**Are Angiotensin-Converting Enzyme Inhibitors and Beta-Blockers Ineffective in Children With Dilated Cardiomyopathy and Heart Failure?**


**Correspondence**

Tajinder P. Singh, MD, MSc

Christopher Almond, MD

Department of Cardiology

Children’s Hospital Boston

300 Longwood Avenue

Boston, Massachusetts 02115

E-mail: tp.singh@cardio.chboston.org

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However, the introduction of ACEI therapy in our series (1) occurred many years before (1983) the availability of heart transplantation, and in the case of beta-blocker therapy, most patients (1998 to 2004) began to receive this well after transplantation was established. Moreover, we showed that the patients most likely to die or receive a transplant were those who did not receive any oral agents. Regarding the propensity for transplantation, we have acknowledged this limitation, but have also shown that the advent of transplantation did not change the probability of the combined end point (death or transplantation) being reached when the pre-transplantation and current eras were compared. In addition, and contrary to their assertion, we did not show that patients receiving digoxin were more likely to die than to receive a transplant.

Drs. Singh and Almond’s concern that transplant availability acts as a bias in treatment strategy is overwrought and also unsupported by any data. Almost every patient in our practice has undergone transplantation from a status of refractory heart failure, thus representing a de facto failure of medical therapy and justifying the concept of a composite end point. This concept is also broadly accepted in the pediatric cardiology literature (2,3).

We agree, however, that there has been a tendency to treat patients with these medications absent a compelling level of evidence, and we believe also that our experience is helpful in demonstrating equipoise regarding their effectiveness in this setting. Our data emphasize the need for adequately powered prospective randomized trials of therapy for children with this group of diseases.

*Paul F. Kantor, MB.BCh, DCH

*Hospital for Sick Children
Cardiology, 1725 I
555 University Avenue
Toronto, Ontario M5G 1X8
Canada
E-mail: paul.kantor@sickkids.ca

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