

# letters to the editor

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: [clinicalmedicine@rcplondon.ac.uk](mailto:clinicalmedicine@rcplondon.ac.uk)

## Structured clinic letters

Editor – It is very necessary to study efficient and effective communication between hospital and general practice. Tom Parks and others (*Clin Med* April 2011 pp 205–6) found GPs to prefer structured letters but what about the person in the middle – the patient? For many years I dictated the outpatient letter to, and with, the patient in their presence in clinic and sent a copy to the GP. This ensured that the patient agreed with the facts, targets and treatment and that the GP knew what information the patient had been given. I surveyed 120 GPs in North Bristol and 119 were very happy with this and I also had a similar result in Gloucester. I know of other consultants who use this system. Apart from being basic good manners it offers a wonderful opportunity to discuss with, and inform patient, family and doctor.

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## Cardiac involvement in systemic lupus erythematosus not only limited to pericarditis

Editor – We read with great interest the article by Perry and colleagues (*Clin Med* June 2011 pp 268–70) on acute systemic lupus erythematosus (SLE) presenting as pericarditis.

The incidence of cardiac involvement in SLE at post-mortem is approximately 40%, but only 6% of patients had echocardiographic evidence of impairment, and only one death in a cohort of over 500 patients was attributable to cardiac involvement.<sup>1</sup>

The key first step in investigation of SLE-related cardiac disease is the electrocardiogram for analysis of arrhythmias, ischaemic change, and left ventricular function. There are a number of possible cardiac manifestations of SLE, the most common forms being pericarditis, myocarditis, nonbacterial verrucous endocarditis, coronary artery disease, coronary arteritis, premature coronary atherosclerosis, congestive heart failure, cardiac arrhythmias, pulmonary hypertension and conduction disturbances.<sup>2</sup>

While there is no particular consensus on what imaging is required when cardiac involvement with SLE is suspected, the most reasonable second step is transthoracic echocardiography as with many cardiac diseases. Echocardiography can help diagnose SLE-related pericarditis, pericardial effusion, systolic dysfunction, valvular involvement, and cavity thrombus formation with a good sensitivity.<sup>3</sup> The amount of information which is gained from an echocardiogram is especially valuable in such patient cohort. We generally suggest doing an echocardiogram on patients presenting with pericarditis to rule out the above. It can also be organised as an outpatient test if early discharge is contemplated.

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## References

- 1 Busteed S, Sparrow P, Molloy C, Molloy MG. Myocarditis as a prognostic indicator in systemic lupus erythematosus. *Postgrad Med J* 2004;80:366–7.
- 2 Ashrafi R, Garg P, McKay E *et al*. Aggressive cardiac involvement in systemic lupus erythematosus: a case report and a comprehensive literature review. *Cardiol Res Pract* 2011;5:78390.
- 3 Doria A, Iaccarino L, Sarzi-Puttini P *et al*. Cardiac involvement in systemic lupus erythematosus. *Lupus* 2005;14:683–6.

## Acute systemic lupus erythematosus on the acute medical take: are we missing anything?

Editor – I read with great interest the above case by Perry and colleagues (*Clin Med* June 2011 pp 268–70). To assess lupus anticoagulant the assay that is widely available is the Russell's viper venom test. Unfortunately, as pointed out by Perry *et al*, this test cannot be used when patients are on warfarin. Recently, I was educated about the presence of another assay called the Taipan viper venom test. This assay can be used to detect the presence of lupus anticoagulant even if patients have been commenced on warfarin. With respect to this particular patient maybe the doctors would like to explore this option? It would help them exclude or confirm the diagnosis of secondary aPL syndrome and hence decide the duration of anticoagulation accordingly. The pitfall is that this assay is available only in London and Manchester as far as I am aware.

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## In response

We thank Garg *et al* for their feedback. Cardiac involvement in SLE is indeed important. In our case with a history consistent with pulmonary embolus, the absence of marked cardiovascular compromise on clinical examination, CTPA confirming pulmonary embolus and showing no evidence of pericardial effusion. Echocardiography was performed as a later