Sabharwal reported a case of Sheehan’s syndrome that developed acute psychosis following a single tablet of 5 mg of prednisolone. Patients with adrenal insufficiency are extremely sensitive to steroids. Acute psychotic reactions are rare and occur during initial days of therapy. Reduction in the dose of steroids helps recovery which is usually rapid.

Sheehan’s syndrome is rare in developed countries, but is a significant cause of maternal morbidity and mortality in developing countries like ours. Timely and efficient management of the condition requires high index of suspicion and awareness among the general practitioners, obstetricians and physicians.

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REFERENCES


API Expert Consensus Document on Management of Ischemic Heart Disease

Sirs,

There are two issues which need additional clarification

1. Routine CAG after thrombolysis -

   Can data from CAPITAL AMI, GRACIA I, and SIAM III be extrapolated in Indian settings? In all these trials a fibrin specific agents were used for fibrinolysis, i.e., either TNK, RPA or tPA. In India streptokinase remains the most commonly used agent, which has systemic lytic action, also no trial with SK and immediate angioplasty has shown benefit. (SWIFT and TIMI IIb trials and SIAM)

   Why should a stable patient with small infarct with stable LV function should undergo CAG (coronary angiography)? Patient can always undergo noninvasive testing prior to CAG. These patients if catheterized routinely may show borderline lesions, leading unnecessary interventions without documented objective ischemia.

   Also the apparent coronary stenosis a few days after MI is well documented to reduce in severity and stabilise at the end of 3 months. So early CAG will again lead to unnecessary intervention.

2. 80 mg dose of Atorvastatin

   Dyslipidemia in Indian patients is different from western population with low HDL, high TG with relatively normal LDL also high Lp(a). High dose of statins is not been studied in this subset, additionally worry about side effects with such a high dose always remains. Even with smaller doses many patients complain of myalgia without rise in enzymes, which subside with stoppage of drug. Lastly cost of 80mg dose will burden patient economically to already burdened patient. It is our impression that the vast majority of physicians and cardiologists use much smaller doses (even as low as 5 mg) in view of above factors. In fact, it would interesting to know how many members of this expert committee use 80 mg dose.

Shantanu Deshpande*, Yash Lokhandwala**

*Consultsnt Cardiologist, Bombay Hospital, Mumbai.
**Arrhythmia Associates

REFERENCES


Reply from the Authors

Sirs,

We thank Dr. Y Lokhandwala and Dr. S Deshpande for interest in “API Expert Consensus Document on Management of Ischemic Heart Disease”, published in JAPI, 54, 469–480, June 2006. Drs. Lokhandwala and Deshpande raise two issues and our answers to the same are as follows :

1) The first issue is regarding Routine Coronary Angiography (CAG) after thrombolysis.

   The management of ST-elevation myocardial infarction (STEMI) after thrombolysis has undergone a major change. We have recommended routine coronary angiography after thrombolysis in every case on the basis...
of global practice patterns and the recently published guidelines of European Society of Cardiology (ESC) (Reference 5 in the article). The ESC guidelines recommend routine post thrombolysis coronary angiography and percutaneous coronary intervention (PCI) if applicable as Class IA recommendation (page 817, Table 7 of Reference 2).

The global practice patterns have indicated that a more conservative pattern of care with regards to early revascularization had a detrimental effect on short and long-term prognosis. We quote a few of the major reports. A multilevel analysis of patients in ASSENT – 2 showed a lower mortality in the countries with the highest rates of PCI after thrombolytic treatment. A meta-analysis of 20,101 patients from the TIMI 4, 9 and 10B and InTIME – II trials revealed that PCI during hospitalization was associated with a lower rate of in-hospital recurrent MI (4.5 vs 1.6%, p < 0.001) and a lower 2-year mortality (11.6 vs. 5.6%, p < 0.001). In GUSTO – I, the rates of cardiac catheterization and revascularization during the index hospitalization among US patients were more than twice those among Canadian patients. The 5- year mortality was 19.6% among US patients and 21.4% among Canadian patients (p = 0.02). Another interesting report published from Europe in year 2000 is regarding the difference in use of coronary angiography and outcome of AMI in Toulouse (France) and Gerona (Spain). Angiography was utilized in 93% patients in Toulouse, France whereas it was used only in 6% patients in Gerona, Spain. The 28 day case fatality was 4.3% in Toulouse and 9.4% in Gerona. These reports along with CAPITAL – AMI, SIAM III, GRACIA-I and the European Society of Guidelines form the basis of our recommendations in the article.

Drs. Lokhandwala and Deshpande raise the objection of extrapolating this data in Indian settings where streptokinase is utilized. They also quote a reference of year 1990 to show ineffectiveness of immediate angioplasty with streptokinase. In absence of Indian data, we have no choice but to utilize the available global data. As we mentioned in the article the individual physician can choose what he wishes to do with his patient. However, we reiterate the European Society Guidelines and the vast amount of global data and global practice which recommends routine use of coronary angiography after thrombolysis if there is no specific contraindication.

2) The second issue is 80 mg dose of atorvastatin: There are multiple questions which have been inserted in this issue and we wish to respond in this way. A) Dyslipidemia in a given patient should be treated as necessary. In the consensus document on page 471, para 1, it has been suggested that the necessary lipid lowering agent should be used to achieve the goals. B) There is ample data in the literature which speaks of safety of 80 mg atorvastatin and there should not be unnecessary fears on this account. C) The initial dose of statin which is recommended in acute coronary syndrome (ACS) is 80 mg atorvastatin based on data from MIRACL and PROVE IT-TIMI 22. As we know, the pleiotropic effects of statins are important in ACS and have been demonstrated with 80 mg atorvastatin dose. The TNT trial has emphasized the role of aggressive lipid lowering even in stable CAD. What we wish to emphasize is that the LDL cholesterol should be effectively lowered in the range of 70–100 mg. We are aware of the fact that many consultants in India use a lower dose of statin than what is prescribed in the Western literature. In formulating this consensus document, an attempt has been made to present the available evidence based data. The clinician in Indian certainly has a choice to choose the dose which he thinks appropriate for his patient. D) The 40-80 mg dose have been utilized by many members of the expert consensus writing group.

Chair; **Co-chairs, API Expert Consensus Document on Management of Ischemic Heart Disease.

REFERENCES


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### Announcement

4th National Conference of Cardiology, Diabetology, Electrocardiology and Echocardiography to be held on 18th and 19th Nov. 2006 at Hotel Jehan Numa Palace, Bhopal (M.P.).

#### Registration Fees

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*Accommodation will be provided on twin sharing basis.

Draft drawn in favour of ICC-CON should be sent to address mentioned below:

Conference Secretariat: Dr. PC Manoria, E-5/103, Arera Colony, Bhopal M.P. - 462016
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