Nurses’ reports about the reasons for these requests were unrelated to their support of or opposition to the Oregon Death with Dignity Act, except that those who opposed the law rated dying at home as a less important reason than those who supported it (P=0.002). Nurses’ ratings of the importance of depression for patients requesting a lethal prescription were not associated with nurses’ support of or opposition to the law (P=0.24).

Clinicians who lack expertise in mental health do overlook depression. We reported that hospice social workers, who have expertise in evaluating mood disorders in dying patients, rated depression as the least important reason for the request for assisted suicide. Otherwise, as we noted in the article, we agree that the degree to which the nurses’ responses accurately represent the patients’ views is unknown, and studies of persons in Oregon who request assistance with suicide are needed to validate the importance of all these reasons.

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Polymyalgia Rheumatica and Giant-Cell Arteritis

To the Editor: The prognosis for patients with polymyalgia rheumatica and temporal arteritis may not be as benign as intimated by Salvarani et al. (July 25 issue).1 Despite the rapid initial response to corticosteroids, treatment is usually required for at least two years in the majority of patients. Studies in the United States suggest a shorter duration of therapy, in contrast to the European experience; this difference may be a manifestation of variations in demographic characteristics, the selection of patients, or the study design. In a study in Sweden, only 24 percent of patients with polymyalgia rheumatica, 16 percent of patients with polymyalgia rheumatica and temporal arteritis, and 5 percent of patients with temporal arteritis were able to discontinue prednisolone after two years of treatment.2 In another study, less than 50 percent of patients with polymyalgia rheumatica had discontinued treatment after a mean of 23 months, and among those with both polymyalgia rheumatica and temporal arteritis, only 28 percent had stopped treatment after a mean of 31 months.3 We have previously reported that only 24 percent of patients with polymyalgia rheumatica were able to discontinue corticosteroids successfully after two years.4

The results of a preliminary study suggest that severe polymyalgia rheumatica may be identified on the basis of a combination of the erythrocyte sedimentation rate and the interleukin-6 level.5 If this finding is confirmed, prognostication may improve, leading to clearer guidelines on the length of treatment required. We currently tell patients that treatment is usually required for at least two years and may be required for a longer period. Furthermore, a small proportion of patients require treatment indefinitely, and such patients have a greatly increased incidence of corticosteroid complications.

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To the Editor: Salvarani et al. report that giant-cell arteritis causes visual loss from “ischemic optic neuritis.” No such disease exists. They have conflated optic neuritis and ischemic optic neuropathy. The former is an inflammatory disease often associated with multiple sclerosis; the latter is an ischemic disease that can occur in patients with giant-cell arteritis.1 The authors also recommend that, when possible, a temporal-artery biopsy be performed before treatment is initiated. In patients with visual symptoms, corticosteroids should be administered immediately, not withheld until a biopsy has been performed. There is no evidence that a few days of corticosteroid treatment will mask the histopathological features of giant-cell arteritis. However, this delay is plenty of time for a patient to go blind.

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To the Editor: Salvarani et al. suggest the use of calcium and vitamin D supplementation to prevent glucocorticoid-
induced osteoporosis. In its 1996 recommendations for the prevention and treatment of glucocorticoid-induced osteoporosis,1 the American College of Rheumatology suggests the use of bisphosphonates only in patients with reduced bone mineral density.

Salvarani et al. did not consider that the American College of Rheumatology Ad Hoc Committee on Glucocorticoid-Induced Osteoporosis updated those recommendations in 2001,2 suggesting that for patients who are beginning therapy with glucocorticoids (a prednisone equivalent of 5 mg per day), with plans for three months or more of treatment, bisphosphonates should always be prescribed, irrespective of the bone mineral density. As the authors say, in these patients serious corticosteroid-related complications are very frequent; thus, we think it is important to stress their correct prevention.

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To the Editor: Salvarani et al. do not mention positron-emission tomography (PET) with the use of 18F-fluorodeoxyglucose (FDG) as an imaging tool. My colleagues and I and other groups have shown that this scintigraphic technique can be used to visualize thoracic large-vessel inflammation in polymyalgia rheumatica and giant-cell arteritis.1-2 In patients with mainly systemic symptoms (e.g., fever, weight loss, and malaise), its sensitivity reaches 75 percent (Fig. 1), with a specificity exceeding 95 percent.1 Our results also demonstrate that in the majority of cases, giant-cell arteritis involves not only the temporal arteries but also the aorta and its proximal branches. One examination can demonstrate vasculitic involvement in the whole body. Therefore, I suggest that FDG PET scintigraphy be performed, in addition to arteriography, computed tomography, and magnetic resonance angiography, as Salvarani et al. suggest, whenever extracranial giant-cell arteritis is suspected. FDG PET scintigraphy is of great value for the diagnosis of giant-cell arteritis and of polymyalgia rheumatica when typical clinical signs are absent, when systemic symptoms predominate, or when temporal-artery biopsies are negative.

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The authors reply:

To the Editor: We did not mean to imply that polymyalgia rheumatica and giant-cell arteritis are benign conditions. Some cases of giant-cell arteritis are fatal, and with both syndromes, the majority of patients have important adverse effects of treatment. However, overall, we have found no significant reduction in life span. Drs. Ostor and Hazleman raise an important question about reported prognostic differences in northern European and U.S. studies of polymyalgia rheumatica and giant-cell arteritis. The reports suggest the presence of two subgroups of patients. One subgroup presents with mild, self-limiting disease requiring short-term treatment; the other subgroup has persistent disease requiring long-term treatment.1-2 The conflicting data on the duration of corticosteroid therapy in polymyalgia rheumatica and giant-cell arteritis may be related to differences in the study setting. Studies in the United Kingdom and Scandinavian countries, which report a longer duration of corticosteroid therapy, enrolled patients with more severe disease who were recruited at secondary or tertiary referral centers. Our studies were population-based and included all diagnosed cases, without selection bias.

We are also convinced that some cases of polymyalgia rheumatica and giant-cell arteritis are overtreated. Corticosteroid therapy is sometimes continued late in the course of the disease for indeterminate musculoskeletal symptoms and normal or slightly elevated values for the erythrocyte sedimentation rate, C-reactive protein, or both. Such atypical symptoms are more likely due to noninflammatory causes such as corticosteroid withdrawal than to active polymyalgia

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rheumatica. Aside from the erythrocyte sedimentation rate and C-reactive protein level, interleukin-6 appears to be a promising marker but is not routinely used in clinical practice.

We thank Dr. Horton for his clarification. We agree that ischemic optic neuropathy is the more correct term for the visual lesion in giant-cell arteritis. We agree that in the presence of visual symptoms, corticosteroids should be administered immediately rather than withheld until a biopsy has been performed. Temporal-artery biopsy specimens may show arteritis after more than two weeks of corticosteroid therapy.

In the American College of Rheumatology’s recommendations for the prevention and treatment of corticosteroid-induced osteoporosis, men and postmenopausal women who are beginning corticosteroid therapy, with a planned treatment duration of at least three months, are differentiated from those already receiving long-term corticosteroid therapy. Bisphosphonate therapy is recommended only in the first group, whereas in the second group, it is recommended when the T score for bone mineral density at either the lumbar spine or the hip is below normal. Apart from the erythrocyte sedimentation rate, interleukin-6 appears to be a promising marker but is not routinely used in clinical practice. Aside from the erythrocyte sedimentation rate and C-reactive protein level, interleukin-6 appears to be a promising marker but is not routinely used in clinical practice.

We discussed FDG PET in our review. Although promising, it is an experimental technique for the diagnosis of giant-cell arteritis and is not routinely used in clinical practice.

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Self-Cardioversion of Paroxysmal Lone Atrial Fibrillation with Exercise

To the Editor: Endurance athletes may be at increased risk for lone atrial fibrillation. We describe a middle-aged physician athlete with paroxysmal lone atrial fibrillation in whom cardioversion consistently occurs with vigorous exercise.

At 45 years of age, the patient had atrial fibrillation at an average ventricular rate of approximately 55 beats per minute. The results of physician examination, echocardiography, tests of thyroid function, and measurements of electrolytes were normal. After 24 hours of observation, external electrical cardioversion was attempted at progressive energy levels up to 400 J, without success. The patient was discharged home with instructions to take aspirin. The day after discharge, after being in atrial fibrillation for 48 hours, the patient resumed his schedule of normal exercise with a cross-country ski machine. Despite dyspnea with exertion, he achieved a maximal ventricular rate of approximately 170 beats per minute for 20 minutes, at which point he converted to sinus rhythm.

The patient had recurrences of atrial fibrillation at a slow ventricular rate during the following year, all of which were successfully converted to sinus rhythm with exercise. Noninvasive evaluation by an electrophysiologist, including multiple-event recording, resulted in a final diagnosis of paroxysmal atrial fibrillation, most likely a focal atrial fibrillation variant. Its features were not suggestive of vagally mediated atrial fibrillation.

Approximately 30 episodes of atrial fibrillation occurred during the following eight years. The patient successfully terminated all known episodes of atrial fibrillation through exercise, with the use of either a cross-country ski machine or an elliptical trainer. The interval between the onset of atrial fibrillation and the initiation of exercise ranged from approximately 1 hour to 48 hours. The total duration of exercise necessary for cardioversion ranged from approximately 20 minutes to 240 minutes. A ventricular rate of more than 160 beats per minute was achieved before successful cardioversion. Episodes of paroxysmal atrial fibrillation terminated with exercise were recorded with a multiple-event recorder.

Paroxysmal lone atrial fibrillation appears to be more common in endurance athletes than in the general population with a reported incidence of approximately 5.3 percent in a selected population of athletes. Methods of treatment of atrial fibrillation include ablation, electrical cardioversion, drug-assisted cardioversion, heart-rate control, and anticoagulation. Vigorous exercise may be a noninvasive method of managing atrial fibrillation in athletes.

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