Coma or collapse with impaired consciousness developing during prolonged strenuous exertion, in an apparently healthy individual, may be safely regarded as a consequence of heat stroke, if as in this case no other obvious cause is found.[2] Mild hypothermia does not alter mental status and other causes that may account for coma in this context, such as hypoglycaemia, disturbed electrolyte balance or cardiac disease were excluded by history, physical examination and laboratory results. Also, the substantially elevated muscle enzymes with CK reaching 40 times the normal value, is typical of heat stroke or strenuous effort and not of short-lived, mild hypothermia.

Several case reports[3,4] and our own experience confirm that heat stroke may occur in cold weather. The apparent paradox of hypothermia developing shortly after hyperthermia is explained by an accelerated heat loss occurring under these circumstances. A decline in body temperature to a normal level during evacuation of heat stroke victims is common.[5,6] Individuals who perform in the cold consider the weather as protective against heat stroke. Our experience indicates that, in cold weather, the necessary practice of work–rest cycles, proper fluid intake and initiation of the extreme physical effort at an optimal physical state are, as in this case, constantly ignored. This case illustrates that measures to prevent heat stroke in cold weather are as important as in a warm climate.

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Digital clubbing in a patient with McCune Albright syndrome

Sir,

McCune Albright syndrome is characterized by polyostotic fibrous dysplasia, cutaneous pigmentation and endocrine hyperfunction.[1,2] Several endocrinopathies including Cushing's syndrome, hyperprolactinaemia, acromegaly and hyperthyroidism have been reported.[3,4] Polyostotic fibrous dysplasia may cause pathological fractures, facial asymmetry and hearing impairment.[5] We describe a case of McCune Albright syndrome in which there was digital clubbing of fingers with radiologically abnormal bone, a finding not to our knowledge previously reported.

A 36 year old woman was admitted to hospital because of her fourth pathological leg fracture since the age of 12. At the age of five, her family noticed bowing of her right leg. Physical examination revealed facial asymmetry with prominence of the right orbit. Areas of flat, irregular cutaneous pigmentation were present over the shoulder and left buttock. We noticed painless clubbing of the second and third fingers on both hands. The results of complete blood count, urine and biochemical analysis were within normal limits except for a high level of alkaline phosphatase of the healing fracture. Detailed endocrinological investigation revealed no evidence of any associated endocrine or metabolic disorder other than early menarche. Skeletal roentgenograms showed extensive bone lesions. Hand X-rays disclosed lytic and sclerotic changes of the fingers which were remarkable in the second and third fingers of both hands (Figure 1). The phalanges were also expanded by the lesions. These fingers are characterized by clubbing. The other fingers were relatively free of disease. There was a close relation-

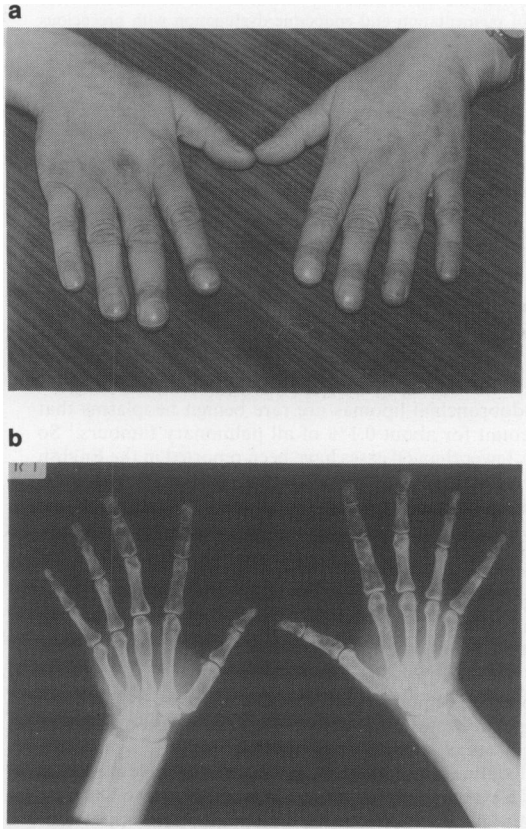

Figure 1 Finger clubbing (a) and bone changes (b) of second and third fingers in a patient with McCune Albright syndrome.

ship between clinical appearance of digital clubbing and radiological changes of the same fingers.

To our knowledge, digital clubbing associated with McCune Albright syndrome has not been reported previously. Since the patient had no disease known to be associated with digital clubbing, such as chronic obstructive pulmonary disease and cirrhosis. We think that clubbing of the fingers was due to bony lesions of McCune Albright syndrome.

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Endobronchial lipoma simulating bronchogenic carcinoma

Sir,

Endobronchial lipomas are rare benign neoplasms that account for about 0.1% of all pulmonary tumours.[1] So far, fewer than 60 cases have been reported in the English literature.[2] They are much more common in males, the male–female ratio being 45:7.[3]

A 68 year old man presented with a 3 month history of non-productive cough, left-sided chest pain, weight loss of 3 kg and one episode of haemoptysis. He was a chronic cigarette smoker. His chest X-ray taken 2 years earlier was normal. The patient was not obese and had no cutaneous lipomata.

The chest radiograph showed left upper lobe collapse. Computed tomography revealed atelectasis of the left upper lobe without any obvious mass lesion, hilar or mediastinal lymphadenopathy.

Routine laboratory tests were unremarkable except for an elevated erythrocyte sedimentation rate of 83 mm/hour. At fibreoptic bronchoscopy the left upper lobe bronchus just after branching off of the lingular bronchus was completely occluded by a pink round smooth-surfaced endobronchial tumour. Bronchoscopic biopsy specimen revealed normal intact bronchial epithelium covering mature adipose tissue. The histological diagnosis was endobronchial lipoma.

The endobronchial lipoma which measured 1 cm in diameter was removed by a left upper lobectomy.

Endobronchial lipomas arise from the submucosal or interstitial adipose tissue of the large bronchi. They consist of histologically normal adult fat cells.[3] Diagnosis of these tumours is often by bronchoscopic biopsy but the usually intact epithelium and fibrous capsule may render such a biopsy difficult and non-diagnostic, in which case the diagnosis can only be made after bronchotomy or thoracotomy. The majority of patients with endobronchial lipoma present in the sixth and seventh decades. The common presenting symptoms include cough, chest pain and fever.[1] Our patient also had haemoptysis which tends to be a late symptom occurring in about 30% of cases.[3] Haemoptysis is related to distal lung disease such as bronchiectasis rather than directly to the tumour. Our patient also had weight loss which is only seen in 8% of cases.

Chest X-rays may show enlarged hilar shadows, as endobronchial lipomas are more commonly found in the large bronchi.[4] Distal collapse of a lobe secondary to bronchial obstruction, as in this case, may be seen.[5] Such radiological appearance and our patient's symptoms are similar to those of bronchogenic carcinoma, and a confident diagnosis of endobronchial lipoma from an adequate biopsy is essential as the two tumours tend to affect the same age group.

This case illustrates that symptoms and chest radiograph abnormality highly suggestive of bronchogenic carcinoma in an elderly smoker may occasionally be due to a benign lesion like endobronchial lipoma.

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