Atrium

This issue opens with a discussion by Fernando A. Navarro on the origin of the Spanish term *estatinas*. The author explains why this is a poor translation of the English statins and proposes various alternatives, which are possibly more appropriate in terms of etymological and lexicographic criteria.

This issue also includes 3 editorials discussing 3 distinct original articles. In the first, Stiermaier et al. comment on an interesting article by Fernández-Friera et al. examining the usefulness of T2-weighted cardiovascular magnetic resonance imaging to delineate ischemic myocardium at risk. In an experimental study in a swine model, the authors provoked infarction after occlusion of the left anterior descending (n = 4), right coronary (n = 4), and left circumflex arteries (n = 4). There was good concordance between cardiac magnetic imaging and histological analysis for quantification of the area at risk in anterior and inferior infarctions but not in territories depending on the circumflex artery. Stiermaier et al. highlight the interesting concept of establishing the area at risk based on the extent of edema in T_2-weighted sequences, which has been mentioned in other experimental studies, but also stress the need for future research to explain the lack of correlation in the circumflex territory.

Kalogeropoulos and Butler discuss an original article by Gómez-Otero et al., based on a prospective registry of 1420 patients admitted to hospital for heart failure, in which the authors compare the clinical characteristics and outcomes of patients with a midrange ejection fraction (40%-49%), corresponding to the new patient classification proposed in the European Society of Cardiology heart failure guidelines, with the patient groups with ejection fraction < 40% and > 49%. Kalogeropoulos and Butler point out that the group with midrange ejection fraction is not highly prevalent (16%) and shares baseline clinical characteristics with the other 2 groups. Irrespective of this consideration, outcomes were similar in the 3 groups, both in terms of mortality and hospital admissions. In this regard, the authors of the editorial mention 2 interesting concepts. First, a preserved ejection fraction does not necessarily mean preserved function, as shown by the worse outcomes of patients with preserved ejection fraction but alterations in longitudinal strain parameters. Second, patients with heart failure who, at some time in their clinical course, have a reduced ejection fraction that subsequently recovers have a more favorable prognosis than those with a persistently reduced ejection fraction and even those with symptoms of heart failure and persistently preserved ejection fraction. Kalogeropoulos and Butler agree with the authors both in the possible futility of the isolated use of ejection fraction as a prognostic marker in the acute phase and in the apparent lack of usefulness of the new classification of midrange ejection fraction, and stress the need for the use of biomarkers to refine risk-stratification models in this population.

Last, San Román and Rubio discuss an interesting article by Gutiérrez Carretero et al., in which the authors present their 30-year experience of 325 infections in cardiac implantable electronic devices; most were pacemaker infections (n = 229), which were followed up for at least 1 year. The most frequent extraction procedure was percutaneous traction (n = 280) and complete device extraction was achieved in 82.5%; the authors report few complications. Moreover, implantation of a new device, which was required in 209 patients, was carried out in a 1-stage procedure in most patients (73%), with good results. San Román and Rubio, in addition to reviewing major concepts in device infection, stress the most controversial aspect of the study: placement of the new device in the contralateral side in a 1-stage procedure, which requires negative blood cultures.

Among the original articles, Ladeiras-Lopes et al. present a provocative retrospective cohort study in 713 patients without known heart disease. The authors found that the ratio between visceral and subcutaneous adipose tissue, quantified by computed tomography, was associated with the combined event of death, infarction, or revascularization after 1.3 years of follow-up and that this association was independent of traditional risk factors and coronary artery calcium score. Whether this is a spurious finding or, as postulated by the authors, could be related to the role of adipose tissue as a modulator of cardiovascular homeostasis will have to be elucidated by future, specifically-designed studies.

On the topic of heart failure, Álvarez-García et al. present a retrospective analysis of the data from 2 multicenter national registries of patients treated by cardiologists (REDINSCOR, n = 2150) and internists (RICA, n = 1396), with the aim of comparing the clinical profiles and outcomes of patients with heart failure treated by these 2 specialties in the ambulatory setting. Cardiologist-treated patients were younger, predominantly male, and had reduced left ventricular ejection fraction and ischemic heart disease, while internist-treated patients were older, predominantly female, and had preserved left ventricular ejection fraction. After propensity-score matching in 558 patients in both groups, no differences were found in the readmissions rate, although belonging to the REDINSCOR registry was associated with a lower risk of mortality at 9 months (relative risk [RR], 0.64; 95% confidence interval [95%CI], 0.48-0.85). The question of whether this association can be explained by certain health care-related factors will have to be elucidated in future studies.

The final original article in this issue is a study by Meroño et al. exploring the impact of iron deficiency on functional capacity and quality of life at 1 month after an acute coronary syndrome in 244 patients. Of note, iron deficiency was found in up to 46% of patients: this group was older and had more comorbidities. Curiously, iron deficiency was associated with worse functional capacity, adjusted for the main comorbidities, even in patients without anemia. This condition was also associated with worse quality of life scores, even when adjusted for anemia. This study is especially interesting because of contradictory evidence in the literature on the role of serum iron concentrations in patients with acute myocardial infarction.

In our eagerness to offer our readers specialized reviews on topical issues, this issue contains 2 review articles on heart failure dealing with highly specific aspects not usually encountered by most clinical cardiologists in their routine practice. In the first, Sánchez-Enrique et al. discuss the basic principles of cardiac transplantation in advanced heart failure, summarizing its indications, assessment of possible candidates, current immunosuppression strategies, complications, and short- and long-term outcomes. The lack of donors, the long waiting times and the growing number of hemodynamically unstable patients have encouraged the development of mechanical circulatory support. Consequently, Sánchez-Enrique et al. discuss the fundamentals,

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advantages and disadvantages of this modality in these patients. In the same vein, Amat-Santos et al. provide a review summarizing the state-of-the-art of circulatory support, but in the context of acute heart failure, also discussing the rationale and the use of new percutaneous techniques in chronic heart failure aimed at left atrial decompression, left ventricle restoration, and pressure-guided implantable therapies.

As always, don't forget to take a look at the excellent images in this issue or read the scientific letters and letters to the Editor, which will undoubtedly stimulate an enriching debate, or participate in our monthly ECG Contest.

Ignacio Ferreira-González
Editor-in-Chief