GORDON LEITCH (1946–1996)

His many friends and admirers in Edinburgh, Scotland, Britain and abroad are devastated by the sudden tragic loss of Gordon Leitch, who was at the height of his powers and had still so much more to contribute.

At Edinburgh University he obtained a BSc in Physiology with First Class Honours, won numerous prizes and medals. He qualified in 1970 as the most distinguished graduate of his year. This was followed by a Research Fellowship and then a Lectureship (1972–76) in the Department of Medicine during which he obtained a PhD. In 1976 he moved to a Lectureship in the Department of Respiratory Medicine. During this he spend a year at Cincinnati with Dr Robin Loudon and later, from 1981 to 1983, was a Research Fellow with Dr Frank Austen at Harvard. He returned to become Physician and Honorary Senior Lecturer in the Chest Unit at the City Hospital. He moved with that Unit to the Royal Infirmary in 1993.

In spite, in recent years, of heavy clinical, teaching and administrative loads, he maintained a remarkable record of research. In his earlier academic career this was mainly in respiratory physiology and related moleculat biology. As a consultant with responsibility for tuberculosis his research concentrated on tuberculosis, but his interests remained wide. He was largely responsible for organising one of the first controlled trials in methods of communicating with patients. He made important contributions to the study of the chronic fatigue syndrome and to medical audit, besides producing papers on various clinical aspects of respiratory diseases. In all he published over 90 papers in the scientific literature; 26 of these were concerned with tuberculosis and 7 were reviews on various subjects for journals in Britain, Singapore and India. He contributed chapters to no less than 12 different textbooks, British and American. Among these, he was one of the three authors to whom Andrew Douglas and I handed over the fourth edition of our textbook *Respiratory Diseases* (1989); this appeared in Far Eastern (1990) Italian (1991) and Greek (1992) editions. He was working on the 5th edition at the time of his death. He wrote two important chapters for the recent textbook *Clinical Tuberculosis* (1993) edited by P. D. O. Davies.

In recent years Gordon had become interested in the international aspects of tuberculosis, working with the International Union against Tuberculosis and Lung Disease. The Union had already done much for the appalling problems of the disease in the Third World. He became a member of its Tuberculosis Control Committee in 1992 and its Programme Secretary in 1994. In 1995, with Dr Hans Rieder of Switzerland, he visited Tanzania and briefly Uganda, to encounter these immensely challenging problems at first hand. Many will have admired his report *Tuberculosis in Tanzania* in the July issue of the College Proceedings. Following this trip I had a charming letter from Hans Rieder saying what a delightful companion Gordon had been and how much he had contributed. This visit to Africa would, I am sure, have been the start of important contributions to the control of the present world crisis in tuberculosis, exacerbated by the pandemic of HIV and threatened by multiple drug resistance. He was becoming well-known internationally, both through the College and through the Union. He had examined in Libya, lectured and examined in Singapore and was going to lecture and advise in Chile. With all this, Gordon had also made notable contributions to the College and to the Health Service in Lothian and Scotland. At the time of his death he was the Chairman of the Lothian Health Board Division of Medicine.

Because of his high intelligence, and his skills in making the best use of his time, he managed to carry out this wide range of activities with a minimum of fuss or fatigue; recently he assured me that he was in no risk of burn-out; he would know when to stop. I kept receiving golden opinions of him from people in many fields. His reputation was soaring. He was clearly going to be one of the outstanding medical leaders of his generation. How cruel that medicine is to be denied the full reward of such talents.

John Munro writes: Over a short period of time Gordon made a remarkable contribution to the College. As a member of Council he was something of an enigma. Although a staunch defender of the best College traditions, Gordon was not prepared to accept any proposal, or indeed established practice, without question. His innate intellect and his innovative thinking were such that his contributions at Council meetings were always meaningful and usually unexpected. They were also frequently humorous.

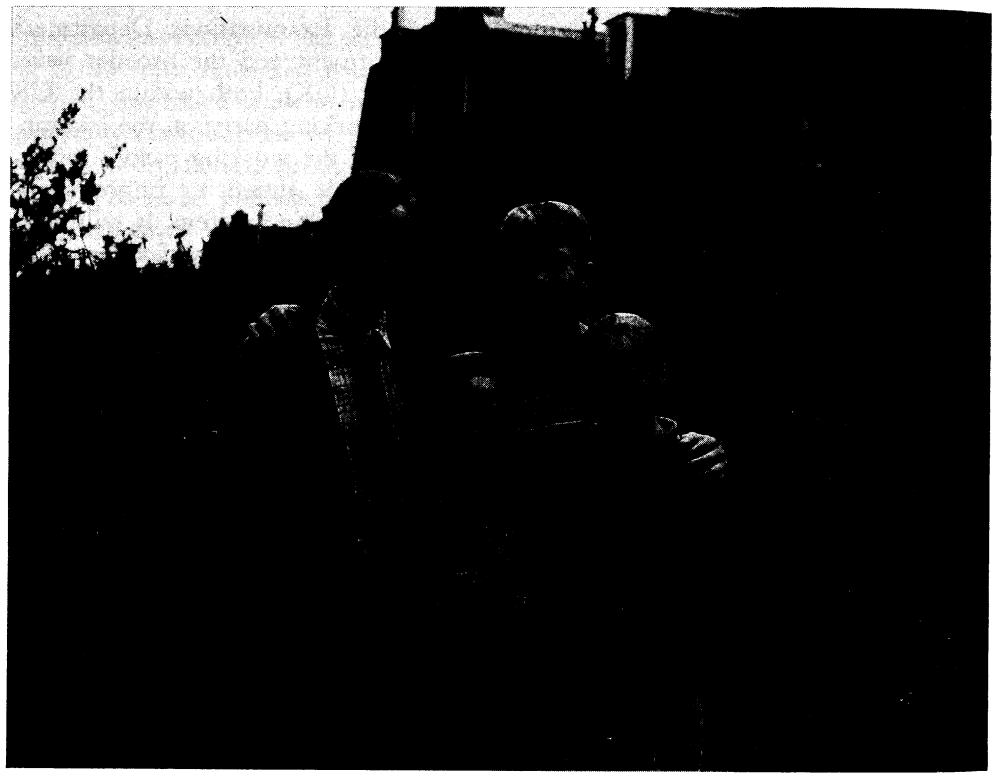
As the Assistant Registrar, Gordon visited the Examinations Department regularly, quickly grasped the duties of the appointment and the broader issues regarding changes and developments in the MRCP (UK), both within the UK and overseas. In particular he convened a College working party on the examination. Shortly before his death Gordon had submitted the working party's report. Predictably the report contains a range of proposals aimed to improve the MRCP (UK) and to enhance the objectivity of the marking system. It will form an excellent foundation for an inter-Collegiate working party which has now been set up to propose changes in the exam.

Gordon was an outstanding ambassador for the College. Those of us who have accompanied Gordon on an overseas visit have been greatly privileged. Dr Chew Chin Hin, the College's Overseas Adviser in Singapore has written 'Gordon has contributed much to our advanced medicine course and was enormously appreciated by his students and the postgraduate school. Only six weeks ago he came to Singapore to examine in the M.Med, a most able and fair examiner, gaining the respect and friendship of so many of us. He, with Stephen Holgate, gave outstanding lectures to the Fellows of the Academy and the postgraduate school. He will be long remembered in Singapore as an outstanding Physician and teacher'. The College is organising a memorial fund, details of which will be sent to Members and Fellows in due course.

Reg Passmore writes: The sea is ever a mystery. The waves at Pathos, which millennia ago are said to have washed up the goddess Aphrodite, cruelly have now claimed the body of Gordon Leitch. This they did just four days before we received from the publishers the July issue of *Proceedings* containing two articles by Gordon on *Tuberculosis and Tanzania* and on *Rabelais*. These followed *Two men and a bug: one hundred years of tuberculosis in Edinburgh* in the April issue and *The chronic fatigue syndrome* (1994; **24:** 480–508). These four article are written in a clear style, informative and on four very different subjects. Each has an appeal to general readers, as well as to specialists. One can predict that they will continue to be read in the years to come. They are a lasting memorial to Gordon. Gordon's literary skills were developing steadily, he may well not have reached his full potential and we may have lost one of the great medical writers.

When Gordon was an honours student in physiology, one of the staff, David Bell, took him, myself and my undergraduate son to play on the old course at St Andrews and afterwards entertained us in the Royal and Ancient club house. This was a memorable day. The day before he left for Paphos, Gordon told me that he had arranged another match against my son and I, this time at his beloved Luffness with Tony Toft as his partner.

Hector Chawla writes: Gordon's friendship was special to me. It began with a tarsal cyst, blossomed at Luffness and survived partnership in the winter foursomes. I remember him for a gauntness that defied the consumption of more butter than seemed politically correct, for the reek of bogie roll and paraffin when he set fire to his pipe, for a majestic triumph over adversity and for his unique blend of trenchant wit, perception and compassion. A man of quality.



With all his professional achievement Gordon remained devoted to his local church, of which he was an elder, and was deeply attached to his family. His many friends are shattered by our personal loss, as well as by the loss to medicine and society. We feel very deeply for his wife, a GP, who has given him such wonderful support over the years, and for his three children to whom he was so close. They can indeed by proud of a man who has given so much, and in so many ways, over his all too short life.

JOHN CROFTON

ANTITHROMBOTIC STRATEGIES IN THE MANAGEMENT OF ACUTE MYOCARDIAL ISCHAEMIA AND THE PREVENTION OF ITS RECURRENCE*

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Coronary atherosclerosis an insidious disease of unknown cause is highly culture and race related. It is a slowly progressive disorder which is silent for many years and can only be diagnosed non-invasively by electrocardiography or scintiography at rest or during exercise. Coronary collaterals can be recruited by asymptomatic ischaemia, severe coronary arterial stenosis may be asymptomatic due to extensive collateral circulation. Also myocardial infarction can be silent or accompanied by non-specific symptoms. Therefore the first manifestations of ischaemic heart disease can be misdiagnosed, and the ultimate manifestation, sudden death, may be the first and also the last symptom.

First symptoms of ischaemic heart disease

Ischaemic heart disease becomes symptomatic, when the impediment to coronary blood flow results in a dysbalance between oxygen demand and oxygen delivery in the myocardium. The symptoms so induced include chest pain, arrhythmia and heart failure. This condition can be complicated by superimposed acute occlusion of an already narrowed coronary artery resulting in persisting myocardial ischaemia and eventually in infarction, the size of which depends on the presence or absence of the collateral circulation. Otherwise, coronary atherosclerosis is a relatively benign disorder whose symptoms can be easily managed.

In general, the first manifestations of ischaemic heart disease are angina, stable or unstable, and acute myocardial infarction. In many patients the first signs and symptoms are insidious and a clinical picture of stable angina pectoris evolves. However, in a considerable number of patients the initial signs are sudden, rapidly progressive angina pectoris, acute myocardial infarction or sudden death. The pathogenic mechanisms differ between the two groups. With slowly progressive signs the progress of atherosclerosis is the basis for the symptoms, whereas with unstable or acute ischaemic syndromes, thrombosis on an atherosclerotic plaque is the final pathway to symptomatic ischaemia. These considerations are important in the selection of appropriate measures for the primary and secondary prevention of ischaemic heart disease.

The slow phase of ischaemic heart disease

The process of atherosclerosis has been extensively described, although causative mechanisms are almost unknown. The first event is ulceration of the endothelium, which exposes subintimal collagen-like material to the bloodstream. The stimuli that lead to endothelial ulceration are unknown; arterial bifurcations are prone to endothelial loss, especially in the presence of elevated blood pressure.

*A Sydney Watson Smith Lecture delivered at the Symposium on *Cardiology* held in the College on 30 November/1 December 1995.