

progression. Nevertheless, a randomised controlled trial of high dose prednisolone (up to 60 mg per day according to age and weight) in 143 patients with active constrictive pericarditis in South Africa suggested that patients treated with steroids have a greater resolution of their symptoms (exercise capacity) and signs (pulse rate and height of jugular venous pulse) during treatment.¹⁰ This effect was not completely sustained once the treatment was stopped. In addition fewer patients progressed to pericardectomy (21% v 30%) or death (4% v 11%) in the steroid treated group. One fifth of patients will require pericardectomy once they constrict regardless of the treatment they receive.

Pericardectomy is now a safe procedure with a 97% survival rate if performed early in a patient with good left ventricular function.¹¹ It is generally recommended that the pericardium is removed from the anterolateral and diaphragmatic aspects of the left ventricle extending to the atrioventricular sulci and subsequently removed from the anterior and inferior surfaces of the right ventricle, especially around the inflow tracts.

Discussion

GJD: Tuberculous pericarditis remains an uncommon disease in the United Kingdom and normally presents late in the effusive stage. The striking feature of this case is the rapidity with which classic tamponade progressed to classic constriction. The South African study included only patients who had already developed constrictive physiology, and there is no evidence that steroids prevent the development of constriction. Once constriction has developed early pericardectomy has a better prognosis than delaying the operation and therefore giving steroids at this stage is probably not beneficial.

ss: The usefulness of adjunctive steroid therapy in tuberculous infection has been shown for only pericardial effusion and meningitis. This patient did not receive steroids. Tuberculosis is commonly associated with HIV infection, especially in patients from sub-Saharan Africa.

js: This case highlights the current lack of understanding of mechanisms by which acute inflammation may become persistent and lead to scarring with loss or serious derangement of organ function. Apparently successful treatment, with a fall in markers of acute inflammation, failed to prevent postinflammatory scarring. This is commonly seen in inflammatory disease of other organs, including the kidney, where

despite high efficacy in suppressing acute inflammation no clear evidence has emerged that steroids prevent scarring. New approaches to this problem are required.

JSC: Was it possible to make a diagnosis in this case from the pericardial fluid?

CPC: No; neither the Ziehl-Neelsen staining nor the subsequent culture of the fluid showed any evidence of tuberculosis.

JSC: What is the differential diagnosis based on the histology?

JBS: The two main differential diagnoses are lymphoma and sarcoidosis. Granulomas may be seen in both these conditions, but in lymphoma an infiltrate of atypical lymphoid cells is present and the granulomas are not necrotising. In sarcoidosis caseation is not usually seen. Mycobacteria are often difficult to identify in tissue sections and the most likely diagnosis remains tuberculosis.

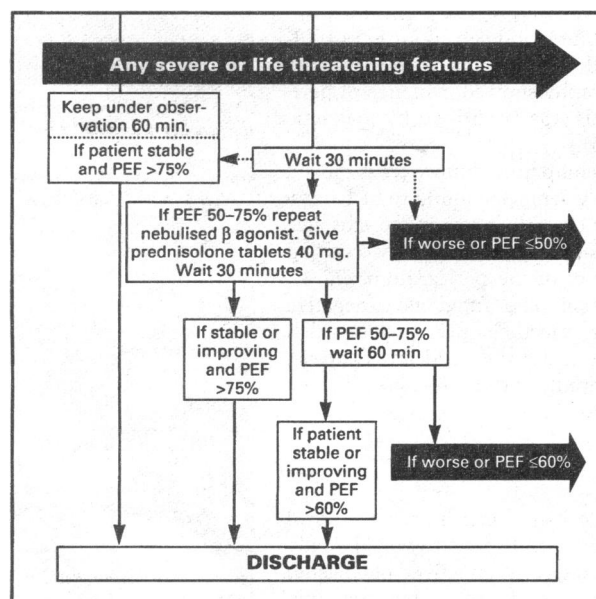
JSC: What is the role of the polymerase chain reaction in diagnosing tuberculosis when bacteriology has been unhelpful?

CPC: It has been shown to be helpful in diagnosing tuberculosis in clinical specimens when conventional bacteriological tests are not diagnostic.¹² The increased sensitivity of this technique would be useful in establishing the diagnosis of tuberculous pericarditis in difficult cases, but it has not been widely applied in clinical practice.

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Correction

Guidelines for the management of asthma: A summary



Several authors' errors occurred in chart 6 of the British Thoracic Society and others' guidelines for the management of asthma (20 March, pp 776-82). In the pathway for moderate asthma the >50-75% values should read 50-75% throughout. Further amendments are shown as dotted arrows (or a dotted line in the box to the left) in the figure below, which is a detail of the chart showing the management of moderate and mild categories of asthma.

