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LETTERS TO THE EDITOR

More on the History of Arrhythmia in Long QT Syndrome

I read with great interest the report by Etheridge et al. (1) entitled "A New Oral Therapy for Long QT Syndrome."

First, I should like to congratulate the investigators for their valuable contribution. They found that in patients with long QT syndrome due to HERG mutations there was an improvement in repolarization in parallel with a normalizing serum potassium level after oral potassium (and spironolactone) administration.

Their final sentence summarizes the present situation as follows: "Further studies are warranted to determine whether they will reduce the incidence of life-threatening events in LQTS patients" (1).

We agree with this statement completely, but I would additionally draw the attention of the authors of the study and the Editorial Comment (2) to the family reported by Gamstorp et al. (3) some 40 years ago. Although the affected members of the family were slightly hypokalemic, the administration of potassium led not only to a diminishment of the electrocardiographic abnormalities but also to cessation of the Adams-Stokes attacks.

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REPLY

We thank Dr. Csanády for his interest in our report (1) and for bringing to our attention the report by Gamstorp et al. (2) of a family whose members presented with syncope associated with hypokalemia. Although hypokalemia is a known trigger for life-threatening arrhythmia in long QT syndrome (LQTS) patients, the consistent finding of hypokalemia in this family suggests a fundamental abnormality of potassium homeostasis. Hypokalemia is a common feature of Andersen-Tawil syndrome, triggering both skeletal muscle paralysis and ventricular arrhythmias. We would like to emphasize that no subject in our study was hypokalemic at baseline, and therefore the therapy did not normalize patients' serum potassium but, rather, increased their serum potassium to the upper limits of normal.

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Impaired Vascular Reactivity in Patients With Erectile Dysfunction

In the January 21, 2004 issue of the *Journal,* Kaiser et al. (1) reported about endothelial function in patients with erectile dysfunction (ED) and no vascular risk factors. They found this group as having significantly less vasodilation to both ischemia (endothelium dependent) and nitroglycerin (endothelium independent) stimuli than normal subjects. These data led the investigators to conclude there was a peripheral vascular defect occurring before the development of overt vascular disease, thus reinforcing the concept of ED as an early marker for systemic vascular disease (1).

We believe that one major point needs clarification. Patients were classified as having ED according to the International Index of Erectile Function (IIEF) (2). This is a 15-item validated self-administered questionnaire that explores five domains of sexual function: erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. Erectile function is specifically addressed by six questions, 1, 2, 3, 4, 5, and 15, which form the so-called "erectile function domain" of the questionnaire. Each question is scored 0 (or 1) to 5 with a minimum and maximum score of 1 and 30, respectively. Erectile dysfunction is defined as any value <26. Below this cut-off