Reply

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We would like to thank C. Stöllerberger and J. Finsterer for their interest, comments and questions regarding our paper 'Epidemiology of idiopathic cardiomyopathy in Qatar during 1996–2003' [1].

Cardiomyopathy was most common in young people and they are the most active group in the community. Hence, we recruited subjects below 50 years. Qataris are the nationals and non-Qataris are foreigners who come to Qatar for employment, most of them being mainly from Asian countries: India, Pakistan, Jordan, Palestine and other Arabian Gulf countries. The non-Qatari male population is high because the majority of them do not have their families in Qatar.

The incidence of diabetes mellitus (25%) and hypertension (15%) is high in the State of Qatar [2]. Qataris who are employed in certain jobs such as military and police services and athletes are screened for left ventricular hypertrophy and hypertrabeculation (LVHT). Dilated cardiomyopathy was present in the patients who had suffered a stroke [1]. We reviewed the records of the echocardiographic examinations retrospectively during the period from 1996 to 2002 and the same criteria were used to collect the data prospectively during the period from 2002 to 2003.

Left atrial enlargement did not affect the inclusion criteria of the study. The authors used the echocardiographic definition for restrictive cardiomyopathy suggested by Ammash et al. [3]. The same type of echocardiographic machine (HP) was used. In patients with LVHT, it is difficult to interpret the study finding that 20% of the patients were below 16 years and 1% above 16 years.

There was a follow-up for all patients. Dilated cardiomyopathy was the most common cause of death. Qatari children outnumbered the non-Qatari children because most of the non-Qataris are residing in the State of Qatar without their family. Since cardiomyopathy was most common in young people and the young population in Qatar comprises more Qataris than non-Qataris, deaths occurred more often among Qataris.

Only 1 patient underwent muscle biopsy. All the patients listed in table 3 (see El-Menyar et al. [4]) with myofibrillar myopathy and restrictive cardiomyopathy are published cases.

The higher incidence of pediatric cardiomyopathy was due to the high consanguinity rate in Qatar [5], not only among Qataris, but also among non-Qataris.

It is true that consanguinity was found in 57.1% of the Qataris with cardiomyopathy [2, 6, 7]. In general, 46% of the population is consanguineous. This could be due to the genetic background of cardiomyopathies. No family study was conducted in patients with cardiomyopathy. We are planning to perform research on cardiomyopathy using molecular genetics and linkage analysis in two or possibly three generations in the near future.

References

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