Suppressor T lymphocyte function in patients with idiopathic congestive cardiomyopathy

Sir,

Dr Lowry and her colleagues reported (1987;57:458–61) that they were unable to detect a defect in T lymphocyte function in their patients with dilated cardiomyopathy. At first sight this might appear to contradict our results from patients with dilated cardiomyopathy studied in Kenya where we found that about half the patients had a high helper/suppressor (OKT4/OKT8) T lymphocyte subset ratio. This apparent difference may be explicable, however. All our patients with a high helper/suppressor ratio were seen within three months of the onset of their symptoms (Lowry et al do not state the duration of illness in their patients) and we felt that the higher ratios merely represented an active immunological reaction as part of a chronic or subacute myocarditis.

As the myocarditis “burns out”, the helper/suppressor ratio will return to normal. At this later stage there may be no immunological changes to detect. Furthermore, the high helper/suppressor ratios in our patients were caused by an increased number of helper cells rather than a significant reduction of suppressor cells, so that the changes are not likely to be non-specific and due to heart failure alone.

I would agree with Lowry et al that there is unlikely to be a permanent defect in T lymphocyte function that is specific to these patients but this does not rule out the possibility that an immunological reaction (which may be excessive) is part of the early pathogenesis of dilated cardiomyopathy. And this may be detected only if the patients are studied early after the onset of their illness.

John Sanderson,
Musgrove Park Branch,
Taunton and Somerset Hospital,
Taunton,
Somerset TA1 5DA.

Reference