Unreviewed Reports

Relation between acceptance of measles and pertussis immunisations

All children born during four calendar months of 1983 and hence eligible to have received both pertussis and measles immunisations were identified from the district computerised immunisation records (n=651). A significant relation ($p<0{\cdot}001$) was found between the uptake of pertussis and measles vaccines; 85·7% of children receiving at least one pertussis immunisation subsequently received measles vaccine, compared with 50·7% of those not. Corresponding figures for those children completing the three doses of pertussis were 90·5% and 61·2% respectively. Further clarification of the relation between the two vaccines is important if immunisation rates are to be increased.—EDWIN J PUGH, EDDIE HENSON. Correspondence to: E J Pugh, Wellhouse, East View, Sadbeige, Co Durham DL2 1FF. *(Accepted 19 July 1985)*

Exacerbation of hypersensitivity by hydrocortisone

A 51 year old woman was given an intravenous injection of Urografin (50 ml) for pyelography. After a few minutes she developed an urticarial rash, which was alleviated by an intravenous injection of chlorpheniramine maleate (10 mg). Hydrocortisone phosphate (100 mg) was then injected intravenously and the urticarial reaction reappeared, with paraesthesiae of the hands and feet and dryness of the mouth. Symptoms resolved with a second injection of chlorpheniramine maleate.

Corticosteroids may occasionally produce hypersensitivity reactions, usually exacerbations of bronchospasm in asthmatics. Exacerbation of an urticarial rash, as in this case, may also occur.[1] Life threatening anaphylactic reactions to intravenous hydrocortisone have been reported, and this form of treatment is not indicated for most acute hypersensitivity reactions.—A R MARKOS, R S SAWERS, Department of Obstetrics and Gynaecology, Coventry Maternity Hospital, Walsgrave, Coventry CV2 2DX. *(Accepted 29 July 1985)*

1 Bailey A, Ashford RFU. Angioneurotic oedema and urticaria following hydrocortisone—a further case. *Postgrad Med J* 1980;**56**:437.

Gastric outlet obstruction caused by pericholecystic abscess

A middle aged woman presented with symptoms of gastric outlet obstruction and a tender lump in the right hypochondrium. Barium meal examination showed a dilated stomach with pyloric obstruction. Cholelithiasis, cholecystitis, and a pericholecystic abscess were detected on ultrasonography. Laparotomy showed a gall bladder mass with adherent omentum causing pyloric obstruction. Vagotomy-gastrojejunostomy, cholecystostomy, cholecystolithotomy, and drainage of the pericholecystic abscess were performed. Pericholecystic abscess occurring as a complication of acute cholecystitis may result in pressure on the pylorus and the proximal duodenum and cause gastric outlet obstruction.[1]—V K KAPOOR, L K SHARMA, Department of Surgery, All India Institute of Medical Sciences, New Delhi 110029, India. *(Accepted 29 July 1985)*

1 Vandyk K, German JD. Empyema of the gall bladder causing gastroduodenal intramural abscess and pyloric obstruction. *Am J Surg* 1967;**113**:295-7.

Chylothorax: a rare complication of empyema in childhood

A girl aged 7 with cough and chest pain for 10 days was treated with oral amoxycillin. Subsequently she developed a right sided empyema from which sterile pus drained for four weeks. After two months of antibiotic treatment she returned home and remained well at follow up. Her chest *x* ray film showed pleural thickening. One year later she developed a right sided effusion. Aspiration yielded a sterile milky fluid containing abundant lymphocytes, protein content 28 g/l. This resolved rapidly and did not re-accumulate.

Postneonatal chylothorax usually follows thoracotomy or chest trauma,[1] and chylothorax caused by lymphatic damage from pleural fibrosis has not been reported.—P J COOPER, N K GRIFFIN, Northampton General Hospital, Northampton NN1 5BD. *(Accepted 2 August 1985)*

1 Kirkland I. Chylothorax in infancy and childhood. *Arch Dis Child* 1965;**40**:186.

Polyneuropathy and myalgia in a child with Yersinia enterocolitica infection

A 10 year old girl presented with a three week history of fever, fatigue, weight loss, and painful neck, shoulders, and proximal limb muscles. Her leg muscles were tender on palpation and there was wasting of the proximal arm and leg muscles and of the interosseus muscles of the hands. Her condition deteriorated with the development of paraesthesia and hyperaesthesia of hands and feet that prevented walking. Erythrocyte sedimentation rate was 87 mm in the first hour; agglutinating antibodies against *Yersinia enterocolitica* serotype 3 were present in a titre of 1/3200. Immunofluorescence staining of a muscle biopsy specimen showed IgM, C3, and fibrinogen deposits. Her symptoms improved with prednisolone and co-trimoxazole. Yersinia infection should be considered in children presenting with neurological and muscular symptoms.[1] —MINNA BLOCH PETERSEN, HENRIK M U FRIIS, Department of Neonatology, Rigshospitalet, State University Hospital, DK-2100 Copenhagen, Denmark. *(Accepted 5 August 1985)*

1 Sotaniemi KA. Neurologic complications associated with yersiniosis. *Neurology (NY)* 1983;**33**: 95-7.

Autoimmune primary hypothyroidism and severe iron deficiency anaemia

The most severe anaemia related to hypothyroidism reported has been a haemoglobin concentration of 65 g/l.[1] A 72 year old woman presented with hypochromic microcytic anaemia (haemoglobin 26 g/l) without anorexia, gastrointestinal symptoms, menorrhagia, or haematuria. Severe iron deficiency (normal B_{12} and folate) and profound autoimmune hypothyroidism with a mildly hypocellular iron depleted marrow were established. Relevant investigations gave negative results. Forty two days after starting iron and thyroxine supplements, her haemoglobin concentration was 103 g/l. Hypothyroidism may thus present as a severe treatable anaemia. The mechanism may be reduced iron absorption with or without depressed haemopoiesis.—S T GREEN, S W DAHILL, *et al*, Stobhill General Hospital, Glasgow G21 3UW. *(Accepted 23 August 1985)*

1 Horton L, Coburn RJ, England JM, Himsworth RL. The haematology of hypothyroidism. *Q J Med* 1976;**45**:101-23.

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