

## **Incidence of Mitral Valve Prolapse in Children**

Gupta *et al.*(1) observed a higher prevalence (13.1%) of mitral valve prolapse (MVP) in children in Jaipur. They have based their results on an echocardiographic study. They have mentioned that studies by McLaren *et al.*(2) and Greenwood(3) used bedside cardiac auscultation for diagnosis of MVP and estimated its prevalence to be about 5%.

Mitral valve prolapse is a clinical diagnosis with ultrasonographic corroboration, not the other way round. If the click and/or murmur is not heard, one should be suspect of all other methods of diagnosis(4). Hugh(4) has aptly mentioned that we do not have a sudden epidemic of a disease, we have an epidemic of overdiagnosis.

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### **REFERENCES**

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2. McLaren MJ, Hawkins DM, Lachman AT, *et al.* Noninjection systolic click and minimal systolic murmur in black school children of Soweto, Johannesburg. *Br Heart J* 1976, 38: 718-724.
3. Greenwood RD. Mitral valve prolapse: Incidence and clinical course in a pediatric population. *Clin Pediatr* 1984, 23: 318-320.

4. Allen HD. Mitral valve prolapse: Back to the basics. *Am J Dis Child* 1991, 145: 1095-1096.
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### **Reply**

We thank Dr Yash Paul for comments on our article about epidemiology of mitral valve prolapse (MVP) in children(1). MVP was initially described as a clinical entity with apical midsystolic click and late systolic murmur. Subsequent studies identified clinical features of this condition, along with echocardiographic and cardiac catheterization features. It was also realized that this condition could lead to disabling symptoms in children and adults, and rarely lead to disabling cardiac arrhythmias, act as focus for infective endocarditis and lead to cerebrovascular accidents(2).

Epidemiologic studies depend upon echocardiography for confirmation of diagnosis of MVP. In earlier years, some confusion about the exact echocardiographic criteria existed and the diagnosis was made by demonstration of billowing of mitral valve cusp(s) in left atrium on either parasternal long axis views or apical views. These criteria resulted in inappropriately high diagnosis of MVP, specially in children(3). However, recently the diagnostic criteria have been revised and MVP is diagnosed only when prolapse is seen in parasternal long axis view and confirmed by both two dimensional and M-mode echocardiography(2). We have used these recently revised criteria and although the