Fibrosis

Editor’s choice

I am pleased to draw your attention to the start of another miniseries in the journal, this time on the subject of fibrosis. Prof. Seamus Donnelly is the guest editor and in his introduction he describes the aim and scope of the series. Fibrosis of any tissue represents a healing response to an injury. In most cases, complete tissue repair is achieved with normal organ functioning. However, if a single injury is severe enough or if chronic repetitive injury takes place, permanent tissue damage with resulting fibrosis may result. It is a complex area representing an interplay between inflammation and dysfunction of the normal tissue repair processes following injury. How and why fibrosis happens is the subject of much debate and current research. It would seem appropriate therefore that the first paper in this series by Prof. Bucala should focus on the fibrocyte, a key player in a pathway that ranges from chronic inflammation to deposition of collagen. Further papers in this series will consider fibrosis of the liver, kidney, lung and heart.

Coronary heart disease: the end of an epidemic?

Grimes, in his commentary, considers the public health implications of coronary heart disease (CHD) which he describes as representing an ‘epidemic’. Certainly much attention, research and intervention has been devoted to the prevention and treatment of CHD over the last six decades. From an historical perspective, the death rate from CHD in the UK peaked around 1970: death rate from this disease at that time was over 500/100,000 population for the UK (the rate for men in Scotland in that year nearly 1000/100,000!). Hence, the concept of CHD representing an emerging epidemic was probably justified. Since then, there has been a sustained and dramatic reduction in death rate from CHD and is currently 25/100,000 in the UK. How has this reduction been achieved and what has been the role of medical intervention? Primary preventive measures including smoking cessation, reduction in cholesterol and control of hypertension are credited with playing a major part in the reduction of death due to CHD. In addition, improved intervention measures have undoubtedly enhanced survival rates of patients with CHD in recent years. Grimes proposes that the reasons, both for the initial epidemic of CHD and its subsequent decline, are not fully understood and cannot be fully attributed to the preventative measures described above. The potential role of infectious agents in the development of CHS is discussed. The review considers the implications of the decline in CHD for developed countries where increased rates of cancer is observed as people live longer. Furthermore, rates of morbidity and mortality from CHD are rising in developed countries. The latter phenomenon could be attributed to changing lifestyles but the subject is obviously much more complex.

Lyme Disease: experience from a UK clinic

Lyme Disease (LD), when I was a junior physician, was something I read about in preparation for MRCP but was unlikely to encounter in clinical practice unless I moved to North America where it seemed to be much more prevalent. I was aware that LD was a tick-borne disease caused by various species of the spirochete Borrelia. Clinical manifestations represent a spectrum of illness that ranges from a relatively asymptomatic course to one which includes erythema migrans, myalgia and chronic fatigue. More serious complications may develop if the condition remains undiagnosed and untreated. It would appear that the number of laboratory verified cases is rising in the UK and is of the order of 2–3,000 per year. Public awareness of LD in the UK has been increased by media coverage and the fact that information on the risks associated with tick bites is often displayed in parklands, woods and other recreational areas where tick bites are
likely. Cottle and colleagues from the Tropical and Infectious Disease Unit, Liverpool, describe their experience of 115 patients referred with a presumptive diagnosis of LD. The results of their review were interesting. Only a minority of those referred had a confirmed diagnosis of LD and a third had chronic fatigue syndrome but not LD. However, over 70 patients had been inappropriately prescribed antibiotics and the majority of incorrect prescribing had been undertaken by non-NHS practitioners. This study highlights the complexities of ensuring a correct diagnosis of LD and concludes that patients with chronic fatigue syndrome were susceptible to misdiagnosis in non-NHS clinical settings.

Research in Clinical Practice: symposium proceedings

As in previous years, QJM will publish the abstracts of the scientific papers presented at the Annual General Meeting of the Association of Physicians. I attended the AGM as in previous years and can confirm the very high standard of the oral presentations and posters. However, in this month’s edition of the journal we publish the abstracts of another scientific meeting, in this case the Research in Clinical Practice 2011 Symposium held at the John Radcliffe Hospital, Oxford. The distinguishing feature of this event is that it is organised by junior doctors in training and aims to provide a platform for them to discuss their research ideas and preliminary research findings in an academic environment. The presentations were impressive considering the fact that the presenters were in fact early-years researchers at the beginning of their academic careers; this should bode well for the future of clinical academic medicine in the UK.

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