Letter to the Editor

Cardiomyopathies and myocardial disorders in Africa: present status and the way forward

Response to Prof Bongani Mayosi

Dear Sir

We are grateful to Prof Bongani Mayosi[1] for his comments on our article 'Cardiomyopathies and myocardial disorders in Africa'.[2] We thank him for bringing to our attention previous publications from Africa on left ventricular non-compaction and ion channelopathies. These publications were not available to us when we wrote the article. It however shows that these diseases also exist in Africa.

Interestingly we have, since our publication, encountered a case of Brugada syndrome in our practice, although we are yet to report the case. We therefore agree that many of the myocardial diseases reported from the rest of the world probably also exist here in Africa.

The current problem however is how to define and classify the cardiomyopathies. One of us (AF) was part of the group that first proposed the name cardiomyopathy for this group of diseases.[3,4] We also classified them at the time, based on existing knowledge. The key principle we agreed upon at our meeting was to name any disease of the myocardium according to the disease that caused it. Those that we did not know the cause or causes of were the ones we regarded as cardiomyopathies.

In our view, subsequent attempts at classifying these disorders of the myocardium have disregarded this basic principle and have labelled virtually all diseases of the myocardium as cardiomyopathy. Such assumptions have made classification of the diseases more complex and difficult to use in routine clinical practice. They also ignore geographic differences in the causation and presentation of the diseases, especially in Africa where the problem of the cardiomyopathies is most profound.

We do not think that the current European Society of Cardiology classification is suitable for clinicians working in Africa.[5] We therefore believe that it is time for Africa to develop its own classification based on the realities on the continent.

Our classification was designed to trigger a debate in Africa towards this end and in so doing we have continued to maintain that basic philosophy of calling every disorder of the myocardium by the disease that caused the disorder. We have through that avoided the unending controversies surrounding the definition of cardiomyopathy and have attempted to bring all the disorders of the myocardium under one classification. We agree that the Pan-African Society of Cardiology (PASCAR) should take further steps to either adopt or modify this classification to suit the clinical realities of Africa.

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EXAMINE Cardiovascular Safety Outcomes Trial

Data from the global EXAMINE (Examination of Cardiovascular Outcomes: Alogliptin vs Standard of Care in Patients with Type 2 Diabetes Mellitus and Acute Coronary Syndrome) cardiovascular safety outcomes trial was recently presented at the European Association for the Study of Diabetes: 49th annual meeting, 23–27 September 2013, in Barcelona, Spain.

Results indicated that alogliptin did not increase cardiovascular ischaemic events including all-cause mortality, non-fatal myocardial infarction, non-fatal stroke and urgent revascularisation due to unstable angina. Exploratory data also showed that rates of hospitalisation for heart failure were comparable across alogliptin and placebo groups.

The EXAMINE trial evaluated a total of 5 380 patients with type 2 diabetes and a recent acute coronary syndrome (within 15 to 90 days prior to randomisation). Alogliptin doses were adjusted according to renal function and the median duration of alogliptin exposure was 533 days.

At study end, mean HbA_{1c} change in level from baseline was –0.33 and 0.03% in the alogliptin and placebo groups, respectively.

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