Correspondence

Anti-CCP antibodies as an aid to prioritization of patients referred to the rheumatology clinic

Sir,
As noted in your review article,1 anti-cyclic citrullinated peptide antibodies (CCP) have been shown to be more sensitive and specific for rheumatoid arthritis (RA) than the rheumatoid factor (RF).2 It is also well accepted that patients with early RA should be seen and treated as soon as possible, as there is a window of opportunity for full remission if treated within the first two years.

We operate a prioritization system for patients in a rapid-access rheumatology clinic based on information supplied by GP letters, whereby patients with suspected inflammatory joint disease (IJD) are seen within 2 weeks of referral. This system has been previously audited and shown to be efficient.3 The main problem revealed by the audit was that many patients without IJD were given inappropriately high priority at the request of the GP, often on the basis of a false-positive RF, whereas the clinical information in the letter did not warrant this high priority. Since it is difficult to see all the patients referred by the GPs as urgent within our desired slot of 2 weeks, we examined the possibility that anti-CCP antibody testing could yield more accurate prioritization of patients who needed to be seen early, by avoiding the false high prioritization given by a false-positive RF.

In this prospective observational study, we tested CCP antibodies in 28 RF-positive patients referred by GPs to our rapid-access clinic. On receipt of the letter, a provisional clinical diagnosis was made on the basis of the information given in the letter (‘paper diagnosis’), and patients were prioritized to categories A, B, and C. Category A meant that inflammatory joint disease was suspected, and this warranted a clinic appointment within 2 weeks. Category B included established RA patients as well as new patients who needed to be seen within 8 weeks. Category C included patients referred by GPs of low clinical priority, to be seen within current guidelines of 13 weeks. We correlated the final diagnosis on follow-up with results of the anti-CCP antibody test.

Of the 28 patients, five were given a high priority (category A) on the basis of their paper diagnosis. All of these patients had positive anti-CCP antibodies, and were found to have IJD on follow-up. Ten patients were placed in category B: 8 were negative for anti-CCP antibodies and 2 were weakly positive. None of these 10 patients had IJD on follow-up. Finally, 13 patients were thought to have a low clinical priority based on their paper diagnosis. In all of these, anti-CCP antibodies were negative, suggesting that the RF was a false-positive result. None of these 13 patients had inflammatory joint disease on follow-up. This supported the clinical decision not to expedite their assessment.

We therefore recommend that anti-CCP antibody testing is made available for RF-positive patients in the community so that the limited number of high priority slots in rapid-access clinics are not wasted.

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A basal variant form of the transient ‘midventricular’ and ‘apical’ ballooning syndrome

Sir,

A 30-year-old Caucasian woman was admitted for a scheduled caesarean delivery at 36 weeks of gestation after an uncomplicated pregnancy. She gave birth to a healthy baby under epidural anaesthesia. One hour post-operatively, she experienced acute substernal chest pain. There was no cardiac history or risk factors for atherosclerosis, and the patient was treated for anxiety disorders. Her blood pressure was 110/65 mmHg, and her heart rate was 80 bpm. Physical examination was unremarkable. The electrocardiogram revealed significant ST segment depression in leads V4 through V6, II and aVF. Serial cardiac enzymes revealed a moderate increase in cardiac troponin I (peak value 1.1 µg/l) and in creatine phosphokinase (peak value 219 U/l). The epicardial coronary arteries were angiographically normal. The left ventriculogram showed basal akinesis with hypercontractile midventricular segments and apex (Figure 1). The patient was managed with conservative medical therapy. A transthoracic echocardiogram obtained 4 weeks later showed complete recovery of the basal wall motion abnormalities (ejection fraction 65%) with minimal mitral regurgitation. The patient did not experience any subsequent cardiac events after >10 months of follow-up.

Apical ballooning syndrome (ABS), or takotsubo cardiomyopathy, is a well-described entity characterized by a typical transient contractile abnormality consisting of extensive apical and midventricular akinesis or dyskinesis with sparing of the basal systolic function. Patients with ABS typically do not have obstructive coronary artery disease, and a unique feature is the occurrence of a preceding physical or mental stress. Although wall motion abnormalities (WMA) were originally thought to invariably involve the ventricular apex, variants have also been recently described with akinesis and ballooning of the midventricular segments and hypercontractile apex and base.

In this case, the presentation and trigger of the episode, the clinical features and the transient nature of the WMA are similar to the ABS, suggesting a common pathophysiological aetiology. This variant has however a unique feature that distinguishes it from the known variant of the ‘classical’ ABS, in that the apex and most of the midventricle were hypercontractile, whereas the base was akinetic.

The report of a variant form affecting the basal ventricular segments with sparing of more apical portions has implications in the appraisal of the proposed pathophysiological mechanisms underlying ABS. For instance, the distribution of the WMA in the present case would clearly argue against the hypothesis of a transient obstruction to left ventricular flow or a multivessel epicardial spasm, as proposed by some authors. The localization of the contractile abnormalities may have to be modified accordingly in future diagnostic criteria of the ‘apical’ ballooning syndrome.

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