con, with one side presenting the case for surgery and the other supporting ablation, each contrasting their treatment of choice with the alternative strategy. However, the decision of Drs. Hess and Sigwart to intentionally leave the readership with a distinct impression that surgery is now obsolete is not only intellectually questionable but also very misleading to the HCM patient population and those practicing cardiologists charged with the role of gatekeeper in referring HCM patients for major interventions—such as surgery or ablation. This is particularly relevant given that myectomy is now associated with lower mortality (and morbidity) than alcohol ablation (1,3,4), and the recognition that arrhythmic sudden death can be a not uncommon consequence of ablation (4,5).

It is our absolute obligation to provide both physicians and patients with complete information regarding all the standard therapeutic options for drug-refractory severe obstructive HCM, and to avoid arbitrarily deciding for patients what they should (or