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Reply to the Letter to the Editor: "The Need for a New Description of Red Flags in Cardiac Amyloidosis in Turkish Population"

Editöre Mektup Yanıtı: Türk Toplumunda Kardiyak Amiloidozda Kırmızı Bayrakların Yeni Bir Tanımına Olan İhtiyaç

LETTER TO THE EDITOR REPLY
EDİTÖRE MEKTUP YANITI

To the Editor,

We thank the authors[1] for their interest in our recent article titled "The Most Predictive Red Flags for Suspecting Cardiac Amyloidosis in Patients with Heart Failure with Preserved Ejection Fraction" and the Journal for allowing us to respond to the comments on our work.[2]

Firstly, this was a prospective, observational study, and the aim was to identify markers of transthyretin cardiac amyloidosis (TTR-CA) and the frequency of TTR-CA in heart failure patients with preserved ejection fraction (HFpEF). Patients were included based on the diagnosis of HFpEF.[3] Patient enrollment started after Ethics Committee approval in 2020. While the included patients were analyzed at the end of the study, the 2021 "Diagnosis and Treatment of Cardiac Amyloidosis: A Position Statement of the European Society of Cardiology"[4] was also taken into consideration during data analysis for red flags. The 2021 position statement of the European Society of Cardiology (ESC) for cardiac amyloidosis (CA) was used just for the evaluation of red flags after patient enrollment was completed.

Secondly, as stated in the methods and results section, not only HFpEF patients with left ventricular hypertrophy (LVH) were included, but also patients diagnosed with HFpEF who had a high clinical suspicion of TTR-CA at the discretion of the patients' physicians, even in the absence of LVH, were included in the study. Once again, we want to remind you that the 2021 ESC position statement for CA was used just for the evaluation of red flags during data analysis, not for the inclusion or screening of the patients. In the literature, it has been reported that TTR-CA etiology is found in 5.2% of HFpEF patients without LVH.[5] In our observational study, if the patient had any cardiac or noncardiac suspicion of TTR-CA, such as neuropathy or atrioventricular conduction disease, the patient was investigated for TTR-CA. Clinical suspicion is the key element for the diagnosis of TTR-CA.

We appreciate your effort in sharing the characteristics of the TTR-CA patients you diagnosed. However, it would not be right to compare the clinical features of your four patients with those of our study population, as we included only HFpEF patients, but it would be complementary to our study results. Management of CA requires close collaboration with other disciplines, including Cardiology, Nuclear Medicine, Hematology, Radiology, Genetics, and Pathology. Experience in the diagnosis of CA is also very important, not only for cardiologists but also for Nuclear Medicine specialists, Hematologists, Radiologists, etc. Centers of excellence for the management of CA would be ideal. As you have emphasized, CA is a disease with increasing awareness and heterogeneous features, and it has a complex diagnostic process. With the increase in the number of experienced clinicians and centers in this field, the most predictive red flags determined to reach the diagnosis will gain more clarity both in our country and all around the world.

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