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The Reply

We thank Dr Reiffel for his letter regarding our recently published article in ***The American Journal of Medicine***.[1] We agree with many of his comments when considering how to apply the study results to clinical practice.

Due to how data was collected in the registry, we do not have specifics about individual patients' heart failure etiology. We agree that atrioventricular (AV) nodal blockade is an important strategy for managing tachycardic-induced cardiomyopathy. However, other strategies can also be considered, including cardioversion and antiarrhythmic medication use.[2,3]

In our analysis, a patient was considered to be taking "multiple nodal blocking agents" if they were discharged on 2 or more of the medications indicated with the asterisk (nondihydropyridine calcium channel blocker, beta-blockers, digoxin, and other antiarrhythmics). Both 86.2% and 20.7% represent the patients discharged on nondihydropyridine calcium channel blocker/beta-blocker and nondihydropyridine calcium channel blocker/digoxin, respectively. There were some patients discharged on all 3 medications.

There was also concern about history of hypertension being associated with calcium channel blocker prescription at discharge. Because we did not consider patients discharged on amlodipine to have received a "contraindicated" medication, most of these patients identified with a "contraindicated" calcium channel blocker were discharged on verapamil or diltiazem. Although these medications are not considered first-line antihypertensive agents,[4] it is certainly possible that these medications could be part a rate control regimen to prevent tachycardia-induced cardiomyopathy.

Dr Reiffel discusses the beneficial use of verapamil with renin-angiotensin inhibition in patients after myocardial infarction heart failure. Regrettably, we did not have the data regarding history of myocardial infarction for the patients in this study, so we were unable to include this in the analysis.

In summary, although guidelines are meant to guide clinical care for most patients, we agree with Dr Reiffel that the nuances of each patient and clinical scenario need to be considered and may warrant deviations from guideline recommendations.

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