rhabdomyolysis associated with the drug have been reported to date: in two cases the patients were taking 10 mg of rosuvastatin per day, and in five the dose was 40 mg per day; in one case the dose was not specified. Minor muscle complaints without elevated creatinine kinase levels may not necessitate discontinuation of the drug. However, patients, particularly those with risk factors for statin-induced myopathy, should be warned of the potential for rhabdomyolysis and told to report immediately any muscle pain, muscle weakness or cramps, or dark urine. If rhabdomyolysis is suspected, the drug should be stopped immediately, and appropriate medical management should be instituted as well as a work-up of predisposing risk factors. In our patient as his risk for future coronary events was very high it was essential to exhibit combination therapy to control his dyslipidemia. As he had evidence of rhabdomyolysis early on exhibiting combination treatment with Rosuvastatin and Fenofibrate, the therapy had to be stopped immediately.

Therefore, in high risk patients with atherosclerosis, on combination therapy with fibrates and statins it is essential to instruct patients regarding the possible adverse effects and need for regular follow up. Myopathy is reversible on withdrawal of the combination therapy.

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Infectious Causes of Peripheral Autonomic Neuropathy

Sir,

I read with interest an article “approach to a case of autonomic peripheral neuropathy” by Chowdhury and Patel. The authors have given a long list of various causes of autonomic peripheral neuropathy. Of course the main theme of the article was an approach towards this entity, but I would like to add two important infections as the cause of autonomic peripheral neuropathy, that is P. falciparum malaria and brucellosis which are quite pertinent in tropics. I myself have seen autonomic involvement in patients of falciparum malaria.

As the authors have said in the last “treatment aims to treat specific cause of the neuropathy” our patient improved with specific therapy i.e. anti-malarial drugs.

The aim of my this correspondence is to make aware the primary care physicians in general and neurologists in particular that as India is witnessing outbreaks of falciparum malaria at one or the other part from time to time, we should look for P. falciparum malaria in a patient with fever and autonomic involvement in a particular setting.

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Reply from Author

Sir,

We appreciate the valuable addition to the long list of causes of autonomic peripheral neuropathy mentioned in our article. Falciparum malaria and neuro-brucellosis can occasionally cause autonomic manifestations associated with radiculoneuropathy. However, our main emphasis in the article was to highlight conditions in which the autonomic neuropathy is the major or sole manifestation of the disease. Treating the underlying causes of autonomic neuropathy including the infectious causes can be quite rewarding.

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Effect of Valsalva Maneuver on QT Interval, QT Dispersion and Rate Pressure Product

Sir,

Autonomic tone modulates the ventricular recovery time dispersion indices (QTc and QTd). Valsalva maneuver (VM) modifies the autonomic tone and thus employed is a test of cardiac function. However, effect