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Reply to 'Bromocriptine for the treatment of peripartum cardiomyopathy: comparison of outcome with a nationwide Danish cohort'

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It is important to note that patients in our and the Danish cohort may not be completely comparable, since in our study, peripartum cardiomyopathy (PPCM), which is a diagnosis of exclusion needing a high level of expertise, was clinically confirmed by well-trained cardiologists, while this was probably not the case in the retrospective analyses of the Danish cohort.[1,2] Use of medication was also different between the two cohorts since in our study use of standard heart failure therapy with anticoagulation on top of bromocriptine was ensured,[1] while the Danish cohort was not controlled for heart failure medication.

Follow-up times were different as well.[1,2] We therefore looked at 34 patients from our trial for whom comparable (1 year) follow-up data were available. These 34 patients had a mean baseline left ventricular ejection fraction (LVEF) of 22 ± 7% and a full recovery rate of 74% (LVEF ≥ 50% in 25/34 patients, unpublished data). Comparing these data to the patients in the Danish cohort not obtaining a prolactin blocker where only 43% (16/37) recovered,[2] the full recovery rate in our study appears substantially higher. In addition, 14.8% of patients in the Danish cohort but none of our patients had a major event (no death, heart transplantation (HTX), or left ventricular assist device (LVAD)) and only 3% (1/34) of our patients remained in heart failure (unpublished data). In turn, the 1 year full recovery rate in our study is quite comparable to the subgroup of patients the Danish cohort treated with cabergoline (67%, 16/24 patients).

Therefore, we actually quote the trend towards better outcome of patients obtaining cabergoline in the Danish cohort as a positive support for the efficacy of prolactin blockers in PPCM and would advocate for the use of bromocriptine, anticoagulation, and standard therapy for heart failure in all patients with acute PPCM, but especially those with severe acute heart failure or cardiogenic shock. Stopping lactation allows also early initiation of all standard heart failure drugs and no clinical study ever showed that heart failure medication, which is transmitted into the breast milk, is not harmful for the infant.

We agree that a larger placebo controlled trial would be needed to finally proof efficacy of bromocriptine in PPCM. Such a trial has been started in Canada (ClinicalTrials.gov Identifier: NCT02590601). In addition, the large prospective international EURObservational Research Programme (EORP) registry on 750 PPCM patients with information on treatment and outcome just finished recruitment and will also provide more data on the efficacy of bromocriptine treatment.

Conflict of interest: none declared.

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