We greatly appreciate the interest of Dr. Falk in our study (1). When designing our study, it was unclear whether bendopnea was mediated via an increase in ventricular filling pressures or some other process (e.g., abdominal girth). Our study demonstrated that the mechanism of bendopnea was a further increase in filling pressures among those with a baseline increase in such.

Regarding the pathophysiology leading to this increase in filling pressures with bending in heart failure patients, we hypothesized that the key determinant would be an increase in intrathoracic pressure (1). We did not assess hepatomegaly, previously demonstrating that hepatomegaly was not associated with increased pulmonary capillary wedge pressure (PCWP) independently of the jugular venous pressure in patients with advanced heart failure (2). We believe that the available data do not suggest that an increase in intra-abdominal pressure will be the key mediator of bendopnea, although we agree that this hypothesis is interesting and warrants further study. Others have demonstrated no association of increased intra-abdominal pressure (>8 mm Hg) with an increase in PCWP (3). Additionally, an increase in intra-abdominal pressure led to a sustained increase in the right atrial pressure (i.e., a positive result on an abdominojugular test), which was then paralleled by an increase in the PCWP, almost entirely among those who at baseline already had an elevated PCWP (>15 mm Hg) in Dr. Ewy’s seminal study (4). In contrast, in our study, the PCWP increased comparably with bending, irrespective of whether the baseline PCWP was high. For example, when our cohort was stratified by whether the baseline supine PCWP was >15 mm Hg or not, the median (25th, 75th percentiles) change in PCWP with bending was 10 mm Hg (4, 14) versus 9 mm Hg (3, 9), p = 0.3, respectively.

An appropriate name for this symptom is important. We chose bendopnea because we sought a name that would be easily recognizable by both the medical community and patients and anecdotally have found this to be the case already. Rather than shrouding terminology in “classical” linguistics, we prefer that our patients can understand us, a goal increasingly valued as important by the medical community as we move toward shared decision making and patient-centered medicine (5).

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