

noncardiologic treatments. This would appear to go against encouraging self-care, one of the initial objectives and one that has been assessed in previous studies.⁵

With regard to the multidisciplinary approach, we should not forget other levels of care and seek the involvement of primary health care professionals, who are usually the first point of contact when older patients attend the clinic for symptoms of acute heart failure.⁶ In addition, it would be a good moment to establish strong alliances with community nursing, which is also promoting goals such as self-care.

In summary, the authors are right in affirming that their results may be relevant for planning future heart failure units. In our humble opinion, it is necessary to standardize interventions through a health plan or program that overcomes the barriers between patients and their treatment.

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Comments on the Analysis of Telephone Calls to a Heart Failure Unit: Reasons for the Call and Resource Use. Response



Comentarios al análisis de la demanda telefónica en una unidad de insuficiencia cardíaca: motivos de consulta y utilización de recursos. Respuesta

To the Editor,

We read with interest the letter by Alconero-Camarero et al about our article, “Analysis of Telephone Calls to a Heart Failure Unit: Reasons for the Call and Resource Use,”¹ and we would like to make certain clarifications.

Our study merely refers to an assessment of the reasons for spontaneous telephone calls made by patients. The attention provided by telephone was not subject to a prior protocol. Likewise, the nurses’ responses were not standardized (Figure) and, as was stated, depended on the type of consultation. Obviously, this activity is complementary to other more important activities undertaken by the unit (education, supervision, treatment optimization, care for cases of decompensation, etc.). In no way should this task be compared with care programs or telephone-based follow-up of patients referred to by Alconero-Camarero et al.

We do not believe that our results indicate the telephone calls can be attributed to the lack of prior educational intervention in the patient’s treatment plan. They simply highlight that, among all the calls made, the main causes are related to treatment. Often, the caller was seeking a positive reinforcement, that is, confirmation of aspects dealt with in the educational intervention. In fact, although the concept of self-care includes a dimension of self-management, it is also important to know when to contact health care professionals. We also do not share their opinion that greater confidence in the staff of the unit and their accessibility, a crucial aspect of heart failure units, are in conflict with promoting self-

care, as the authors suggest. On the contrary, it can be considered a mechanism of self-care and encourages greater vigilance on the part of the patient.

We do agree, however, that the number of bureaucratic questions answered by nurses is worthy of attention, and this was behind our comment in the article.

Finally, we are (and have provided sufficient evidence of being) staunch supporters of a multidisciplinary approach and integration of other levels of care, such as primary health care, without this being mutually exclusive with facilitating as much as possible patient access to heart failure units.

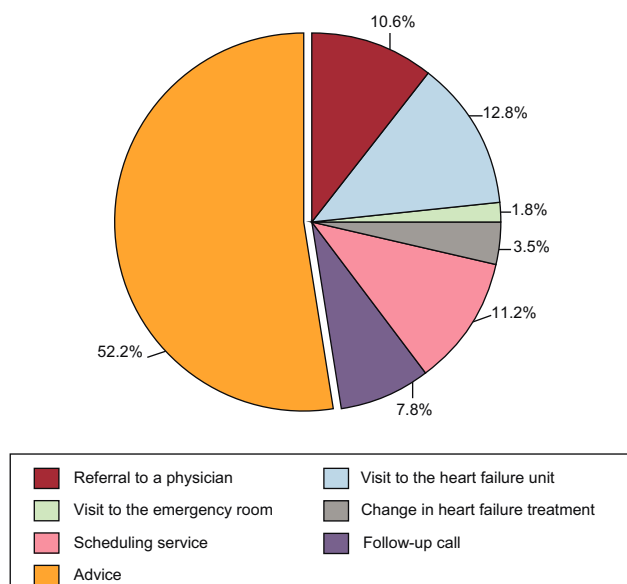


Figure. Type of response or intervention performed by nurses.

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Massive Left Ventricular Calcification: Related to Endomyocardial Fibrosis or Idiopathic?



Calcificación masiva del ventrículo izquierdo: ¿relacionada con la fibrosis endomiocárdica o idiopática?

To the Editor,

In a recent issue of *Revista Española de Cardiología*, Flores-Ríos et al¹ briefly reported the case of a 66-year-old woman with massive left ventricular calcification and concluded that the underlying cardiac disease was endomyocardial fibrosis. However, we consider that their conclusion is questionable.

Endomyocardial fibrosis is a restrictive cardiomyopathy of unknown etiology that occurs almost exclusively in tropical and subtropical regions, particularly in some countries of Africa, India, and Brazil. The disease is characterized by irregular fibrous thickening of the endocardium in the apex and inflow tract of one or both ventricles. Superimposed thrombosis and endocardial calcification is common in advanced cases. Partial or total obliteration of the apical region of the ventricular cavities leads to diastolic dysfunction.² Echocardiography and, more recently, magnetic resonance imaging can demonstrate the typical lesions and constitute the most valuable techniques to confirm the diagnosis.³ Endomyocardial biopsy is useful only in the putative acute-subacute phase of the disease, when endomyocardial inflammation containing degranulated eosinophils and thrombosis would be present.⁴

In the reported case, the patient showed mild systolic, not diastolic, dysfunction and the massive calcification was located mainly in the myocardium. No ventricular apical obliteration was reported on echocardiography. An endomyocardial biopsy showed nonspecific findings, ie, cardiomyocyte hypertrophy and endomyocardial fibrosis bands. Therefore, the diagnosis of endomyocardial fibrosis lacks consistency.

Tissue calcification can be metastatic or dystrophic. Metastatic calcification occurs in normal tissue due to hypercalcemia; we have no data about the serum calcium levels of the reported patient. Dystrophic calcification of the myocardium is secondary to tissue necrosis and has been reported in several conditions such as

myocardial infarction, myocarditis, idiopathic mitral annular calcification, and endomyocardial fibrosis.⁵

In conclusion, although endomyocardial fibrosis could be a possibility, on the basis of the reported data, we consider that there are no definite criteria for this specific diagnosis and that the massive left ventricular calcification in the patient should be considered of unknown etiology.

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