Letters to the Editor

PERIPARTUM CARDIOMYOPATHY AND ANAESTHESIA

Dear Editor,

This is with reference to the case report "Peripartum Cardiomyopathy and anaesthesia (MJA 1994; 50 : 221-2). Certain features about the case require reconsideration as explained below.

1. Common ECG changes of dilated cardiomyopathy are non-specific ST-T changes and anterior Q waves. Changes of LVH are rare. In this case, a possibility of pre-existing hypertensive heart disease is likely, which could have aggravated the cardiomyopathy. Alternatively since echocardiography did not dem-

onstrate LVH, the ECG changes could be non-specific rather than of ventricular hypertrophy.

2. The X-ray changes should read as pulmonary venous hypertension/pulmonary vascular redistribution.
3. As the patient was maintaining normal sinus rhythm the role of digitalis is controversial. Diuretics and vasodilators would alone have sufficed and low dose aspirin could have been added as it is indicated cardiomyopathy.

Maj RG PODUVAL
Graded Specialist (Medicine)
Military Hospital Kamptee

Author's Reply

1. Non-specific ST & T changes may be common ECG finding in dilated cardiomyopathies. However in this particular case, the patient showed clear clinical features of LVF and ECG findings were typical of LVH with strain pattern i.e. depressed ST segment and inverted T waves. This patient did not give any history of hypertensive heart disease prior to present pregnancy. Her previous pregnancies and deliveries were uncomplicated. However, I agree that echocardiography findings were suggestive of dilated cardiomyopathy.
2. I also agree with the writer that chest radiograph findings were those of pulmonary venous hypertension.

3. As the patient showed signs of congestive heart failure with marked tachycardia and poor myocardial contractility, she was digitalised to improve cardiac output, to reduce mismatch and to improve oxygen delivery to tissues. As the plan was to take up the patient for LSCS at the earliest to save the mother as well as the baby, initial trial with vasodilators and diuretics would have perhaps delayed this life saving operation with unfavourable outcome.

Lt Col PM VELANKAR
Reader, Dept of Anaesthesiology,
Armed Forces Medical College, Pune.

TUMOUR ASSOCIATED BLOOD EOSINOPHILIA

Dear Editor,

We wish to share with our readers a study pertaining to tumour associated eosinophilia (TABE). A total of 596 patients with biopsy confirmed malignancy were screened for eosinophilia. A differential leukocyte count in excess of 10% was taken as significant [1]. The patients having eosinophilia due to known causes as parasitic infections, allergies, collagen vascular diseases, drug reactions etc were excluded from this study. A control group from a similar cross section of population was also screened for eosinophilia. It was observed that the inci-

dence of eosinophilia in patients suffering from malignancy was 12.6%. The overall incidence of eosinophilia in the control group was 6%. The highest incidence of eosinophilia was in Hodgkins disease, followed by Non Hodgkins lymphoma and carcinoma cervix. Patients with disseminated disease often showed eosinophilia.

The association between blood eosinophilia and malignant tumours was described by Isaacson in 1946. It is an easily recognisable condition and is often associated with poor prognosis [1,2]. It has been reported in various types of malignancies. A high incidence of TABE in Hodgkins disease is recorded in literature [2]. The cause for eosinophilia is not yet clearly defined. It has been linked with necrosis in the primary tumour or its metastases [3], immune complex formation with

subsequent histamine release [2] etc. It is presently considered that TABE is due to production of granulocyte-macrophage stimulating factor by the tumour, but this has not been conclusively proved [4]. The role of eosinophils is still uncertain and needs further research both morphologically and immunologically at the affected tumour site.

Maj HARSH KUMAR, Surg Cdr P SIVADAS,
Lt Col R RANGARAO, Col JR BHARDWAJ
Dept of Pathology,
AFMC, Pune.

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