catheterization. Both these patients show systolic paradoxical septal motion as well as an early diastolic anterior, then posterior, motion of the septum, similar to that described by the authors.

These comments are not meant to detract from the careful observations of the authors, but rather to caution the zealous echocardiographer from grasping a new sign as highly specific in itself and perhaps over-interpreting his studies out of clinical context.

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References

The authors reply:
To the Editor:

We agree with Dr. Hoche's comments that no echocardiographic pattern should be considered in itself pathognomonic of any particular disease. In fact, in our paper, specificity of our findings was not claimed, but only suggested.

The two echocardiograms presented by Dr. Hoche really show the pattern described by us. However, in case 2, constrinctive pericarditis cannot be ruled out with absolute certainty without cardiac catheterization.

Since our paper was submitted for publication we have studied seven more cases of constrinctive pericarditis; all of them showed the peculiar septal diastolic motion. In addition, we have seen three new instances of restrictive cardiomyopathy. Interestingly, in one of them the "specific" septal motion was present as well. This latter observation and Dr. Hoche's comments point to the need of further investigating the prevalence and specificity of the pattern described by us.

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Editor's Note: The following letter was received after the author's reply to the above letter. No further comment was felt necessary.

Sudden Early Diastolic Anterior Movement of the Septum in Endomyocardial Fibrosis

To the Editor:

We read with interest the paper by Candell-Riera et al.1 describing a brisk early anterior interventricular septal diastolic motion (IVSDM) in seven out of eight patients with chronic constrinctive pericarditis. They suggested that "it may prove to be a very useful sign in the usually equivocal diagnosis between restrictive cardiomyopathy and noncalcific chronic constrinctive pericarditis."

We recently had a patient with necropsy proven endomyocardial fibrosis which also showed the same echocardiographic appearance (fig. 1), but the pericardium was completely normal.

The patient was a 49-year-old white male with hypereosinophilic syndrome and a generalized pruriginous rash of unknown etiology for 5 years. The blood pressure was 135/80 mm Hg, the heart rate was 94 beats/min. Mitral and a tricuspid incompetence murmurs

Figure 1. A) and B) are examples of diastolic septal motion in two patients examined recently with no clinical signs of constrictive pericarditis.