ventricular lead placement, whereas Bogaard et al. measured \(\text{dp/dt}_{\text{max}}\) after implantation and a guided approach may explain differences in remodeling and outcome. In keeping with our results, optimal left ventricular lead positioning produces marked variation in acute \(\text{dp/dt}_{\text{max}}\) (3), better remodeling, and reduced events (heart failure hospitalizations/death) (4). It is also important to appreciate that remodeling may not always correlate with clinical outcome especially in ischemic cardiomyopathy patients.

Bogaard et al. (2) reported clinical outcome and remodeling or hospitalization for heart failure. Data were not consistently available or reported (nearly 50% of deaths were noncardiac or unknown) and they state that whether acute improvement in \(\text{dp/dt}_{\text{max}}\) correlates to morbidity still needs to be determined (2).

In summary, we are in agreement with Prinzen et al. that a prospective randomized controlled study will be needed to confirm a favorable effect of \(\text{LVdP/dt}_{\text{max}}\)-guided therapy on prognosis and functional status after cardiac resynchronization therapy.

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ACCF and AHA Presidents’ Letter on MEDCAC

On January 25, 2012, the Centers for Medicare and Medicaid Services (CMS) convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) to review the evidence on the management of patients with carotid atherosclerosis with particular reference to revascularization. We are gratified that MEDCAC’s recommendations reflect those in the ASA/ACCF/AHA/AANN/AANS/ACR/ASNR/CNS/SAIP/SCAI/SIR/SNIS/SVM/SVS Guideline on the Management of Patients With Extracranial Carotid and Vertebral Artery Disease (1).

The MEDCAC decision reaffirms the utility and validity of the multidisciplinary guideline that has been endorsed by these organizations as a sound basis for clinical practice.

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