when patients are asked merely to check the number of “drinks” they take in an average day. In a British study, the presence of abnormal liver function tests alerted the investigator to the possibility of excessive alcohol consumption in hypertensive patients. Raised serum transaminase levels are not found in moderate drinkers or after the occasional drinking session, but indicate that alcohol consumption has been sufficient (i.e., 80–300 g/day for at least 1 year) to produce some degree of liver cell necrosis.  

The importance of the link between alcohol consumption and hypertension is that blood pressure falls in the majority of patients, usually to “normal” levels. Strict abstinence may not be necessary, but it is advisable to limit alcohol intake to not more than 20–30 g/day. In our experience and that of others, treatment with antihypertensive drugs is usually of no avail while patients continue to drink heavily.

J. B. Saunders, M.B.
Liver Unit
King’s College Hospital
London, England

D. G. Beevers, M.D.
Hypertension Research Unit
Dudley Road Hospital
Birmingham, England

A. Paton, M.D.
British Postgraduate Medical Federation
London, England

References

I feel I must draw attention to this important paper lest any reader conclude that patch aortoplasty is necessarily the treatment of choice for any variety of coarctation.

Fergus J. Macartney
Department of Pediatric Cardiology
The Hospital for Sick Children
London, England

Benefits of Exercise for CAD Patients
To the Editor:

The recent article by Ehsani and colleagues was encouraging to those of us who believe in the health benefits of an exercise program for patients with coronary heart disease. However, I have several questions for the authors.

(1) You report a highly selected group of 10 patients with coronary heart disease, all with asymptomatic exercise-induced ST-segment depression. This is a rather unusual group. How many patients did you screen to get these 10?

(2) In addition, they all sustained high levels of exercise, levels that younger, healthy men frequently cannot tolerate. Of those admitted to your intensive exercise program, how many adhere? How many have orthopedic or cardiovascular complications?

(3) The specific lead with ST-segment depression was not given. Was ST-segment depression in lead Z included? In lead Z, ST-segment depression is really ST elevation anteriorly and is not due to ischemia when it occurs over Q waves.

(4) How many of these asymptomatic men with coronary disease actually had false-positive ST abnormalities (i.e., depression not due to ischemia)? Even though they had coronary disease, they might not have had ischemia. Did you perform radionuclide tests on them?

(5) In postinfarction patients, how could you measure left ventricular mass when the M-mode beam can cut through areas of scar or compensatory hypertrophy? Even using a cross-sectional area approach, we have been unable to find changes.

Though these results differ from those of most others, they are exciting, but their generalization to clinical practice is uncertain. The 10 men reported are a highly selected group with asymptomatic ST-segment depression and able to exercise at levels often difficult for younger men. If applied to most patients with ischemic heart dis-

Coarctation Resection vs Patch Angioplasty
To the Editor:

Connor and Baker, in their recent paper comparing coarctation resection with patch angioplasty, stated that “the long-term results of patch angioplasty are not available, so the long-term complications of this procedure are not known.” This may have been true at the time the manuscript was submitted, but by the time their revision was accepted, Bergdahl and Ljungqvist had already described a disturbingly high incidence of aneurysm of the aorta, unrelated to infection on the opposite side from the patch. They postulated that because the Orilon or Dacron patches used are less elastic than the aorta, they could therefore increase the forces acting on the aortic wall opposite, and therefore cause aneurysm formation. All these patients had been followed for at least 17 years after operation.

Connor and Baker, in their recent paper comparing coarctation resection with patch angioplasty, stated that “the long-term results of patch angioplasty are not available, so the long-term complications of this procedure are not known.” This may have been true at the time the manuscript was submitted, but by the time their revision was accepted, Bergdahl and Ljungqvist had already described a disturbingly high incidence of aneurysm of the aorta, unrelated to infection on the opposite side from the patch. They postulated that because the Orilon or Dacron patches used are less elastic than the aorta, they could therefore increase the forces acting on the aortic wall opposite, and therefore cause aneurysm formation. All these patients had been followed for at least 17 years after operation.
Benefits of exercise for CAD patients.
V F Froelicher

Circulation. 1982;65:1039-1040
doi: 10.1161/01.CIR.65.5.1039

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/65/5/1039.citation