Correspondence

Early diagnosis of myocardial infarction

The assertion that "giving thrombolytic agents on the basis of clinical features alone will confer no benefit in the absence of ST segment elevation"¹ 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.² 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% v 37–43%) and negative predictive value (84–89% v 72–77%).³ Of all the therapeutic time windows, however, the earliest ones are prognostically the most important,³ 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

Department of Medicine for the Elderly, Tameside
General Hospital, Fountain Street, Ashton under Lyne
OL6 9RW

- 1 Collinson PO. Early diagnosis of myocardial infarction: why measure cardiac enzymes? *J Clin Pathol* 1998;51:2–4.
- 2 Fibrinolytic Therapy Trialists Collaborative Group. Indications for fibrinolytic therapy in suspected acute myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomised trials of more than 1000 patients. *Lancet* 1994;343: 311–22.
- 3 de Winter RJ, Koster RW, Sturk A, et al. Value of myoglobin, troponin T.m. and CK-MBmass in ruling out an acute myocardial infarction in the emergency room. *Circulation* 1995;92:3401–7.

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 alteparin following the results of the FRISC study, and it may be that this is the group that would benefit from glycoprotein IIb/IIIa antagonist.

PAUL O COLLINSON

Department of Chemical Pathology, Mayday
University Hospital, Croydon, Surrey

Book review

Dental Diagnostic Imaging: Diagnostic Features And Pathology. Robert P Langlais, Koji Hashimoto, Hirotsugu Yamamoto. (\$52.95.) Charles C Thomas, 1997. ISBN 0 398 06784 8.

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.

The aims of the book are hindered in various ways. The classification and terminology used in the chapter on odontogenic cysts does not follow the WHO 1992 histological classification cited in the text. For example, the use of the term "fissural cysts" does not appear in this recent classification, as a fissural pathogenesis for these cysts is no longer accepted.

The chapter on odontogenic tumours uses the WHO 1972 classification instead of the 1992 version. Thus the separation, for example, of lesions considered benign neoplasms from those recognised as dysplastic is not made.

More discussion on the use of MRI and CT would have enhanced the chapters on

oral malignancy and salivary gland disease, as in general MRI in the head and neck is considered a superior diagnostic imaging technique. A review of newer imaging techniques, for example PET, would also have been valuable.

A chapter on diseases of the bone to include Paget's disease and Langerhan cell granulomatosis (histiocytosis X, eosinophilic granuloma) would have been appropriate.

Within its limits this book is a relatively valuable and informative text on diagnostic imaging, but some alterations to the pathological content need to be considered in further editions for this text to become a standard adjunct to other head and neck pathology texts.

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 (N Kirkham), heart (M Sheppard), soft tissue (C Fisher), breast (F Tavassoli), 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