Discussion

Numerous cutaneous manifestations have been reported in association with myelomatosis and other immunoproliferative disorders. Pruritus, which is the outstanding feature of many skin diseases, is also well-recognised in systemic disorders[3] and is commonly seen in association with lymphoid neoplasms, myeloproliferative disorders, and other haematological diseases. Pruritus often antedates the correct diagnosis by some time. The present cases illustrate that myelomatosis may present with generalised pruritus, an association that has apparently not been reported. Zelicovici *et al*[4] reported three cases of generalised pruritus with a paraproteinaemia, but these patients were eventually classified as benign gammopathies. Rajka[5] suspected myelomatosis in one patient with pruritus but did not substantiate the diagnosis. Pruritus has been reported in myelomatosis but only as a feature of renal disease and not underlying malignancy.[1] Renal hypofunction was not present in either of our patients. The pattern of response after treatment suggests a direct cause and effect relationship. Thus myelomatosis should be considered in the differential diagnosis of generalised pruritus due to internal disease.

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Acute splenic abscess due to Salmonella chester

Isolated splenic abscess presenting as an abdominal emergency is an uncommon occurrence. Moreover, in the case we report it was due to a salmonella of unusual serotype.

Case report

A 20-year-old man was admitted to hospital with a three-day history of increasing pain in the left hypochondrium and loin, worse on inspiration and associated with vomiting, constipation, and frequency of micturition. Two days earlier urinary infection had been diagnosed as his urine had been found to contain protein and blood; he had been treated with co-trimoxazole. He had no history of abdominal trauma or travel to the tropics.

He was ill and dehydrated, with a temperature of 37·7°C, pulse 112/min, and blood pressure 125/75 mm Hg. His abdomen was distended and a tender mass was palpable in the left upper quadrant; the bowel sounds were infrequent. A clinical diagnosis of intra-abdominal abscess was made. The results of investigations showed: haemoglobin 13·2 g/dl; leucocytes 12·5 × 10^9/l (12 500/mm^3; 90% neutrophils); ESR 105 mm in first hour; blood urea concentration 9·9 mmol/l (70 mg/100 ml); serum amylase concentration 50 Somogyi units; blood glucose concentration 6·8 mmol/l (120 mg/100 ml); blood culture sterile; *x*-ray films of the abdomen after intravenous urography confirmed the presence of a mass in the left hypochondrium displacing the left kidney inferiorly. Laparotomy disclosed a large splenic abscess, its wall being necrotic adjacent to the hilum, which contained over two litres of turbid fluid, which was aspirated to facilitate splenectomy. The splenic bed was drained. Postoperatively he was given ampicillin, 500 mg six-hourly for 10 days, and gentamicin, 80 mg eight-hourly for five days.

The spleen weighed 1430 g, and contained a large cyst, whose wall was composed of fibrous tissue with evidence of acute and chronic inflammation. The inflammation had destroyed the lining in many places, but the appearances were those of an infected simple cyst. Culture of the fluid yielded *Salmonella chester*, sensitive to ampicillin, chloramphenicol, and gentamicin. The patient had been shown to have achlorhydria and to be passing *S chester* in his stools. A person involved in the preparation of the patient's food has been found to be a carrier of *S chester*.

Discussion

S chester is an unusual serotype which has been recognised as causing sporadic cases of salmonellosis. *S typhimurium*[1] and *S agona*[2] have been reported as causing splenic abscess, illustrating the need to consider Salmonella spp as a cause of splenic abscess.

Splenic abscess is commonly a metastatic infection, organisms multiplying in a post-traumatic subcapsular haematoma or simple cyst following bacteraemia, perhaps otherwise insignificant. In this case the achlorhydria was probably responsible for his developing bacteraemia. Less frequently, an abscess may arise as a direct extension of a contiguous infection, or as a primary feature in tuberculosis, typhoid, leprosy, melioidosis, and relapsing fever.[3]

The presentation with signs of infection and an intra-abdominal mass is typical,[4] but it is difficult to differentiate splenic abscess from subdiaphragmatic, perinephric, and hepatic abscess, owing to the rarity, and the unfamiliar nature of splenic abscess. Careful plain and simple contrast abdominal radiography are the most useful investigations, but, where available, selective coeliac angiography may be more accurate.[4]

The treatment of choice is abdominal splenectomy and drainage, though in very sick patients, in the presence of dense adhesions and massive abscesses, splenotomy and drainage with interval splenectomy have been successful.[1 4 5]

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Adrenergic crisis due to phaeochromocytoma

A sudden crisis is a recognised complication of poorly controlled hyperthyroidism in patients exposed to infection or surgery.[1] We report a similar situation arising from a phaeochromocytoma.

Case report

A man aged 38 presented with vomiting and pain in the left shoulder and a history of polydipsia and polyuria for one month with weight loss of 6·4 kg. He was very ill. Although not feverish, he was sweating excessively and had a peculiar blue, mottled skin. His pulse rate was 160/min, blood pressure was 190/130 mm Hg, and chest *x*-ray examination showed consolidation in the right lower lobe and a mass in the left hypochondrium thought to be the spleen. The ECG showed a supraventricular tachycardia. The urine contained glucose 2% and acetone. The plasma glucose was 31·5 mmol/l (568 mg/100 ml) and the actual bicarbonate 18·9 mmol (mEq)/l. He was rapidly rehydrated with physiological saline and given 20 units of insulin intramuscularly immediately, followed by 10 units intramuscularly hourly.

Four hours later his pulse rate had risen to 180/min, the blood pressure was 160/130 mm Hg, the plasma glucose was 33·9 mmol/l (611 mg/100 ml),