thromboembolic and heart failure risk. Determining whether patients can safely stop taking anticoagulants after SR is restored by a maze procedure requires long-term follow-up and stroke surveillance beyond the HESTER study. The varying rates of LA functional recovery after maze means that it would be prudent to measure atrial function before considering anticoagulation withdrawal.

In summary, a return to SR after adjunct maze is associated with recovery of LA function but with a mean ALAEF smaller in maze patients than in control subjects. This functional recovery and the variability observed within it may have important implications for survival, heart function, and clinical decisions on long-term anticoagulation.

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Deferred Stenting in STEMI

Still an Interest in Selected Patients?

Deferred stenting (DS) in the setting of ST-segment elevation myocardial infarction (STEMI) has been the subject of numerous controversies, but the current view is that DS should be restricted to very selected cases, as demonstrated once again by Lønborg et al. (1). Notwithstanding, it is widely acknowledged that thrombus plays a key role in the pathophysiology of STEMI, and the size and composition of thrombus may affect the results of primary percutaneous coronary intervention, given the risk of distal embolization. The ratio of plaque to thrombus is highly variable among culprit lesions; it is also highly variable with time, and this represents the conceptual basis of the DS strategy. Despite the overall negative results of this study in terms of microvascular obstruction (1), we think that there is still a place for a "tailored DS strategy," provided that thrombus-laden lesions can be selected. In this respect, Lønborg et al. (1) showed a highly significant interaction between DS and lesion length that may represent an interesting parameter for selection of patients who are potentially eligible for DS.

This finding is perfectly in line with our observation that, in patients with STEMI who are treated with DS, the longer the culprit lesion, the greater is its shortening with time (2). In particular, for lesions longer than 23.7 mm (very close to the 24-mm cutoff reported by Lønborg et al. [1]), this shortening could reach more than 7 mm (2). Within such a brief time frame, this result clearly implies that the length of the lesion is associated with thrombus content. The paper by Loøborg et al. (1) strongly fuels the hypothesis of a prognostic advantage of DS in the presence of a long lesion, probably through thrombus regression. Although it is a post hoc analysis with all the inherent limitations of such a study, we find this result extremely promising for tailoring the best strategy during primary percutaneous coronary intervention. However, we acknowledge that routine DS in all patients with STEMI is probably not an option. We believe that further adequately designed clinical trials that have an evaluation of thrombotic load and lesion length as their basis should be encouraged.

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REPLY: Deferred Stenting in STEMI

Still an Interest in Selected Patients?

We thank Dr. Harbaoui and colleagues for their interest in our work evaluating the effect of a deferred stenting strategy versus immediate stenting on myocardial damage in patients with ST-segment elevation myocardial infarction (1). On the basis of the current evidence, we agree that deferred stenting as a routine strategy in patients with ST-segment elevation myocardial infarction cannot be recommended (1,2). The hypothesis has been that stenting in the presence of thrombus increases the risk of flow disturbances and distal embolization. Thus, deferred stenting could limit the occurrence of this phenomenon because thrombus burden is reduced when stent implantation is deferred to a second procedure. Although routine deferral is not advocated, the question is this: Will there still be room for deferred stenting in selected patients? Obviously, a high thrombus burden increases the risk of embolization, and as shown from our data, this also holds true for long lesions with expected heavy thrombus formation. Equally important, it was recently found safe to defer stenting for 7 days in patients with a high thrombus burden who were treated with additional glycoprotein inhibitors (3). Therefore, the benefit of the doubt could be given to recommending deferral of stenting in the subset of patients with a long lesion and a heavy thrombus burden (4). However, a considerable fraction of the patients in DANAMI-3 (Third Danish Study of Optimal Acute Treatment of Patients With ST-Elevation Myocardial Infarction) who had deferred stent implantation were also treated with glycoprotein IIb/IIIa inhibitors. The benefits of this alternative approach thus need to be evaluated in a larger randomized setting that takes the inherent risk of bleeding into account.

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Hormone Status Correlates With Incidence of Heart Failure

The paper by Hall et al. (1) published in the *Journal* and describing the effect of reproductive factors such as duration of productive time and nulliparity among participants of the Women's Health Initiative on incident heart failure elicited great interest among members of our research working group. Hall et al. (1) found that shorter total reproductive duration and nulliparity were associated with a risk of incident heart failure.

Because the precise cause of heart failure among participants of the Women's Health Initiative was not defined, it is possible that a significant portion of cases could in fact be Takotsubo syndrome (TTS). TTS predominantly affects postmenopausal women. This observation suggests a role of estrogen in TTS, which is associated with 5.6% mortality rate per patient-year (2). However, the pathogenesis of TTS is still not fully understood. A popular hypothesis suggesting involvement of a catecholamine-mediated mechanism triggered by stress has been debated (3).

Therefore, more evidence of factors such as the cause of heart failure and coronary status would be of interest before the final conclusion can be made about the correlation between the duration of productive time and nulliparity and incident heart failure in postmenopausal women.