

Letters to the Editor

New Data About Atrial Fibrillation, Comment to the OFRECE Study**Nuevos datos sobre fibrilación auricular, observaciones al estudio OFRECE****To the Editor,**

We have read with interest the timely article on the OFRECE study by Gómez-Doblas et al.¹ This study exclusively focused on the prevalence of atrial fibrillation (AF) in Spain and provided interesting data on the characteristics of AF in Spanish primary care (PC) centers.

The VAL-FAAP study² had previously demonstrated a prevalence of AF of 6.1% in a very large sample of patients receiving PC. Given the high number of patients included in the study, this figure could be close to the actual percentage of a population attending a PC center. Determining the actual percentage is the aim of this type of sampling. The methodology used in the OFRECE study may provide an even more accurate estimate. In this study, prevalence was around 4.4% of patients older than 40 years. This figure is very similar to that reported in a study conducted by our group in 2000,³ which included 6325 consecutive patients presenting at the PC center for any reason. Of these patients, 3.86% had a diagnosis of AF, although this finding is limited to the PC centers in a specific geographic area.

Our interest focuses on the OFRECE study,¹ conducted with the support of the Research Agency of the Spanish Society of Cardiology, because it attempted to determine the prevalence of AF in Spain. However, the study did not present data on thromboembolic risk in this population, although this could have been derived from the data. A future article may provide details on the distribution of CHADS₂ and CHA₂DS₂-VASc scores in this population in Spain, an issue that has gained increased importance in the clinical practice guidelines for AF.

The authors of the VAL-FAAP study recently presented an article on thromboembolic risk management.⁴ They suggested that there is a great deal of room for improvement in the application of antithrombotic therapy in AF patients at PC centers, because the treatment these patients receive does not match what they should be receiving according to their scores on the CHADS₂ and CHA₂DS₂-VASc risk stratification scales. Given these findings, we believe that the training and continuing education of PC physicians

should play a pivotal role in identifying patients at high thromboembolic risk. It could also be very useful to identify thromboembolic risk in the patients who attended Spanish PC centers in the OFRECE study.

We also believe that studies like OFRECE¹ or VAL-FAAP^{2,4} offer an excellent opportunity to obtain new data on AF, which has high morbidity and mortality and is frequently seen in PC centers. Any additional information on this disease should always be welcomed.

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New Data About Atrial Fibrillation, Comment to the OFRECE Study. Response**Nuevos datos sobre fibrilación auricular, observaciones al estudio OFRECE. Respuesta****To the Editor,**

We appreciate the interest shown by Vidal-Pérez et al. in our article published recently in *Revista Española de Cardiología*,¹ which provides us with an opportunity to present some interesting

additional information not included in the article itself. We agree on the importance of knowing the thromboembolic risk of the population included in the OFRECE study, both for patients with a diagnosis of atrial fibrillation and for the general population. In our study, the mean (standard deviation) CHADS₂ and CHA₂DS₂-VASc of patients with atrial fibrillation was 2.3 (1.3) and 3.8 (1.6), respectively. In the general population, the mean (standard deviation) CHADS₂ and CHA₂DS₂-VASc of patients with atrial fibrillation was 0.8 (1) and 1.8 (1.5), respectively. The distribution of both scales is in agreement with that of the Val-FAAP and AFABE studies,^{2,3} although the similarity is greater in the

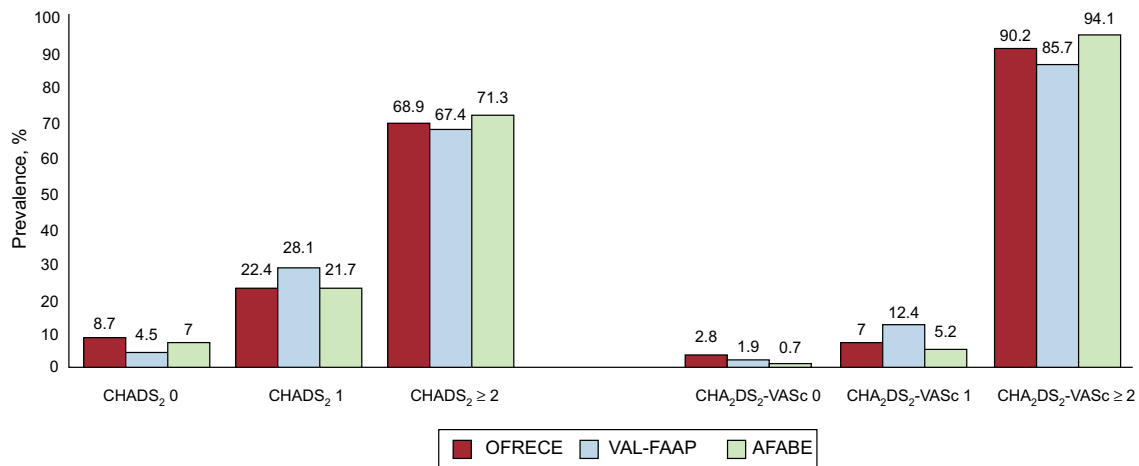


Figure. Prevalences by thromboembolic risk scales in the OFRECE, AFABE, and Val-FAAP studies.

2 population-based studies (Figure). These data are, we believe, relevant because they show that the level of risk in the population with atrial fibrillation is very similar to that of the populations included in clinical trials with new oral anticoagulants. In addition, an increasing body of evidence suggests that thromboembolic risk, as measured with these scales in the population without a diagnosis of atrial fibrillation, is associated with the onset of events.⁴

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Specific Modeling and Quantification of the Aortic Valve



Modelo de cuantificación específico de la válvula aórtica

To the Editor,

I read with great interest the article “New Quantitative Model of Aortic Valve in PreTAVI Patients.”¹ The authors implemented a new, specialized software (Auto Valve Analysis, Siemens; California, United States) to evaluate transcatheter aortic valve implantation. Although the authors focused only on aortic annulus, this novel software can provide more accurate and additional information to the interventional cardiologist.

For patients presenting with severe aortic stenosis and at high risk for surgery transcatheter aortic valve implantation, this is an alternative therapy.^{2,3} Coronary obstruction due to the displacement of the calcified native valve leaflets over the coronary ostia, especially in the setting of lower-lying coronary ostium and shallow sinus of Valsalva, is a life-threatening complication of

transcatheter aortic valve implantation. The combination of a relatively low-lying coronary artery ostium and a large native aortic valvar leaflet can obstruct the flow. Therefore, it is essential to assess the relation between ostia and leaflet position before the procedure. Additionally, the width of the sinus of Valsalva should be assessed. Aortography, computed tomography, and transesophageal echocardiography are used to evaluate the annulo-ostial distance and width of sinus of Valsalva. With the advent of the automated quantitative modeling of the aortic root from 3D-transesophageal echocardiography (Auto Valve Analysis, Siemens), leaflet anatomy (leaflet length and height), annulus to coronary ostia distance, and height and width of sinus of Valsalva can be measured. Besides the assessment of aortic annulus to determine the ideal implant valve size, the position of the coronary arteries relative to the aortic leaflets (annulus-leaflet-ostia relationship) can be assessed by this novel software.^{4,5}

The aortic annulus is formed by joining the basal attachment points of the leaflets within the left ventricle.⁶ The shape of the annulus is noncircular, may be oval or elliptical shape, and with calcification becomes nonhomogenous. The noncircularity of