

## Use of Viagra by patients with heart disease

Sir,

In the last year or two, cardiologists and other physicians have noticed an increasing number of enquiries from older male patients concerning the possibility of taking Viagra for impotence (now less demeaningly termed erectile dysfunction, ED). This phenomenon clearly indicates a well of unfulfilled expectation in males with cardiovascular disease. The efficacy of Viagra has focussed attention on this poorly explored aspect of our patients' lives. Dr Jackson (p. 526) has reviewed the cardiovascular effects of sildenafil citrate (Viagra) and presents a practical approach to the management of ED in cardiac patients.

Sexual activity after myocardial infarction (MI) is bedevilled by ignorance mainly on the part of patients, but also sadly on the part of doctors and other health-care professionals. Yet considerable knowledge exists about the subject. It is important to recognize that sexual dysfunction post-MI is as common in women as in men. Thus, although it's an understandably (perhaps male) reaction to focus on the physiology of erection, other underlying psychological anxieties play a part in the disease.

Cardiovascular risk stratification (see *Table 1* of Dr Jackson's editorial) is an important part of overall cardiovascular management as well as a prerequisite for counselling a patient with ED. There is no conflict in these recommendations.

The only contentious part of the editorial lies in Dr Jackson's assertion that cardiovascular investigation is needed in an asymptomatic male presenting with ED. The practicality of this is a matter for debate. Nonetheless, Dr Jackson has performed a service for all if he has at least exploded the myth that we were once taught at medical school, namely that 9% (or thereabouts) of impotence is 'psychological'.

Cardiac rehabilitation programmes should always be formulated to allow patients to express fears, anxieties, and specific problems concerning sexual function post-MI. The provision of educational materials can help generally in de-mythologizing coronary artery disease. This 'third person' technique ensures that topics are implanted in the patient's mind, often allowing a non-confrontational approach to expressing concerns.

Whether a direct approach is always the best way is far from clear. A survey in our unit revealed a sizeable minority of patients unwilling to discuss sexual function. Rehabilitation professionals need to judge how best to advise patients with cardiovascular disease about sexual function, but it should always be on the agenda.

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Sir,

Despite the significant amount of data available on the safety of Viagra, particularly in patients with suspected or known coronary artery disease, I sense a reluctance to prescribe Viagra for fear of adverse cardiac effects. This is probably driven partly through ignorance and we are grateful to Dr Jackson for his succinct editorial on the subject.

ED is common in patients with vascular disease and yet it is rarely specifically sought by cardiologists and unlikely to be volunteered, at least initially, by the patient. Moreover, many cardiovascular drugs cause or aggravate ED. Dr Jackson provides clear and concise advice which is much needed, together with a simple table of cardiovascular risk and management recommendations. He also refers to a consensus statement on the management of ED in the cardiovascular patient (Jackson et al, 1999). This is a sizeable document produced by a multidisciplinary panel, covering not only the role of Viagra but all aspects of care in these patients, which will prove useful to those seeking more detailed information.

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Jackson G, Betteridge J, Dean J et al (1999) A systematic approach to erectile dysfunction in the cardiovascular patient: A consensus statement. *Int J Clin Pract* 53: 445-51

## Does smoking help spread MRSA?

Sir,

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a common cause of nosocomial infections. Infected and colonized patients provide the primary reservoirs for transmission. The number of patients admitted to UK hospitals with MRSA colonization is increasing, leading to unavoidable increased transmission to inpatients. In a UK teaching hospital, an MRSA control policy applied consistently for over 10 years with the aim of eradication still showed an increase in MRSA-positive admissions (Farrington et al, 1998).

Aggressive control measures to prevent transmission are necessary because:

1. MRSA causes significant morbidity and mortality
2. MRSA does not replace susceptible strains but adds to nosocomial infection
3. Serious MRSA infections require treatment with vancomycin which in turn may increase vancomycin-resistant enterococci
4. The incidence of nosocomial MRSA reflects the effectiveness of infection control measures for that institution (Herwaldt, 1999).

The cost of MRSA to the NHS is substantial. The Royal London Hospital spends £90 for each screen of a 30-bed vascular ward and treating an infected patient with Aquasept, nasal mupirocin and vancomycin costs approximately £180/week. There are also indirect costs such as increased nursing/medical time, prolonged treatment and

inpatient stay (Menon et al, 1999), loss of physical function, increased time to return to work, and anxiety for patients and their families. The total cost for 980 beds is difficult to quantify, but it is a considerable financial burden for the trust.

Elderly males are the most common group that require vascular surgical admission. Studies have shown that the highest rate of MRSA isolates was in men aged over 75 years (Morgan et al, 1999) and cross-contamination occurs between nasal MRSA and intravascular devices (Frebourg et al, 1999), putting our patients at particularly high risk.

Infection of a prosthetic graft with MRSA is extremely difficult to eradicate, usually resulting in graft removal and threatening limb survival. Contamination of an aortic graft can have more severe consequences. We performed a femoropopliteal bypass with prosthetic graft in a 53-year-old man. Postoperatively superficial MRSA infection developed in the distal wound, which contaminated the graft necessitating its removal. The failure to eradicate MRSA denied the possibility of re-vascularization for the ensuing critical ischaemia, which required an above-knee amputation. Prevention of cross-contamination between vascular patients has proved extremely difficult, even with a stringent infection control policy.

It has been shown that closer proximity of patients increases the risk of cross-infection of MRSA (Kibbler et al, 1998). In our ward, at certain times of the day there is a mass movement of patients towards the smoking room, where MRSA-positive and negative patients congregate together for a number of hours in a confined space. We have advised against this, but patients have been unwilling to comply with a timetable introduced to separate MRSA-positive and negative smokers.

The majority of patients with peripheral vascular disease continue to smoke cigarettes. Admission to hospital heightens their urge to smoke because of increased anxiety and boredom. Despite different methods of encouraging cessation they find it very difficult to stop. Without wishing to condone this habit, a possible solution could be separate 'MRSA smoking rooms'.

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