Correspondence

Dr. B. G. Wells, consultant cardiologist at the North Middlesex Hospital, London, kindly analysed the electrocardiograms.

Eleven patients (4 men and 7 women) aged 31 to 74 (median age 59) with various connective tissue diseases, including two with rheumatoid arthritis, four with a recent history of angina pectoris, had 12-lead electrocardiograms and were then instructed to take two 25 mg. capsules of indomethacin at night. The E.C.G.s were repeated after taking the drug for seven days when the patients were questioned as to development or worsening of anginal pain. Electrocardiograms after surgery were also taken before and after indomethacin in seven patients (it was not considered prudent to record after repeated E.C.G.s in those who had a past or present history of angina of effort).

One patient who had angina for some months previously developed myocardial infarction four weeks after taking indomethacin. The other three angina patients did not observe any aggravation of cardiac symptoms. Of the seven patients with no history of angina one thought the drug gave her palpitations, but none had minor E.C.G. changes of ischaemia before indomethacin and showed some aggravation of ischaemia in E.C.G.s taken while on indomethacin, and four patients showed no E.C.G. changes after taking the drug.

It appears from this short series that indomethacin can aggravate myocardial ischaemia in some patients, and though the occurrence of myocardial infarction in one patient with a history of angina may of course have been fortuitous, the possibility arises that this drug may predispose certain patients to infarction. A controlled trial is now in progress.—I am, etc.,

W. R. Thrower.

Bridgewater, Somerset.

Angina and Indomethacin

SIR,—I have noted on occasion that the anti-inflammatory drug indomethacin appears to aggravate anginal pain in some patients with this condition. Because this effect of the drug has not previously been noted, I carried out a pilot investigation with a view to determining whether in fact indomethacin could bring on or aggravate angina, and whether significant electrocardiographic changes were induced in patients taking this drug. The following is a preliminary report on the trial which is to be fully described elsewhere.

Dr. G. M. Wells, consultant cardiologist at the North Middlesex Hospital, London, kindly analysed the electrocardiograms.

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gt all concerned with brucellosis will be gratified to see the final analysis of the survey made on veterinary surgeons in Northern Ireland. As might be expected, practitioners likely to be in frequent contact with infectious material revealed the effects of such contact in their sera more strikingly than those further removed from infection. After all, human contact with many infectious diseases does not necessarily mean that an infection becomes clinically manifest, and the intermittent nature of brucellosis can make it notoriously difficult to relate serology to symptoms.

There is good reason to believe that in England somewhat similar findings would result from a survey such as that made by Dr. G. G. McDowell, because, as is generally known, the incidence of overt infections in veterinary surgeons is causing disquiet. The serological reactions to brucella infections in bovines, the natural reservoir of Br. abortus, would be more clear-cut than in man but for the widespread use of vaccines, and much attention has been given to this problem since the present campaign started to eliminate brucellosis from the United Kingdom.

Those of us who have seen the human disease in its various forms and its wide variation in symptomatology and acuteness appreciate how difficult it can be at times to make an absolute diagnosis, even with all laboratory aids. This is the chief reason why what can be such a disabling disease has never been effectively treated, but even now no one knows how widespread it really is. It is to be hoped that the situations being uncovered during the eradication of the disease from bovines is in no way indicative of the position in human beings, in whom missed diagnosis is commoner than overdiagnosis even allowing for the fact that symptoms of brucellosis are not unlike those of Br. abortus. The number of these cases must be infinitely smaller than those in whom the disease is not diagnosed by failure to apply or to persist with whatever tests are available.—I am, etc.,

D. G. McDewitt.

Christian Medical College, Bareilly, India.

References


**Dr. McDewitt's letter has been shown to Dr. Thrower, who makes the following reply.—Ed., B.M.J.

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G. M. Hall.

Department of Anesthesia, Edgeware General Hospital, Edgeware, Middlesex.

References