Letter to the Editor

Silent Myocardial Ischaemia and RBBB

Sir

I have read with interest the new column "Teaching file" started in our journal. I must congratulate Wg Cdr SN Sharma[1] on taking up most important topic of SMI as opening salvo.

There is a factual error in the aero-medical disposal of the civil aircrew. The author has mentioned that "ECG abnormality other than Right bundle branch block ....." As per the rules laid down for initial entry to flying branch, First degree (Incomplete Right bundle branch block is acceptable[2]. The abnormality can be accepted only when there are no associated abnormalities.

It would have more appropriate if the final diagnosis could have been made available.

References

1. Sharma SN : Teaching file Silent Myocardial Ischaemia : Ind J Aerospace Med 1991; 35(1) : 35-37.

2. IAP 4303 (May 1987) 2nd Ed : 2-3-5

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Reply from the Author

I thankfully acknowledge the appreciation expressed by our esteemed colleague Wg Cdr Kulkarni for the new column "Teaching file" started in our journal. He has rightly pointed out that silent myocardial ischaemia (SMI) is a burning issue in the spectrum of coronary artery disease and needs evaluation and treatment at par with the symptomatic ischaemia. Infact SMI carries more ominous prognosis[1] than the symptomatic ischaemia because it largely remains undetected and untreated.

Regarding the ECG abnormality, I agree that as per IAP 4303, the incomplete right bundle branch block (IRBBB) is acceptable for entry into service (both ground duty and flying) provided the benign nature of IRBBB is ascertained and I have stressed the later point in part III of the quoted article "Teaching file". There has been an omission of excluding the word "incomplete" before RBBB.

However for clinical purposes, the above omission is though not purposeful, is not ill founded either. For last 18 months I have been working on cases of RBBB and have found that even complete RBBB is on many occasions benign provided underlying cardiac disorder is excluded. Even serving personnel with IRBBB have shown progression to complete RBBB over the time remaining asymptomatic and warranted evaluation because of change in ECG pattern. The clear picture will emerge on completion of this ongoing project of evaluation protocol for cases of RBBB. A longitudinal study of cases with IRBBB would help in assessing progression to complete RBBB and onset of other conduction disorders, if any.

The final diagnosis of the case presented could not be given as being a civilian he was lost on follow up.

Reference

1. Sharma SN : Silent Myocardial Ischaemia (Editorial) MJAFI 1990; 46 : 155-157

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