PostScript

LETTERS

If you have a burning desire to respond to a paper published in *ADC* or *Fe²N*, why not make use of our "rapid response" option?

Log on to our website (www.archdischild.com), find the paper that interests you, click on "full text" and send your response by email by clicking on "submit a response".

Providing it isn't libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on "read eLetters" on our homepage.

The editors will decide, as before, whether to also publish it in a future paper issue.

Break dancer's lung

Break dancing was at its peak of popularity in the 1980s, but evidently is still part of today's youth culture. There have been several reports of injuries associated with this activity, although none recently.[1–4] While mainly of an orthopaedic nature, the injuries reported are quite varied. This is a report of a previously fit and healthy 16 year old non-smoking young man who was 5 foot 5 inches tall. He developed a right sided pneumothorax during an evening spent break dancing. He ignored the discomfort for a few days, and then after a visit to his general practitioner, a chest *x* ray confirmed the diagnosis. He required an intercostal drain for 2 days before resolution. Six months later, while again break dancing, he developed another pneumothorax, this time on the left side. Again he ignored it for a few days before consulting his GP. On this occasion, it was treated conservatively and resolved after 2 weeks without a drain, at which stage he was referred to our centre.

Examination and lung function were normal and a CT chest scan revealed tiny subpleural bullae at the apex of the left lung. He was advised to avoid break dancing, although the chance of adherence to this advice was small. Two months later he had a further recurrence on the left side (during sleep) which was treated conservatively and resolved after 2 weeks. He then underwent a left thoracotomy (which revealed multiple bullae up to 1 cm diameter over the surface of the lung) and a pleurectomy from which he made a good recovery.

To my knowledge this is the first report of a spontaneous pneumothorax associated with any form of dancing. Presumably lying on his back with his legs fully flexed increased his abdominal pressure, and possibly combined with a Valsalva manouevre, this was enough to rupture one of the bullae. Although it was the presence of bullae that was responsible for the pneumothoraces, the risk (albeit small) of pneumothorax should now be added to the list of conditions associated with break dancing.

I would like to thank Dr Sinan Al-Jawad for looking after this patient duing his acute pneumothoraces and Mr Peter Goldstraw for performing the surgery.

I M Balfour-Lynn
Consultant in Paediatric Respiratory Medicine, Royal Brompton & Harefield NHS Trust, Sydney Street, London SW3 6NP, UK; i.balfourlynn@ic.ac.uk

References

1 **Lee KC**, Clough C. Intracerebral hemorrhage after break dancing. *New Engl J Med* 1990;**323**:615–16.
2 **Sharma V**, Knapp JK, Wasserman GS, *et al*. Injuries associated with break dancing. *Pediatr Emerg Med* 1986;**2**:21–2.
3 **Gearhart JP**, Lowe FC. Genitourinary injuries secondary to break dancing in children and adolescents. *Pediatr* 1986;**77**:922–4.
4 **Norman RA**, Grodin MA. Injuries from break dancing. *Am Fam Physician* 1984;**30**:109–12.

Kocher Debre Semelaigne syndrome: regression of pesudohypertrophy of muscles on thyroxine

Myopathy associated with hypothyroidism classically presents with proximal weakness, fatigue, exertional pain, slowed movement, diminished deep reflexes, stiffness, myalgia, myoedema, and less commonly, cramps. Rarely, muscle enlargement is also seen, and the term Kocher Debre Semelaigne syndrome (KDS syndrome) is used.[1–3]

We report the case of an 11 year old boy presenting with poor growth, mental retardation, diffuse exertional pain in both lower limbs, and progressive difficulty in squatting for six months.There was no family history. On examination he showed coarse facies, large tongue, athletic build, with height 110 cm and weight 22 kg. His IQ was assessed as 60, power in proximal group of muscle was Grade III, and calf muscles showed firm enlargement with delayed deep tendon reflexes.

Investigation showed normal haemotology and renal function, electrocardiogram, and skull and chest *x* rays. Serum thyroxine was 72 nmol/L (n = 64–154 nmol/L), serum triiodothyronine was 1.8 nmol/L (n = 1.1–2.9), serum thyroid stimulating hormone = 10.0 mU/l (n = 0.4–5.0 mU/l) and serum creatine phosphokinase was 2246 U/ml (n = 35–145 U/ml). Muscle biopsy showed patchy atrophy, necrosis, and increased interstitial connective tissue without any fibre enlargement.

He was started on thyroid hormone (Eltroxin) 0.1 mg per day and was followed up at monthly intervals. After six months of hormone replacement therapy his signs of hypothyroidism, associated myopathy, and hypertrophied calf muscles regressed. Repeat muscle biopsy revealed a decrease in interstitial connective tissue, atrophy, and necrosis with areas of muscle regeneration. Serum T3, T4, and TSH values also returned to normal.

Previous case reports of this variant of hypothyroid myopathy have described improvement of clinical features.[3 4] However, we found that maintenance of euthyroid state not only improved clinical features including the neurological manifestations of hypothyroidism, but also a marked regression of muscle enlargement. In our case we also demonstrated histological regression of changes in histopathology of hypertrophied muscle.

P Mehrotra, M Chandra, M K Mitra
Department of Medicine, B/127 Nirala Nagar, Lucknow, PIN 226020, India

Correspondence to Dr Mehrotra; punmel@yahoo.com

References

1 **Yeshwanth M**, Benakappa DG, Gautham KS. Kocher Debre Semelaigne syndrome. *Indian Pediatr* 1987;**24**:346–8.
2 **Tashko V**, Davachi F, Baboci R, *et al*. Kocher-Debre Semelaigne syndrome. *Clin Pediatr* 1999;**38**:113–5.
3 **Mastaglia FL**, Ojeda VJ, Sarnat HB, *et al*. Myopathies associated with hypothyroidism: a review based upon 13 cases. *Austr N Z J Med* 1988;**18**:799–806.
4 **Virmani A**, Gambhir A, Iyer PU. Kocher Debre Semelaigne syndrome mimicking primary muscle disease [letter]. *Indian Pediatr* 1990;**27**:88–9.

Figure 1 The pleasures and perils of breakdancing. Reproduced with kind permission from the Jhoon Rhee Institute of Tae Kwon Do, Woodbridge, VA, USA.