

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

Cardiac imaging to investigate suspected cardiac pain in the post-treadmill era

Editor – I was pleased to see a review of cardiac imaging in patients with suspected cardiac chest pain, since this is a common problem with frequently an inconsistent approach to investigation (*Clin Med* 2014;14:475–81). However, I was saddened by its lack of proper perspective. X-ray computed tomography (CT) and cardiovascular magnetic resonance (CMR) were appropriately described, less so stress echocardiography, and myocardial perfusion scintigraphy (MPS) was relegated to three small paragraphs and was not mentioned as an option in the conclusion. In fact, MPS is the most commonly performed non-invasive test of coronary function in Europe, including the UK, and elsewhere. A brief letter is not the place to redress the balance but it may partly suffice to make the following points.

The diagnostic accuracy of each of the techniques is similar and individual comparative studies can give misleading results that may not be applicable outside the research setting.¹ This equivalence has been recognised by the National Institute for Health and Care Excellence (NICE) and European Society of Cardiology (ESC) in their chest pain guidance.^{2,3} In truth, the diagnostic accuracy of a technique depends more upon the operator than the technique, which is why those who focus too closely within cardiac imaging may not see the full picture.

The prognostic accuracy of MPS in stable coronary disease has much greater evidence to support it than the other techniques, although the main determinant of events is the ischaemic burden rather than the technique used to assess it. The advantage of MPS is its ability to measure the ischaemic burden and that it can be used to predict which patients will do better with revascularisation than with medical therapy. Because of this, MPS is the only technique that has been shown to influence patient outcome for the better, albeit mainly in non-randomised trials.^{4–6}

Although there are concerns related to ionising radiation, no technique is free of debateable harmful effects.^{7,8} MPS and CT benefit from methods of reducing radiation exposure to the equivalent of one year of background radiation, which may be below the threshold for significant harm, depending upon one's take on extrapolating the harm of higher exposures to levels below 10 mSv.⁹ For MPS, these techniques include the increased

sensitivity of solid state gamma cameras and the short half-life radionuclides of positron emission tomography.

MPS has good evidence for its cost-effectiveness^{10,11} and the only prospective randomised trial comparing the techniques in the setting of stable chest pain showed that, in contrast to MPS, stress echocardiography and perfusion CMR are unlikely to be cost effective compared with invasive coronary angiography.¹² Indeed, there was evidence of harm in the group randomised to CMR.

Mark Twain is dubiously credited with saying that, to the man with a hammer, every problem looks like a nail. Such an attitude in cardiac imaging may benefit the carpenter but it may be of less benefit for our patients. ■

S RICHARD UNDERWOOD

Professor of cardiac imaging, Imperial College London London, UK, and honorary consultant, Royal Brompton and Harefield NHS Foundation Trust, London, UK

Pericardial mass and cardiac tamponade associated with *Mycoplasma pneumoniae*

Editor – This interesting case report (*Clin Med* 2014;14: 549–50) raises the interesting issue of positive *Mycoplasma* serology and the interpretation of serology in general. The titre of the initial antibody, IgM, is the only *Mycoplasma* serology reported with the laboratory results in Table 1. This is usually reported as a titre (eg 1 in 40) although here is expressed as units. Low titres of *Mycoplasma* IgM are often false-positive results, thought to be due to problems of cross-reactivity with polyclonal IgM. Even in scientific studies, specificity and sensitivity of the test is suboptimal, and depends on the assay used.¹ IgG is more reliable but the reliability of this test is based on an increase in titre between the acute and convalescent phase. A single positive IgG alone simply means that the patient had been exposed to *Mycoplasma* infection at some point, possibly years earlier. To determine if *Mycoplasma* infection may have contributed to causation in this case, it is essential that the authors report the initial and follow-up titres of IgG. It is not clear from the text that the case was discussed with their local infection specialist. Had they done so, I am sure this specialist would have pointed out to them the complexities of interpreting *Mycoplasma* IgM and the difficulties in presuming that *Mycoplasma* infection was a contributing factor in the clinical illness reported here. It is critical that your readers are not misinformed on this clinical condition and the difficulties in interpreting positive serology. ■

ANNA GOODMAN

Locum consultant in infection, Guys and St Thomas' Hospital NHS Trust, London, UK

Suspected neutropenic sepsis during chemotherapy is a medical emergency

Diagnosis

- Neutropenia ($\leq 0.5 \times 10^9/l$)
- Temperature $>38^\circ\text{C}$
- Other symptoms or signs of significant sepsis such as:
 - > systolic blood pressure <90 mmHg
 - > heart rate >130 bpm
 - > respiratory rate >25 /min
 - > sats $<91\%$ or lactate >2
 - > purpuric rash
 - > reduced responsiveness

Investigations

- Urgent FBC, U&E, LFTs, CRP and lactate.
- Send peripheral blood cultures (and central blood cultures if an *in situ* device is accessible).
- Send urine sample in children under 5 years.

Avoid

- Do not request a chest X-ray unless clinically indicated.
- Do not remove a central venous access device.
- Do not use glycopeptide (eg vancomycin or teicoplanin) or aminoglycoside (eg gentamicin) antibiotics without specific microbiological reasons.
- Do not give GCS-F prophylactically unless part of the current chemotherapy regimen.

Management

- Start piperacillin and tazobactam (Tazocin) immediately unless contraindicated.
- Ask for experienced senior assistance.

Prophylaxis in adults (>18 years)

- If neutropenia is anticipated in response to chemotherapy, consider fluoroquinolone (eg ciprofloxacin) prophylaxis (depending on local microbiological sensitivities).

Fig 1. Revised protocol. CRP = C-reactive protein; FBC = full blood count; GCS-F = granulocyte-colony stimulating factor; LFTs = liver function tests; U&E = urea & electrolytes.

Reference

- 1 Beersma MF, Dirven K, van Dam AP, Templeton KE, Claas EC, Goossens H. Evaluation of 12 commercial tests and the complement fixation test for *Mycoplasma pneumoniae*-specific immunoglobulin G (IgG) and IgM antibodies, with PCR used as the “gold standard”. *J Clin Microbiol* 2005;43:2277–85.

Communication is key

Editor – Protocols are increasingly important in clinical practice. They are the fingerprint, the biometric, the iris recognition of evidence-based medicine. In the article ‘Neutropenic sepsis: a potentially life-threatening complication of chemotherapy’ (*Clin Med* 2014;14:538–42), the authors reproduce an algorithm from NICE guidelines [CG151]. The original NICE version contains poorly sequenced, disorganised, repetitive and often self-evident copy. In adapting this original for printing in the journal, *Clinical Medicine* staff have exacerbated these problems by introducing dominant, asymmetrical colour bars that draw the eye away from a spatter of five-point text that is far too small to see comfortably, while typographical errors (eg Examination and spectic) and script that breaches the edge of densely coloured boxes further reduce clarity.

If communication is key and timely intervention critical, why is so little care taken by the National Institute of Health and Care Excellence and others to incorporate even the most basic elements of graphic design?

Not very much is missing from the following 155 words (Fig 1), compared with the original 461 words. ■

ANDY LEVY

*Professor of endocrinology, University of Bristol
University Hospitals Bristol NHS Foundation Trust, Bristol, UK*

References

- 1 Underwood SR, Harbinson MT, Kelion AD, Sabharwal N. CMR versus SPECT for diagnosis of coronary heart disease. *Lancet* 2012;379:2146–6.
- 2 National Institute for Health and Care Excellence. *Chest pain of recent onset: assessment and diagnosis of recent onset chest pain or discomfort of suspected cardiac origin*. 2010. Available online at www.nice.org.uk/guidance/cg95 [Accessed 12 October 2014].
- 3 Montalescot G, Sechtem U, Achenbach S *et al*. 2013 ESC guidelines on the management of stable coronary artery disease. *Eur Heart J* 2013;34:2949–3003.