presence of RF was independent of C reactive protein. This suggests that inflammation may influence mortality and ischaemic heart disease in a much more sophisticated way than previously thought. It appears that multiple different patterns of inflammation and immune activation may lead to a poor outcome. The relative balance of these different mechanisms may produce different patterns of disease and provide new opportunities for treatment. RF is strongly associated with autoimmune disease such as rheumatoid arthritis but is also present in large numbers of people in the general population and can easily be measured. It remains to be seen if RF is acting directly to cause tissue damage or is a secondary marker of a particular variety of inflammation. Further studies are needed to determine if measuring RF is a useful method of predicting poor prognosis in clinical practice.

We are also grateful for the comments of Dr Srinivasan. We agree completely that our work showing an association between the presence of rheumatoid factor (RF) and ischaemic heart disease (IHD) in men lends further support to the importance of inflammation in the aetio-pathogenesis of atherosclerosis.¹ We are

currently measuring other markers of inflammation including highly sensitive C reactive protein in our study population. This will provide further information about whether RF has a special role in the development of atherosclerosis and IHD or whether it is merely a non-specific marker of inflammation. Our findings that there is no association of other common autoantibodies with IHD, including antinuclear antibodies, would argue against the possibility that the association of RF is the result of non-specific polyclonal B-cell activation alone.

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CORRECTIONS

Stewart S, Murphy N, Walker A, McGuire A, McMurray JJV. The current cost of angina pectoris to the National Health Service in the UK. *Heart* 2003;**89**:848–53.

An author of this paper, N Murphy, should be listed as NF Murphy.

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IMAGES IN CARDIOLOGY

Single coronary artery: circumflex/right coronary circle

A 70-year-old woman with a background history of hypertension and hypercholesterolaemia presented with an anterior myocardial infarction. She received thrombolytic treatment, with resolution of her ST-segment elevation. She had a diagnostic coronary angiogram via her right radial artery which showed a single coronary artery, with the atrioventricular circumflex artery continuing as the right coronary artery (panel). There were no significant obstructive lesions in her left anterior descending artery. Although an anomalous circumflex artery arising from the right coronary artery is relatively common, and a right coronary artery arising from the left anterior descending artery is well reported, this seemingly intuitive type of anomalous right coronary artery has not previously been reported.

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