Letters to the Editor

Hypoglycaemia and heart failure

Sir,

The observation that severe hepatic congestion could be complicated by hypoglycaemia,¹ has additional relevance to the management of heart failure with angiotensin converting enzyme inhibitors (ACE inhibitors) in Type II diabetics who are concurrently receiving sulphonylureas. According to one study, captopril increases the sensitivity to insulin by 11% in Type II diabetes.² The consequence of enhanced insulin sensitivity may be the occurrence of hypoglycaemic episodes when this drug is co-prescribed with sulphonylureas.³ Theoretically, the risk of this complication may be increased in patients with severe hepatic congestion.

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Diagnosis and treatment of lymphomatoid granulomatosis

Sir,

The report by Torrelo *et al.*¹ raises important points concerning the diagnosis and treatment of lymphomatoid granulomatosis (LYG) that require further clarification. The authors consider the histopathological features of an angiocentric proliferation of mainly benign cells, and a predominantly T-helper phenotype to be sufficient to enable a diagnosis of LYG to be made.

The delayed recognition that LYG (and some other peripheral T-cell lymphomas) were in fact lymphomas was mainly a result of the prominent infiltrate of inflammatory cells and the frequent absence of an easily identifiable population of malignant lymphocytes.² The malignant lymphoid cells in these lesions are often scanty and lack a homogenous appearance.³ An angiocentric pattern of lymphoid infiltrate is not a consistent feature of the so-called angiocentric lymphomas⁴ and is also not specific for this condition.

Studies showing clonal rearrangement of the beta T-cell receptor gene have confirmed that LYG is a

malignant disorder.⁵ No conclusive phenotypic marker of T-cell malignancy is currently available but the aberrant expression of phenotypic markers is taken as a fairly reliable indicator of T-cell malignancy⁶ and reliable antibodies are available for the diagnosis to be made on paraffin-fixed tissue.⁷ Torrelo *et al.*¹ have clearly not undertaken the minimum investigations required to establish the diagnosis of this uncommon lymphoma. This is of particular concern as the disease presentation in their patient was atypical.

The patient's disease progressed despite treatment with cyclophosphamide and prednisolone. In spite of his age and other symptoms (neuropathy, epistaxis and pulmonary disease), no further chemotherapy was administered. Long-term remissions have only been reported in 50% of patients treated with cyclophosphamide and prednisolone.⁸ The use of Adriamycin-containing chemotherapy regimens has produced long-term survivors amongst patients presenting with aggressive disease.^{9,10} This option should have been considered in this patient.

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