The first case of H7N9 influenza in Taiwan

We report here the first case of H7N9 infection outside mainland China. A 53-year-old male patient was admitted because of fever for 3 days after returning from Suchow, Jiangsu Province, China on April 9, 2013. He had been otherwise well except for a history of hypertension and chronic hepatitis B virus infection. The patient did not report a history of contact with sick persons or animals during the travel. He began to get fever and general malaise on April 12. He had no respiratory symptoms, gastrointestinal symptoms, or myalgias. The patient sought medical attention on April 16 when fevers continued. Two throat-swab specimens tested negative for H7N9 with real-time PCR on April 17 and April 20, respectively. The first chest radiograph was normal. Treatment with oseltamivir was started at a dose of 75 mg twice daily. A follow-up chest radiograph on April 18 revealed interstitial pneumonia at the right lower lung for which moxifloxacin was added. Progressive dyspnoea developed on April 19. Follow-up chest radiographs showed progressive bilateral lower-lung consolidation. He was transferred to National Taiwan University Hospital on April 20. The dose of oseltamivir was increased to 150 mg twice daily. Endotracheal intubation and mechanical ventilator support was given on arrival because of respiratory failure. Ceftazidime and levofloxacin were given on arrival because of respiratory tract infections in infected patients.1,2 extensive preventive efforts are needed to prevent further spreading of H7N9.

We declare that we have no conflicts of interest.

Sui-Yuan Chang, Pi-Han Lin, Jen-Chih Tsai, Chien-Ching Hung, *Shan-Chwen Chang
changsc@ntu.edu.tw

Department of Clinical Laboratory Sciences and Medical Biotechnology, National Taiwan University College of Medicine, Taipei, Taiwan (S-YC, P-HL); and Internal Medicine, National Taiwan University Hospital and National Taiwan University College of Medicine, Taipei, Taiwan (J-CT, C-CH, S-CC)


Statin and exercise prescription

Peter Kokkinos and colleagues (Feb 2, p 394)1 describe the interactive effects of fitness and statins on mortality risk in veterans with dyslipidaemia. They report that increasing physical activity and statins independently lowers lipid levels and total mortality, but that the combination of these interventions is superior to either alone. The authors conclude that prescription of physical activity is as important as prescribing statins in groups with increased cardiovascular risk.

Physically active individuals might have the best cardiovascular risk profile, but they might be more vulnerable to the skeletal muscle side-effects of statins. Sinzinger and O’Grady1 reported statin intolerance in elite soccer players,2 and the PRIMO study1 reported a higher incidence of statin induced myalgia in subjects performing intense sports. We have reported previously that statins magnify the increase in serum creatine kinase produced by exercise.3 Consequently physicians must weigh relative benefits of physical activity and statins in active individuals. Physical activity could produce greater risk reduction than statins. The significant effect of physical activity and statins on cardiovascular risk reduction emphasises the importance of determination of the causes and treatment of statin-induced myopathy, and the need for lipid-lowering agents that do not affect skeletal muscle.

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Thijs M H Eijsvogels, Beth A Parker, *Paul D Thompson
pthomps@harthosp.org

Henry Low Heart Center, Hartford Hospital, Hartford, CT 06102, USA (TMHE, BAP, PDT); Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands (TMHE); and Department of Health Sciences, University of Hartford, West Hartford, CT, USA (BAP)


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