LETTERS TO THE EDITOR

● The British Heart Journal welcomes letters commenting on papers that it has published within the past six months.
● All letters must be typed with double spacing and signed by all authors.
● No letter should be more than 600 words.
● In general, no letter should contain more than six references (also typed with double spacing).

Mitril valve hypoplasia in children with isolated coarctation of the aorta

Sir,—Venugopal et al concluded that, compared with controls, patients with coarctation of the aorta have relative hypoplasia of the mitral valve which is likely to be more pronounced in patients with mitral diastolic murmurs.1 Unfortunately, they do not mention our previous study in which we found that patients with mitral diastolic rumble and coarctation of the aorta have minor abnormalities of the mitral valve or minimal mitral stenosis that significantly increase the rapid ventricular filling and pressure half times and decrease the mitral valve area.

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Please Sir! GP’s treat cardiac failure too!

Sir,—General practitioners did not feature in your supplement on diuretics in heart failure, yet mild to moderate cardiac failure is essentially a general practice diagnosis. In a recent postal survey1 of 1897 members of the Irish College of General Practitioners most GPs reported that they treat most patients with heart failure without hospital referral.2 Only 14% would refer more than 50% of patients, and those who were qualified longer were more likely (P<0.05) to refer to hospital. Cardiac failure is seen as a condition of the older age group, with most cases presenting between 65 and 75 (66%). Most patients are in New York Heart Association grade 1 (50%) or grade 2 (44%) when they attend initially.

Almost all GPs (89%) attempt first line therapy in general practice and only 51% would refer without at least two changes of therapy. GPs believe that drug treatment usually (in 90% of cases) controls symptoms and such control is the priority for peripheral vascular disease: consequence for survival and association with risk factors in the Speedwell prospective heart disease study.

Sir,—We were interested in the findings of Bainton et al that a raised white cell count predicts the development of intermittent claudication.1 An epidemiological study also found a correlation between a raised white cell count and a significant risk of myocardial infarction and stroke. It is generally accepted that massive tissue ischaemia followed by reperfusion has an adverse effect on the systemic vascular endothelium, particularly the pulmonary microcirculation.2 Both suggest an important role for oxygen-derived free radicals, activated neutrophils, and endothelial mediators in this injury, resulting in a systemic increase in vascular permeability. This may be quantified by a local increase in renal permeability, which is reflected by a change in urinary protein excretion—microalbuminuria.3

We have suggested that patients with claudication undergo a series of similar less severe ischaemia-reperfusion injuries with activation of the above mechanisms. This may have an adverse effect on cardiovascular morbidity and mortality in patients. In support of this hypothesis we found an increase in neutrophil activation, lipid peroxidation, and a rise in urinary albumin excretion after exercise in patients with ischaemic claudication.4

Recently we found a decrease in neuropathic deformability, suggestive of activation, and a highly significant rise (P<0.001) in thromboxane B2 concentrations after exercise in patients with claudication. No change was found in the control group and concentrations of thromboxane B2 at rest were significantly lower in the controls. The results support the concept that intermittent claudication results in a series of repeated ischaemia-reperfusion injuries leading to neuropathic activation and increase in systemic vascular permeability. These events seem to play a part in atherogenesis, and we suggest that this may contribute to the excess cardiovascular mortality found in these patients.

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Direct access exercise electrocardiography: a new service that improves the management of suspected ischaemic heart disease in the community.

Sir,—The paper by McClements et al on direct access exercise testing (Br Heart J 1994; 71:531-5) is surely incorrectly titled. A new service that alters the management of suspected ischaemic heart disease would be appropriate but to suggest that it improves the management— I think not. As a result of the open access facility more than half of the patients with chest pain thought to be due to coronary artery disease have hae an abnormal exercise test were not referred for specialist examination and advice, thereby being deprived of access to two of the three available treatment options. Indeed apparently more than 10% of these patients received no treatment at all.

In the current environment where quantity rather than quality of management seems to be the important factor perhaps I
Peripheral vascular disease: consequence for survival and association with risk factors in the Speedwell prospective heart disease study
Harmeet Khaira, Paul Tisi and Clifford Shearman

*Br Heart J* 1995 73: 199
doi: 10.1136/hrt.73.2.199-b

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