believe that priority assessment in patients awaiting heart transplantation on the basis of QT dispersion measurements is premature.

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Reply

We appreciate the interest of Zabel and colleagues in our recent report (1). We also agree that it is important to be clear regarding the interpretation of our results. We would like to respond to their comments.

1. The analysis of QT dispersion risk used two different measures of dispersion: the maximal − minimal QT interval (QTDISP) and the coefficient of variation of all QT intervals (QTCV). These variables were highly significant ($p = 0.009$ and $p = 0.001$, respectively) when analyzed as continuous variables without selection of a cutoff. The dichotomization of patients on the basis of a cutoff for QTDISP of 140 ms and QTCV of 9% presented in our report was for illustrative purposes only. The actual statistical model yields a continuum of risk based on the value for QTDISP and QTCV. The significance of these predictors remained after adjustment for other potential risk factors in a multivariate analysis and after the removal of the 13 subjects with atrial fibrillation. It can be seen in the original report that all analyses consistently showed the utility of QT dispersion as a risk factor when measured as described in the patient cohort under study (1).

Recent prospective studies (1,2) have demonstrated a significant correlation between QT dispersion and mortality in patients with heart failure, although some preliminary studies may suggest otherwise. It is reasonable to assume that patients awaiting heart transplantation represent a sicker subset of patients whose data may not be extrapolated to patients with heart failure in general. We look forward to reading the final published reports on the subject alluded to by Zabel and colleagues (3,4).

2. The issue is raised that U waves may have contributed to an increase in measured QT dispersion in the patients studied. However, U waves were not included in the analysis (1) and therefore did not contribute to increased QT dispersion in the original report.

3. In terms of electrocardiographic (ECG) analysis, the ECGs were read by two independent observers blinded as to outcome, with the aid of a magnifying lens, without a digitizing pad. The method for obtaining ECGs was, as surmized, a standard 4×3 format. We used this ECG format because it is currently the standard method for obtaining ECGs and therefore most widely applicable with existing equipment. Although transient changes in heart rate during the brief period of acquisition could have affected QT dispersion, we doubt that a sizable and systematic pattern would have occurred that would have affected its measurement.

4. We considered the possibility that patients with atrial fibrillation whose RR intervals can vary from beat to beat could have affected the interpretation of our data. In fact, not only did we consider this possibility, but we included specific data on this subject in the published report (1). Although patients with atrial fibrillation were included in most of the overall analyses, we did report specific data in which the 13 patients with atrial fibrillation were excluded from analysis (see Fig. 3 and the results and discussion sections). Indexes of QT dispersion remained significant predictors of risk both before and after the 13 subjects with atrial fibrillation were removed from the analysis.

As ardent students of the scientific process, we hope that our work serves as the springboard for additional studies in this area, so that we can ultimately know how to best select patients who are still likely to die while awaiting a donor heart.

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Echocardiography in *Staphylococcus aureus* Bacteremia

Fowler et al. (1) investigated the diagnostic and prognostic usefulness of transesophageal echocardiography (TEE) in patients with *Staphylococcus aureus* bacteremia. The authors suggest that infective endocarditis is common in patients with *S. aureus* bacteremia and is