Percutaneous balloon mitral valvuloplasty

Sir,

I enjoyed Prendergast and Shaw's article on percutaneous balloon mitral valvuloplasty (vol 62(9), 2001, p.564), but wish to make a few comments.

To the conditions by which percutaneous balloon mitral valvuloplasty is not contraindicated, as listed by the authors, should be added coexistent aortic regurgitation. Chen et al (1993) reported that patients with rheumatic mitral stenosis are suitable candidates for percutaneous balloon mitral valvuloplasty whether or not they have associated aortic regurgitation of mild to moderate severity. Not only were the results in their patients with mitral stenosis associated with aortic regurgitation not significantly different from those obtained in patients with isolated mitral stenosis, but the course of the associated aortic regurgitation was unaffected by percutaneous balloon mitral valvuloplasty. Because aortic regurgitation is frequently associated with mitral stenosis in patients with rheumatic heart disease, such a therapeutic decision takes on a greater significance in the management of these patients.

Preprocedure transthoracic echocardiography is essential, but transoesophageal echocardiography is not. Most patients, except those with known or suspected left atrial thrombi, do not need transoesophageal echocardiography before percutaneous balloon mitral valvuloplasty. Transoesophageal echocardiography not only is more costly but requires special expertise. Furthermore, contrary to transthoracic echocardiography, which gives no discomfort to the patients, transoesophageal echocardiography is not very pleasant for some patients.

Percutaneous balloon mitral valvuloplasty by the Inoue balloon is indeed the procedure of choice at the present time for patients with rheumatic mitral stenosis (Cheng and Holmes, 1998). Both immediate and long-term results of percutaneous balloon mitral valvuloplasty in large series of patients are excellent (Chen and Cheng, 1995; Cheng and Chen, 2000).

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Diagnosing hepatitis E in alcoholic patients

Sir,

We read with interest the editorial and the accompanying case reports on tropical infections mimicking common Western European diseases (vol 62(6), 2001, p. 326). We would like to share our experience of a patient with a history of alcohol abuse presenting with jaundice who was found to have acute hepatitis E.

A 53-year-old Asian man presented with fever, jaundice and loss of appetite of 3 weeks duration. He had a history of drinking up to 60 units of alcohol a week for the last 15 years. He had recently returned from India after a 3-month visit. He was found to be jaundiced but did not have any stigmata of chronic liver disease. The liver function tests (LFTs) showed alanine aminotransferase 1930 u/litre, alkaline phosphatase 264 u/litre, bilirubin 212 μmol/litre, albumin 35 g/litre and γ glutamyltransferase 355 u/litre. His jaundice was provisionally attributed to alcoholic hepatitis but in view of his recent travel history serology for viral hepatitis was requested. The results were negative for hepatitis A, B, C but was positive for immunoglobulin (Ig) M and IgG antibodies to hepatitis E. His symptoms and LFTs returned to normal over the next 3 weeks.

Hepatitis E is a major cause of viral hepatitis in the Indian subcontinent (Krawczynski et al, 2000; Piper-Jenks et al, 2000). There is an increasing number of UK travellers returning from the Indian subcontinent. As routine tests for hepatitis screening in the UK do not include hepatitis E, this should be suspected and tested for in returning travellers with jaundice.

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Managing schizophrenia

Sir,

I read with interest the review of schizophrenia management by Chris Fear (vol 62(9), 2001, p. 549). This concise summary of such a complex issue is to be applauded, but I would like to complement it by presenting an important factor that is missing. The management of patients suffering from schizophrenia has to be addressed individually as age and/or stage of illness are of particular importance.

This is mostly relevant during the early phase of psychosis as it seems that it could be a critical period both biologically and psychosocially. As Birchwood et al (1998) have shown, intervention during the first 3 years of illness can improve outcome.

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