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Prognosis of abdominal aortic aneurysm

SIR,—Professor R M Greenhalgh's editorial implies that small (<5 cm) asymptomatic aortic aneurysms should probably be left alone.[1] We believe that this is a somewhat dangerous message to convey to general practitioner colleagues.

Small aneurysms can and do rupture—a 39% incidence of rupture was reported in one recent series of small aneurysms managed non-operatively.[2] We have encountered two instances in the past 12 months in which a 3·5 cm aneurysm ruptured, each with a fatal outcome. Although aneurysms do enlarge with time and the risk of rupture increases with increasing size, a sudden split may occur in a degenerate aortic wall at any time in the natural course of the condition. When the excellent results obtained with elective surgery for asymptomatic aneurysms (as evidenced in this and other articles) are considered together with the fact that patients may become frail with advancing age it seems illogical to recommend any approach other than surgery for these patients provided that they are in reasonable health.

The second point of issue concerns the importance of a tender aortic aneurysm. Tenderness is subjective, and it depends on the enthusiasm with which abdominal palpation is carried out. Genuine tenderness over an aneurysm means one of two things: the aneurysm has already ruptured or the patient has the uncommon condition inflammatory aneurysm. These two possibilities can usually be distinguished by the clinical setting. A symptomatic aortic aneurysm is a more helpful pointer to the need for prompt action. It is important, however, not to be stampeded into overhasty surgery in patients with symptomatic aneurysms as this may lead to increased morbidity and mortality due to inadequate preoperative cardiological, renal, and pulmonary work up.[3,4] Clearly, if the patient is thought to have a ruptured aneurysm he or she should be taken straight to the operating theatre without investigation. Outside these circumstances computed tomography is the best current guide to the need for and timing of aortic surgery.

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AUTHOR'S REPLY,—Messrs A J Russell and A S Ward accentuate the dilemma discussed in my editorial. The eventual conclusion should be that the prognosis and ideal management of asymptomatic aortic aneurysm are unclear and that surgery should be performed for tender aneurysms.

When a doctor attributes symptoms to an aneurysm it implies that rupture is imminent and an operation should be performed soon; but abdominal pain, backache, and diarrhoea may derive from another intra-abdominal disorder and the aneurysm could be incidental. Surely finding tenderness on physical examination is what alerts doctors to attribute patients' symptoms to aortic aneurysm. The authors are quite right to stress that the number of tender aneurysms found in different centres will vary with enthusiasm of examination, and this can be used as an excuse for justifying early surgery. Clearly, from our results I cannot accept that tender aneurysm is uncommon, and not all of the 120 we recorded were inflammatory or had evidence of rupture on computed tomography. Despite identical careful preoperative assessment for all elective aneurysms patients with tender aneurysms had a higher 30 day mortality than those with asymptomatic ones, and this is baffling. There is much we do not understand about tender aneurysms.

Unfortunately, Messrs Russell and Ward have misunderstood and misquoted from their second reference. Of 106 aneurysms <6 cm, seven ruptured during the 15 year follow up—that is, 7% not 39% as they quoted. The same study also indicated that few of the deaths were related to aneurysms. Of course, some small aneurysms do rupture; these need to be identified.

Opinion on management of small, asymptomatic, abdominal aortic aneurysms varies among British vascular surgeons from those who, like Messrs Russell and Ward, are convinced that it is dangerous to withhold surgery as the risks of rupture are unacceptable to those who refuse to operate until aneurysms grow to at least 5·5 cm or become tender, fearing an unexpected death during an operation for an asymptomatic condition in an elderly patient. Most surgeons, however, are uncertain of the best management for aneurysms between 4·0 and 5·5 cm and therefore would welcome a national collaborative trial with random allocation of these patients. This could provide the missing prospective data on the growth of small aneurysms, their rate of rupture, and mortality from rupture or other causes during observation. Equally, national 30 day mortality figures for elective repairs according to age, sex, and size of aneurysm would be forthcoming. Then we would know whether to operate on small asymptomatic aneurysms.

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Pulse treatment with methylprednisolone in rheumatoid arthritis

SIR,—Like Dr T M Hansen and colleagues[1] we have attempted to accelerate and improve the beneficial effect of disease modifying antirheumatic drugs in rheumatoid arthritis induced by glucocorticoids.[2]

Rather than using high dose intravenous methylprednisolone we used three intramuscular injections of methylprednisolone acetate 120 mg at four weekly intervals at the start of weekly intramuscular gold therapy for rheumatoid arthritis. Other studies, including that of Dr Hansen and colleagues, have used intravenous methylprednisolone with a variable response.[3,4] Our regimen has a different pharmacokinetic profile from intravenous regimens, giving a continuous concentration of glucocorticoids just above peak physiological concentrations. We postulated that such a pattern may be sufficient to suppress the activity of rheumatoid arthritis.[5] Our finding that low dose intramuscular methylprednisolone acetate hastened the clinical and laboratory response to gold in all variables measured compared with the response to gold alone suggests that this approach is preferable to high dose bolus protocols.

In neither our study nor that of Dr Hansen and colleagues did the advantage of glucocorticoid treatment persist for a prolonged time. We therefore believe that glucocorticoids are best given in short courses in association with treatments likely to produce long term suppression of disease.

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Speed kills

SIR,—After reading Ms Daphne Gloag's article[1] I saw that two of the "quality" Sunday newspapers contained advertisements for radar detectors for cars, which give motorists warning of the presence of radar speed traps up to 4·8 km away. The only purpose of these devices must be to allow drivers to break the law by speeding when they are reasonably sure that they will not be caught. Their use is not confined to the open road. Several models boast motorway and city modes enabling their proud owners to endanger pedestrians and cyclists as well as other motorists.

I have written to the editors of the newspapers concerned and one has already promised action, but I have no doubt that radar detectors will go on being advertised elsewhere. I assume from the fact that they are freely available that they are not illegal. Few doctors will escape seeing patients killed or crippled by road accidents, and this must therefore be a legitimate concern for the profession.

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Screening and genetic counselling for relatives of patients with colorectal cancer

SIR,—Dr R S Houlston and colleagues incorrectly state that the colorectal cancer family clinic at St Mark's Hospital has moved.[1] It continues here under the direction of Dr Shirley Hodgson, who was recently appointed honorary consultant in clinical genetics to the City and Hackney Health Authority.

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1 Houlston RS, Murday V, Harocopos C, Williams CB, Slack J. Screening and genetic counselling for relatives of patients with colorectal cancer in a family cancer clinic. *Br Med J* 1990;**301**:366-8. (18-25 August.)