Letters to the Editor must not exceed 400 words in length and must be limited to three authors and five references. They should not have tables or figures and should relate solely to an article published in Circulation within the preceding 12 weeks. Authors of letters selected for publication will receive prepublication proofs, and authors of the article cited in the letter will be invited to reply. Replies must be signed by all authors listed in the original publication. Please submit three typewritten, double-spaced copies of the letter to Herbert L. Fred, MD, % the Circulation Editorial Office. Letters will not be returned.

The Brugada Numbers

To the Editor:

In a Consensus Report on proposed diagnostic criteria for the Brugada syndrome, Wilde et al1 report an incidence “ranging between 5 and 66 per 10,000.” With a world population of 6,157,000,000,2 that would mean between 3,000,000 and 40,000,000 have the Brugada syndrome, similar in scope to the estimated 36,100,000 infected with HIV.3 This cannot be. More likely, the quoted numbers reflect the prevalence of the Brugada electrocardiographic pattern (the “Brugada sign”).3 Herein lies the dilemma. As the authors and others have clearly stated, the Brugada sign should not be equated with the Brugada syndrome.1,4 How then do we judiciously screen millions of individuals with the Brugada sign, most of whom are at risk for sudden death, to find the small percentage with the Brugada syndrome who are at risk of sudden death and in need of a defibrillator? The report by the Arrhythmia Working Group1 as well as other recent publications3 are “works in progress” to help answer that question.

Laszlo Littmann, MD
Michael H. Monroe, MD
Department of Internal Medicine
Carolinus Medical Center
Charlotte, NC


Reply

We thank Drs Littmann and Monroe for their letter to the editor. The numbers stemming from the calculations presented by Drs Littmann and Monroe are perhaps not as dramatic as suggested, in that the incidence of 5 per 10,000 is limited to those regions of the world where the Brugada syndrome is endemic—parts of Southeast Asia and Japan. The incidence of 66 per 10,000 quoted in our consensus report1 is limited to a small region in Japan. Moreover, it is important to recognize that the actual prevalence of the syndrome is a sensitive function of the criteria applied in the individual studies,2 which is one of the main reasons for the consensus conference and report. With less than a decade since the identification of the Brugada syndrome as a distinct clinical entity, it would be safe to conclude that data on its worldwide incidence remain out of reach. We take no issue with the other excellent points made in the letter and consider the question of how one might go about screening for those at risk for sudden death as rhetorical in that this is the subject of the consensus document.

Arthur A.M. Wilde, MD, PhD
Experimental and Molecular Cardiology Group
Academic Medical Center
Amsterdam, The Netherlands

Charles Antzelevitch, PhD
Masonic Medical Research Laboratory
Utica, NY

Martin Borggrefe, MD, PhD
Fakultät Klinische Medizin Mannheim
Universität Heidelberg
Mannheim, Germany

Josep Brugada, MD
Cardiovascular Institute
Hospital Clinic
University of Barcelona, Spain

Pedro Brugada, MD, PhD
Cardiovascular Center
Onze Lieve Vrouwe Ziekenhuis
Aalst, Belgium

Ramón Brugada, MD
Jeffrey A. Towbin, MD
Baylor College of Medicine
Houston, Tex

Domenico Corrado, MD
Divisione di Cardiologia
Università di Padova, Italy

Richard N.W. Hauer, MD, PhD
Heart-Lung Center Utrecht
University Medical Center Utrecht, The Netherlands

Robert S. Kass, PhD
Department of Pharmacology
Columbia University
New York, NY

Koonlawee Nademanee, MD
Division of Cardiology
University of Southern California
Los Angeles, Calif

Silvia G. Priori, MD, PhD
Molecular Cardiology and Electrophysiology Laboratories
Fondazione Salvatore Maugeri
Pavia, Italy For the Study Group on the Molecular Basis of Arrhythmias of the European Society of Cardiology

The Brugada Numbers
Laszlo Littmann and Michael H. Monroe

Circulation. 2003;107:e122
doi: 10.1161/01.CIR.0000071207.67541.01
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2003 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

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