Postmyocardial infarction syndrome

SIR,

We have read with interest the article by Welin et al. (1983; 50: 140–5) regarding the postmyocardial infarction (Dressler’s) syndrome. The authors reported 60 cases of postmyocardial infarction syndrome in 1809 cases of myocardial infarction in a 10 year period (1968–77). This study makes an interesting comparison with a more recent investigation by Lichstein et al., who suggested that Dressler’s syndrome had decreased in incidence and perhaps disappeared. They considered that the decreased use of oral anticoagulants in their unit and more aggressive treatment of postmyocardial infarction pericarditis were responsible for their findings. Dressler himself postulated that anticoagulants may be implicated in the genesis of the postmyocardial infarction syndrome by causing leakage of blood into serous cavities and thereafter a pericarditis. We would be interested to know whether anticoagulants were given to the patients in Welin’s group, and if so whether cases of postmyocardial infarction syndrome occurred more frequently in these patients. Perhaps in the 10 years of the study their anticoagulation policy changed. It would be relevant to know whether the prevalence of Dressler’s syndrome paralleled this change.

In addition, the authors make no mention of the prevalence of early postmyocardial infarction pericarditis in their group. As suggested by Lichstein et al., perhaps aggressive treatment of this phenomenon may modify the prevalence of Dressler’s syndrome. Did any of Welin’s group develop early postmyocardial infarction pericarditis, and if so did any of these cases evolve into Dressler’s syndrome? The incidence of early postmyocardial infarction pericarditis is 6–8% to 16%3,4; some workers feel that patients who develop Dressler’s syndrome have all had early postmyocardial infarction pericarditis.5 If this is the case, then aggressive treatment of early postmyocardial infarction pericarditis may reduce the prevalence of Dressler’s syndrome. Is there any information from Welin’s group regarding such treatment?

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References

tion syndrome, 14 (23%) had a confirmed early postmyocardial infarction pericarditis. In a previous study from our group of 300 men with a first infarction, early postmyocardial infarction pericarditis was reported among 21 (7%) men. Of our 1809 patients the prevalence of early postmyocardial infarction pericarditis is not known since many observers reported the data, which led to wide interobserver variations. Thus we do not know how many patients with early postmyocardial infarction pericarditis later developed the postmyocardial infarction syndrome.

There has been no rigid policy for treating early postmyocardial infarction pericarditis. In patients with pain non-steroidal anti-inflammatory drugs are given, and if these do not control the pain we give steroids.

With regard to Dr Spodick’s questions, all confirmed cases of early postmyocardial infarction pericarditis had a pericardial rub (see above), and 42 (70%) patients had pleuropericardial chest pain. Rubs were noted in the records of 34 (57%) patients. This is most probably an underestimate of the true prevalence since many rubs are of short duration, sometimes lasting only a few hours.

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**Notices**

**European Society for Clinical Investigation**

The eighteenth annual meeting of the society is to be held on 17–19 April 1984 in Milan, Italy. Further information may be obtained from: Fondazione Giovanni Lorenzini, Via Monte Napoleone 23, Milan 20121, Italy.

**Antwerp-La Jolla Research Conference on Cardiac Function**

An international meeting will be held on 2–4 July 1984 in Antwerp, Belgium. The subject of the conference is “Non-uniformity of contraction and relaxation.” Further information may be obtained from: Dr D L Brutsaert, Department of Physiology and Medicine, University of Antwerp, Groenenborghlaan 171, 2020 Antwerp, Belgium.

**British Cardiac Society**

The Annual General Meeting for 1984 will take place in Leicester on 11 and 12 April 1984, and the closing date for receipt of abstracts is 3 January 1984. The Autumn Meeting in 1984 will be held on 3 and 4 December 1984, and the closing date for receipt of abstracts will be 15 August 1984.