Relapse of Henoch-Schönlein disease associated with lung carcinoma[1]

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A relationship between carcinoma and immune complex glomerulonephritis is well established. Membranous glomerulonephritis in particular has been described as a complication of carcinoma of the lung, the colon and other sites (Row *et al.* 1975). Henoch-Schönlein disease is associated with a proliferative glomerulonephritis which is well documented as having an immune complex aetiology (Evans *et al.* 1973). We report a patient with Henoch-Schönlein disease which occurred initially at the age of 8 years and which relapsed with a proliferative glomerulonephritis 49 years later, when he developed a bronchial carcinoma.

Case report

Mr F W, born in 1916, presented in August 1973 with a six-day history of abdominal pain, vomiting, dark urine, cough and blood-streaked sputum, followed by a purpuric rash on his ankles. The only recent drug history was of chlorpheniramine taken six weeks previously for hayfever. He recalled an illness at the age of 8 when he had an identical rash, haematuria and swelling of the wrists. He smoked forty cigarettes a day. Examination revealed anaphylactoid purpura over the lower limbs, and abdominal tenderness. He was normotensive and afebrile.

Investigations showed haemoglobin 15.1 g/dl, white blood count 6.5×10^9/l (normal differential), ESR 40 mm/1 hr, platelets 355 000, Hess test negative, chest X-ray normal, plasma urea and electrolytes normal, creatinine clearance 53 ml/min, antistreptolysin 0 titre less than 50 units/ml. Blood cultures were negative. Total haemolytic complement was 45 units/ml (normal 30–46), C3 was 152% of normal. Urine examination revealed proteinuria, haematuria, and granular and hyaline casts. Intravenous pyelography was normal and renal biopsy showed focal proliferative glomerulonephritis.

While in hospital he developed painful swelling of both knees and left wrist, fresh crops of purpura, bloody diarrhoea and the nephrotic syndrome.

He was treated initially with prednisone and azathioprine, and over the following months with dapsone for recurrent attacks of purpura. He also had episodes of wheezing, cough and sputum with small haemoptysis. Chest X-ray revealed obstructive emphysema of the left lung, and in June 1975 he had a left pneumonectomy for a squamous cell carcinoma of the left main bronchus. Since operation the patient has remained well, with no further purpura, haematuria, proteinuria, and with normal renal function.

Discussion

Most relapses of Henoch-Schönlein disease occur within the first year and may, rarely, feature recurrent haemoptysis (Cream *et al.* 1970). This latter fact delayed the diagnosis of carcinoma in our patient. A relapse (or recurrence) nearly half a century later is exceptional and in itself suggests that the associated bronchial carcinoma was relevant. This view is strengthened by recent reports of three other cases of squamous cell carcinoma of the bronchus presenting with Henoch-Schönlein disease (Cairns *et al.* 1978, Maurice 1978). It is tempting to attribute the recurrence to immunological changes produced by the neoplasm in a predisposed patient. There is increasing evidence for an association between malignancy and proliferative glomerulonephritis (Ozawa *et al.* 1975).

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Massive chondroma of skull base[1]

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This case is reported to illustrate certain problems in the investigation and management of tumours of the postnasal space. Chondromas in the head and neck region have been reported originating from the nasal cartilages and septum, eustachian cushions and larynx. Those arising from the basisphenoid and basiocciput are extremely rare. Two cases have been reported in recent literature (Timmis 1959, Falconer *et al.* 1968).

The postnasal space is difficult to examine. Straight X-rays may show a soft tissue mass and polytomography will demonstrate bone destruction. Computerized tomography has the advantage of high contrast discrimination. Slight differences in density between adjacent soft tissues become visible (Thawley *et al.* 1978).

Operative access to the postnasal space is difficult. Transnasal, transantral and transpalatal operative approaches give limited exposure. A transcranial approach combined with a Moures lateral rhinotomy achieves good surgical exposure (Clifford 1977).

Case report

A 27-year-old man presented with acute sinusitis and deafness. He was found to have nasal speech, blockage of both posterior choanae and gross retraction of the left tympanic membrane. Examination under general anaesthesia revealed a firm submucosal mass, mainly left-sided, which arose from the posterior nasopharyngeal wall. The lesion extended along the nasopharyngeal vault down to the level of the eustachian cushions, blocking the left eustachian tubal orifice.

A biopsy was taken and a chondroma was diagnosed (Figure 1). The findings of straight X-ray, xerography, and polytomography were confirmed by computerized axial tomography at the levels of the orbits and left maxillary antrum (Figure 2B). A dense tumour was shown to extend from the anterior ethmoidal area through the posterior ethmoidal cells, sphenoid sinus, basisphenoid, and basiocciput, to end at the dura of the posterior cranial fossa. The tumour caused the lateral wall of the left ethmoidal labyrinth to bulge into the left orbit. Inferiorly the tumour extended to the level of the palate and into the left maxillary antrum. The tumour had destroyed the posterior nasal septum, the medial wall of the left maxillary antrum, the posterior ethmoidal labyrinth, the lateral wall of the left sphenoidal sinus and the left pterigoid plates.

Initially conservative operative procedures were adopted. In July 1976, using the transnasal, transantral and transpalatal approaches, 39 g of tumour was removed. An anterior myringotomy revealed thin yellow fluid and a grommet was inserted. Postoperatively his condition

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