Depression and hepatitis C

Sir,

We read with interest the article *Managing the neuropsychiatric complications of hepatitis C treatment* (vol 68(10), 2007, p. 520). We have observed a similar incidence of depression and psychosis in patients with chronic hepatitis C treated with PEG-interferon alfa 2a and ribavarin. We treated 58 patients, of whom 12 developed depression within a month. One patient had frank psychosis, requiring psychiatric inpatient treatment.

Interferon-alpha induces depression in approximately 20–30% patients of hepatitis C virus, especially if there are elevated baseline depressive symptoms (Bonaccorso et al, 2002). Interferon-alpha-induced psychosis has also been reported in about 0.01–0.04% (Fattovich et al, 1996) which may explain the lack of study in this area. Functional magnetic resonance imaging studies support the hypothesis that interferon can affect the relative activation of the dorsolateral prefrontal cortex and the ventral anterior cingulate cortex, thus causing depression (Matthews et al, 2004). Particular care should be taken in patients who are at risk of depression before initiating therapy. There should be a low threshold for referral to liaison psychiatry and the use of selective serotonin-reuptake inhibitors in susceptible patients (Ward and Kugelmas, 2005). A lot more work is still needed to investigate the psychosis-inducing effect of interferon on hepatitis C patients.

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Patients with old left bundle–branch block and acute coronary syndromes

Sir,

Patients with associated suspected acute coronary syndrome and left bundle–branch block (LBBB) are categorized as having either old or new-onset LBBB. Only the latter are eligible for thrombolysis (Anbe et al, 2004) or primary angioplasty (Widimsky et al, 2007). This categorization, however, does not account for the fact that, in at least one study, the proportion of myocardial infarction (MI) patients with old LBBB was virtually identical to the proportion of MI patients with new-onset LBBB, nor the fact that new-onset LBBB may only be transient in some patients with suspected MI (Gann et al, 1975). Conversely, although patients with old LBBB are at high risk of unstable angina, and although most patients in the non-ST segment acute coronary syndrome category are those with unstable angina (Collinson et al, 2006), opinion is divided as to whether or not to include bundle–branch block in the enrolment criteria for non-ST elevation acute coronary syndromes (Collinson et al, 2006; Lgerqvist et al, 2006).

The recognition that, among patients with suspected MI, bundle–branch block (including LBBB) conferred a 25% mortality risk which could be favourably modified by thrombolytic therapy dates back to the ISIS-2 trial (1988), and has been the basis for triaging new-onset LBBB in the same category as ST segment elevation MI for the purpose of thrombolysis (Anbe et al, 2004). Since ISIS-2, early invasive strategies such as percutaneous coronary intervention and coronary artery bypass surgery have emerged as modalities capable of improving the prognosis in non-ST-segment elevation acute coronary syndromes, including those attributable to enzymatically proven MI (Lgerqvist et al, 2006). This has not translated into a recognition that patients with old LBBB, although deemed ineligible for thrombolysis or for primary percutaneous coronary intervention, might benefit from these early reperfusion strategies (Lgerqvist et al, 2006).

Inclusion of patients with LBBB in the category of non-ST elevation acute coronary syndromes deemed to be at highest risk, namely those with ST segment depression (Collinson et al, 2006), was a major step towards mitigating this oversight, but there has not been a corresponding acknowledgment of old LBBB as a specific high-risk entity in recent guidelines for the management of non-ST elevation acute coronary syndromes (Bassand et al, 2007). As a result, opportunities are being missed to evaluate the outcomes of reperfusion strategies in patients with old LBBB *vs* counterparts with ST segment depression (in the absence of LBBB), and the outcomes of troponin-positive patients with old LBBB *vs* troponin-negative counterparts. Such evaluations could change the management of acute coronary syndromes.

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