Correspondence

Early diagnosis of myocardial infarction

The assertion that “giving thrombolytic agents on the basis of clinical features alone with no benefit in the absence of ST segment elevation” needs to be qualified to include bundle branch block (BBB) as an even stronger indication for thrombolytic treatment, given the fact that the 23.6% mortality risk of BBB related myocardial infarction is significantly and favourably modified by this treatment. The paradox is that the masking of electrocardiographic (ECG) criteria of myocardial infarction by BBB also increases the risk of inappropriate thrombolysis, rendering patients in this subgroup the ones in greatest need of a short time window marker, which, however, should complement but not replace the ECG in the diagnostic process. For this purpose, myoglobin may be preferable to troponin, given the fact that three to four hours after onset of suspected myocardial infarction, this variable is acknowledged to have superior sensitivity (68–77% vs 37–43%) and negative predictive value (84–89% vs 72–77%). Of all the therapeutic time windows, however, the earliest ones are prognostically the most important, thereby mandating sole reliance on ECG stigmata for validation of suspected myocardial infarction until such time that an enzymatic marker becomes available also for the <3 hour time window, serving, once again, to complement but not replace the ECG in clinical decision making.

O M P JOLOBE
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Book review


The authors aim to present to both student and practitioner the range of pathological lesions encountered in the maxillofacial regions, to illustrate their radiological and histological features, and to highlight the differential diagnoses which should be considered. This has been done well, dividing the book into 11 chapters. The use of case based studies is highly appropriate in fulfilling the authors' aims. The amount of clinical detail given in each case enhances the book in showing the advantage of a clinicopathological approach to oral diagnosis. The radiographic illustrations are of a high standard except in the chapters on TMJ disease and fractures. The line drawings corresponding to the radiographs are predominantly excellent and aid in the interpretation of the radiographic image. Line drawings would also have been valuable for the pathological photographs which were overall of poorer quality. Black and white photographs can be difficult to interpret and would have benefited from being in colour. This, however, would have increased the cost of the book considerably.

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The aim of the book is to provide an overview of early mortality and major morbidity results from all randomised trials of treatment, given the fact that the 23.6% mortality risk of BBB related myocardial infarction is significantly and favourably modified by this treatment.

The paradox is that the masking of electrocardiographic (ECG) criteria of myocardial infarction by BBB also increases the risk of inappropriate thrombolysis, rendering patients in this subgroup the ones in greatest need of a short time window marker, which, however, should complement but not replace the ECG in the diagnostic process. For this purpose, myoglobin may be preferable to troponin, given the fact that three to four hours after onset of suspected myocardial infarction, this variable is acknowledged to have superior sensitivity (68–77% vs 37–43%) and negative predictive value (84–89% vs 72–77%). Of all the therapeutic time windows, however, the earliest ones are prognostically the most important, thereby mandating sole reliance on ECG stigmata for validation of suspected myocardial infarction until such time that an enzymatic marker becomes available also for the <3 hour time window, serving, once again, to complement but not replace the ECG in clinical decision making.

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H WILLIAMS

Notices

Joint Royal College of Pathologists and Armed Forces Institute of Pathology Meeting

Diagnostic Surgical Pathology
St John’s College, Cambridge, 30 July—2 August 1998

An intensive three and a half day course covering pathology of the lungs (M N Koss), mediastinum (C A Moran), skin (M Kirkham), heart (M Shennan), soft tissue (C Fisher), breast (F Tavossoili), female reproductive system (M Anderson), salivary glands (G Ellis), blood (K Gatter), liver (K G Ishak), and gastrointestinal tract (S Lobin), as well as a session on paediatric pathology (P J Berry).

Registration £275 plus £75/day for accommodation to include all meals (approximate costs)

Further information from:
Scientific Meetings Officer, Royal College of Pathologists, 2 Carlton House Terrace, London SW1Y 5AF; tel +44 (0)171 5862, extension 24/25

The Royal College of Pathologists
One Day Symposium on Diabetes Mellitus
Royal College of Pathologists, London, 30 September 1998

The symposium is open to members of the College, trainee pathologists, and workers in other disciplines with an interest in the subject. The programme is approved for CME.

Registration fees: fellow/member £75; trainee/retired £45; non-members £100.

Further details from:
Scientific Meetings Officer, The Royal College of Pathologists, 2 Carlton House Terrace, London SW1Y 5AF; tel +44 (0)171 5862, extension 24/25

Dr Collinson comments

Dr Jolobe is quite correct in the qualification that left bundle branch block is also an indication for thrombolysis. Unfortunately, the risk—benefit in this group is not clearly defined.

With regard to the role of biochemical markers for selection for thrombolysis, this really remains an open question. No trial to date has provided evidence that biochemical markers can be used for early selection for thrombolysis. Unfortunately, the risk reduction in patients presented without ST segment elevation is likely to be very modest. Hence to power such a trial will involve such large numbers that it is unlikely to ever be performed. Paradoxically, the new markers troponin T and I may well have a role to play in the selection of patients presenting with and without ST segment elevation. Our own studies have suggested that patients who are troponin positive either with or without ST segment elevation have an adverse prognosis. In patients presenting with ST segment elevation who are troponin positive on admission, the optimal treatment may actually be primary angioplasty and stent insertion, while the presence of troponin T in patients without ST segment elevation is certainly an indication for dalteparin following the results of the FRISC study, and it may be that this is the group that would benefit from glycoprotein IIb/IIIa antagonists.

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O M Jolobe

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