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# Letter to the Editor: A Study of Clinical Profile, Chest X-ray, ECG Changes, and 2D Echocardiography in Patients with Chronic Cor Pulmonale

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## To the Editor,

I read with interest the article by Haq et al.<sup>[1]</sup> titled “A study of clinical profile, chest X-ray, ECG changes, and 2D echocardiography in patients with chronic cor pulmonale”, published in the recent issue of the *International Journal of Cardiovascular Academy*.<sup>[1]</sup> The authors provide a pragmatic evaluation of chronic cor pulmonale (CCP), emphasising that conventional diagnostic findings retain considerable significance, particularly in settings characterised by resource limitations.<sup>[1]</sup>

What caught my attention was that all patients in this group had right atrial (RA) and right ventricular (RV) dilatation. This is a sobering clinical observation, suggesting that CCP is often a “silent traveler” diagnosed only in its advanced stages.<sup>[1]</sup> The study effectively highlights the diagnostic value of fundamental tools; specifically, the prevalence of dyspnoea and peripheral oedema as primary clinical markers, the presence of “P-pulmonale” and right axis deviation on electrocardiography, and the classic radiographic signs of pulmonary artery enlargement.<sup>[1]</sup> These findings show that a high level of suspicion is important even before advanced imaging. While the authors’ focus on two-dimensional (2D) echocardiography

internal diameters is relevant, it also highlights the need to think about how we can improve our diagnosis.

The authors rightly emphasise that 2D echocardiography is the most accessible and time-effective diagnostic modality for these patients.<sup>[1,2]</sup> Indeed, advanced modalities such as RV/RA longitudinal strain or three-dimensional (3D) volume analysis, while powerful, are often time-consuming, highly dependent on image quality, and require significant operator experience.<sup>[3,4]</sup> In a busy clinical context, the simplicity of the 2D measurements employed in this study is likely to be the key factor contributing to their significant clinical utility.<sup>[1]</sup>

From a constructive standpoint, however, it may be logical to consider a more multiparametric approach, if time and image quality permit. The integration of parameters such as tricuspid annular plane systolic excursion, tricuspid annular systolic velocity (S’ wave), fractional area change and RV deformation imaging (RV Strain), 3D RV assessment provides a more detailed understanding of RV systolic performance, even in the subclinical stages.<sup>[3,5]</sup> Furthermore, the assessment of RA volume and RA deformation imaging can provide early indicators of pressure overload, even prior to the development of overt RV failure.<sup>[3,4]</sup>

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Congratulations to the authors for documenting this clinical profile so thoroughly. Their work provides a solid foundation for future research into the correlation between these simpler, accessible tools and newer, more advanced functional metrics.

### Footnotes

The corresponding author(s) of the original article were contacted by e-mail on 3 February 2026, 18 March 2026, and 16 June 2026 and were given the opportunity to respond to this letter. However, despite repeated attempts, no response was received.

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