Correspondence

Clinical and serological profile of primary biliary cirrhosis in young and elderly patients

Sir,

Primary biliary cirrhosis (PBC) is a chronic cholestatic liver disease that affects mainly middle age women1,2 with a slowly progression to cirrhosis. Little is known about the clinical expression of PBC in younger and elderly patients. We analysed the clinical profile of patients at presentation on the basis of the age at diagnosis.

One hundred and ninety-eight patients who satisfied the established criteria for a diagnosis of PBC3 were included in this study and subdivided in three groups: group A (including patients with an age <45 years—44 cases), group B (with an age between 45 and 65 years—105 cases) and group C (with an age >65 years—49 cases).

Clinical history, physical examination, routine biochemical and immunological tests were performed in each patient.

Histology was available in 153 (77%) patients, and the stage (I–IV) has been attributed on the basis of the presence of the most advanced lesion in the biopsy specimen.4

As expected, group B was the most represented category (105 of 198, 53%) with respect to group A 44 (22%) and C 49 (25%) patients (P<0.0001 and P=0.0001, respectively). Group A presented a more

Table 1 Clinical, serological and histological profile of PBC patients on the basis of the age at diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Group A (44 cases)</th>
<th>Group B (105 cases)</th>
<th>Group C (49 cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (m/f)</td>
<td>5/39*</td>
<td>8/97*</td>
<td>18/31*</td>
</tr>
<tr>
<td>AST (×unl)</td>
<td>1.6 (0.4–11.4)**</td>
<td>1.0 (0.1–3.5)*</td>
<td>1.0 (0.2–4.2)*</td>
</tr>
<tr>
<td>ALT (×unl)</td>
<td>2 (0.1–13)**</td>
<td>1 (0.3–4.1)*</td>
<td>0.9 (0.2–3.2)*</td>
</tr>
<tr>
<td>ALP (×unl)</td>
<td>2.15 (0.5–6.8)</td>
<td>1.5 (0.4–16)</td>
<td>1.5 (0.3–7.5)</td>
</tr>
<tr>
<td>Gamma-GT (× unl)</td>
<td>4.55 (0.1–17)</td>
<td>3 (0.2–22.3)</td>
<td>2.95 (0.3–16.3)</td>
</tr>
<tr>
<td>Total bilirubin (mg/dl)</td>
<td>0.7 (0.2–5.3)</td>
<td>0.7 (0.2–33.5)</td>
<td>0.95 (0.4–10.8)</td>
</tr>
<tr>
<td>Colesterhol (mg/dl)</td>
<td>216 (108–581)</td>
<td>216 (81–414)</td>
<td>206 (113–683)</td>
</tr>
<tr>
<td>Albumin (g/l)</td>
<td>39 (31–46)</td>
<td>38 (20–45)</td>
<td>35 (23–56)</td>
</tr>
<tr>
<td>Gamma-glob (g/l)</td>
<td>17 (4–36)</td>
<td>15 (9–51)</td>
<td>15 (10–38)</td>
</tr>
<tr>
<td>IgG (mg/dl)</td>
<td>1680 (739–4024)</td>
<td>1440 (664–6040)</td>
<td>1460 (455–3830)</td>
</tr>
<tr>
<td>IgM (mg/dl)</td>
<td>529* (121–1400)</td>
<td>307* (24–2691)</td>
<td>408 (125–1700)</td>
</tr>
</tbody>
</table>

Serological profile

<table>
<thead>
<tr>
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<th>Group A (44 cases)</th>
<th>Group B (105 cases)</th>
<th>Group C (49 cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>38/44</td>
<td>86/105</td>
<td>41/49</td>
</tr>
<tr>
<td>MND</td>
<td>7/44</td>
<td>21/105</td>
<td>6/49</td>
</tr>
<tr>
<td>Anti-centromere</td>
<td>7/44</td>
<td>18/105</td>
<td>5/49</td>
</tr>
<tr>
<td>Rim</td>
<td>6/44</td>
<td>16/105</td>
<td>7/49</td>
</tr>
</tbody>
</table>

Histological profile

| Stage I-II/III-IV     | 26/15a            | 57/24b              | 625a,b            |
| Symptomatic disease   | 26 (59%)c         | 49 (47%)d           | 13 (26%)c,d       |

Test used: Mann Whitney, Fisher’s exact test and Chi-squared test.

Unl: upper normal limit; AST: aspartate aminotransferase; ALT Alanine aminotransferase; ALP: Alkaline phosphatase; MND: Multiple nuclear dots.

P<0.007; P<0.0001; *P=0.0024; $P=0.014.

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‘cytolitic pattern’ expressed by significantly higher serum levels of transaminases than group B and C ($P=0.0001$ and 0.0024, respectively); furthermore, group A and B were significant more symptomatic at diagnosis than older patients (59% and 47% versus 26%; $P=0.001$ and $P=0.02$ respectively).

The most represented symptoms at presentation was represented by pruritus and fatigue; in particular pruritus affected group A (21%) more than group B (11%) and group C (13%), even if the statistical significance was not reached.

In elderly, the frequency of male gender was significantly higher than in middle and youger age (40% versus 8% and 9%, respectively, $P=0.002$ and 0.003);5 Serologically, all three studied group presented the same rate of frequency of the PBC-specific reactivities (AMA, MND, Rim-like/Membranous and anti-centromere antibodies–Table 1).

Under histological profile, older patients (group C) were significantly less affected by initial histological stage 19% than younger (63%, $P=0.003$) and middle age patients (70%, $P<0.001$).

Younger patients at presentation displayed a higher biochemical activity and more symptomatic disease; this could be cause of early diagnosis in this fashion of patients with respect to the other ones. The progression of the disease seems to be independent by the clinical expression given the low degree of initial histological stage in elderly patients where the frequency of asymptomaticity is high.

On the basis of our analysis, we conclude that possibly two types of phenotypic expression of PBC exist; the first is the classical asymptomatic onset in the middle-late age with a mild biochemical activity, the other one is a symptomatic onset in young age with a high biochemical (cytolitic) activity.

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References

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It is important to identify the presence of atrial fibrillation more accurately

Sir,

It may be misleading to state that ‘the duration of atrial fibrillation was significantly longer among the group with diabetes’ than in non-diabetics1 when, on the basis of the author’s own admission, their own measure of the duration of atrial fibrillation (AF) ‘may not reflect the true arrhythmia duration in all cases’. Chief among the reasons for the impossibility of knowing the arrhythmia duration in many of the cases is the fact that, in an unknown proportion of patients with AF, the arrhythmia is asymptomatic.2

It is also misleading to state that 63.7% of patients remained in sinus rhythm when seen in the first follow-up clinic1 without having undertaken regular documentation of heart rhythm so as to detect asymptomatic as well as symptomatic episodes of AF in the interval between the day of cardioversion and the day of the first outpatient follow-up.

The recommendation from a recent consensus conference is that the assessment of rhythm and other electrocardiogram-based (ECG-based) outcome parameters in patients who have undergone cardioversion from AF to sinus rhythm should meet the following requirements2:

(i) All ECG recordings should be analysed blind-to-treatment in a core laboratory.
(ii) Every perceived (symptomatic) episode of AF should trigger an ECG.
(iii) Additional, and mandatory, regular ECG recordings include either 24 h/month Holter ECG, or daily 30–60 s short-term ECG recordings.
(iv) Any ECG-documented AF episode which lasts longer than 30 s should be reported as recurrent AF.

Finally, given the importance of the relationship between hypertension, diabetes, and atrial