Two of the review papers this month have an infectious diseases theme. The first is a joint effort from the Q fever Research Group (Adelaide) and the University of Birmingham. Q fever (the Q stands for query and not Queensland) is caused by infection with Coxiella Burnetti, a bacterium of global distribution that is excreted by farm animals. It is considered to be highly infectious with only a few organisms needed to result in infection. Most acute infections are sub clinical and complete recovery is the usual outcome. However, infection with Coxiella may persist and result in a more serious disease that includes endocarditis. Low levels of Coxiella DNA and antibodies have been shown to persist in infected individuals for many years (as long as 70 years in one instance). Using enhanced laboratory techniques, the authors have confirmed long-term persistence of a non-infective, non-biodegraded complex of Coxiella cell components with its antigens in previously infected individuals. The implications for the development of the more recently described Q fever chronic fatigue syndrome are discussed along with comparisons with other intracellular bacterial infections.

Malaria in developed temperate climates is usually the result of importation from tropical destinations. About 2,000 cases of malaria per year are reported in the UK which result in 10–20 deaths. Hence, malaria is an exotic but important disease and all physicians need to be aware of its presentation and the latest thinking about its treatment. The review by Roe and Pasvol considers all of these issues. Guidance is given on the recognition and treatment of severe falciform and cerebral malaria. Clear indications for when the general physician should involve the support and expertise of units that are specialised in the management of severe malaria are highlighted. The need for meticulous fluid balance and correction of metabolic derangement in acute malaria is also emphasised.

Patients with atherosclerotic renovascular disease (AVRD) are unfortunately at high risk for the development of cardiac disease. Wright et al from Salford had previously demonstrated that a minority of AVRD patients had normal cardiac structure and function at the time of initial diagnosis. They have had the opportunity to further observe both cardiac and renal function in a previously studied group of AVRD patients. Subjects were divided into those who were managed by conservative means and an intervention group who were treated by means of revascularisation. The small intervention sub-group did not demonstrate significant changes in any biochemical or echocardiographic parameters between baseline and one year later. However in the conservatively managed group progressive left ventricular dilatation was observed which was related to severe impairment of renal function at baseline.

Does the term “prehypertension” (PHT) represent a useful diagnosis? Or does it simply refer to the upper end of a normal range of blood pressure measurements? PHT refers to repeated presence of a systolic blood pressure that is between 120–133 mmHg and a diastolic blood pressure that is between 80–90 mmHg. Risk factors for the development of PHT include male gender, being overweight and excessive alcohol intake. There is a body of opinion that once identified, PHT should be managed by appropriate lifestyle advice. Otherwise, it is said there is a risk of progression to true hypertension. Insulin resistance (IR) is also associated with increased risk for cardiovascular disease. Both IR and PHT are relatively common and the question to be answered is: are these two conditions linked in the sense that individuals with PHT are more likely to have higher IR? This is the question that Hwu and colleagues from Taiwan wished to address. Anthropometric and BP measurements were performed in 83 PHT subjects and 192 normotensives. All subjects received a 75-g oral glucose tolerance test for the measurement of IR. It was found that PHT subjects were more likely to be obese, have higher levels of fasting triglycerides.
and to have insulin resistance when compared to normotensives. The inference from this small study is that PHT is associated with IR to some extent and some PHT subjects have the early clinical characteristics of the IR syndrome. Obviously, this represents an important area for further evaluation.

While the prevalence of lead poisoning is less than it used to be, cases are still reported in developed countries. Slow accumulation of lead can lead to significant disease which, if undetected, can result in serious morbidity. Once detected how should lead poisoning be treated? Chelation has represented the main focus of treatment for many years and intravenous sodium calcium edetate has been the favoured therapeutic approach. However, Vale and colleagues make the argument for oral therapy with dimercaptosuccinic acid (DMSA). The latter agent has been shown to be a useful chelator of lead. In the subjects studied it was well tolerated and significantly reduced blood lead concentrations.

Michael Bannon
Editor, QJM