

## Letters to the editor

OVERVIEW

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)

### Non-selective $\beta$ -adrenoceptor blockers in patients with decompensated liver disease

Editor – We read with great interest the excellent article ‘Drug therapies in liver disease’ by Collins *et al* (*Clin Med* December 2013 pp 585–91). However, the section regarding the use of  $\beta$ -blockers warrants further comment.

Although the use of non-selective  $\beta$ -adrenoceptor blockers is strongly supported in the use of primary and secondary prophylaxis of variceal bleeding,<sup>1</sup> there has been some controversy with its use in patients with advanced cirrhosis. In a study by Serste *et al*,<sup>2</sup> 151 patients with Child Pugh C cirrhosis and refractory ascites were assessed. Seventy-seven patients were being treated with  $\beta$ -blockers and 74 were not. At 1 year, 19% of patients treated with  $\beta$ -blockers were alive, compared to 64% who were not ( $p < 0.0001$ ). A follow-up study by the same group found that inpatients with refractory ascites and on  $\beta$ -blockers had a higher risk of paracentesis-induced circulatory dysfunction.

Admittedly the studies have flaws and robust randomised controlled trials are needed, but clinicians should be cautious when using these drugs in patients with advanced liver disease. ■

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### References

- 1 Tripathi D, Hayes PC. Beta-blockers in portal hypertension: new developments and controversies. *Liver Int* 2013;doi: 10.1111/liv.12360 [Epub ahead of print].
- 2 Serste T, Melot C, Francoz C *et al*. Deleterious effects of beta-blockers on survival in patients with cirrhosis and refractory ascites. *Hepatology* 2010;52:1017–22.

### A very unusual headache

Editor – ‘A very unusual headache’ (*Clin Med* February 2014 pp 58–60) is an interesting case indeed. However, the acute severe headache with nausea and vomiting is likely to be an initial presentation of migraine. There is a well described, but poorly understood, relationship between migraine and cervical

artery dissection.<sup>1</sup> There is also evidence that those with aortic root pathology in Marfan syndrome have increased risk of migraine with aura.<sup>2</sup> ■

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### References

- 1 Rist PM, Diener HC, Kurth T, Schürks M. Migraine, migraine aura, and cervical artery dissection: a systematic review and meta-analysis. *Cephalalgia* 2011;31:886–96.
- 2 H Koppen, Vis JC, Gooiker DJ *et al*. Aortic root pathology in Marfan syndrome increases the risk of migraine with aura. *Cephalalgia* 2012;32:467–72.

### Beware the normal angiogram

Editor – Pearson and Snelson presented an interesting case of a patient with purulent pericarditis complicated by septicaemia and acute renal failure (*Clin Med* February 2014 pp 88–89). The patient presented with left-sided chest pain and shortness of breath, and underwent emergency coronary angiography in view of pathological ST elevation on electrocardiography (ECG). However, the decision to perform emergency coronary angiography before other investigations warrants scrutiny. The ECG in fact showed global ST elevation, most marked in all the V leads but subtly present in the limb leads. Global ST elevation without reciprocal ST depression should always alert clinicians to the possibility of pericarditis rather than ST elevation myocardial infarction, and the immediate investigation of choice should be echocardiography since this will determine whether there is pericardial effusion and assess whether there is any regional wall motion abnormality that would indicate an atypical ECG presentation of myocardial infarction.<sup>1</sup> Taking this approach may avoid the need for coronary angiography which carries the risks associated with X-ray contrast medium exposure. One of these risks is contrast nephropathy which can lead to acute renal failure, particularly in those with chronic kidney disease or another cause of acute kidney injury. It is likely that, in the case presented by Pearson and Snelson, the contrast medium administration contributed to the acute renal failure and may also have contributed to the haemodynamic compromise through the development of associated acidosis.

With the ready availability of emergency coronary angiography for patients with chest pain and ST elevation on ECG, the authors rightly highlight the importance of considering other diagnoses, which include stress-induced (Tako-Tsubo) cardiomyopathy, pulmonary embolism and dissection of the thoracic aorta.<sup>1</sup> Clearly it is important to perform emergency coronary angiography if there is any doubt about the diagnosis of ST elevation myocardial