

Letters to the Editor

Bilateral adrenal lymphoma presenting as Addison's disease

Sir,

In their article, 'Bilateral adrenal lymphoma presenting as Addison's disease',¹ Dr Pagliuca and associates state that: 'presentation of lymphoma with the clinical and biochemical features of Addison's disease . . . has only been reported once.'

The fact is that at least 8 such cases have been reported in the English language medical literature, including one reported by us, in the article: 'Lymphoma presenting with adrenal insufficiency: adrenal enlargement on computed tomographic scanning as a clue to diagnosis', published in 1988.²

The case reported by Dr Pagliuca *et al.* may be added to the list of reports in which enlarged adrenal glands seen on computed tomographic scanning during investigation of adrenal insufficiency could serve as a clue to the diagnosis of adrenal lymphoma.

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Loperamide related toxic megacolon in *Clostridium difficile* colitis

Sir,

Antidiarrhoeal drugs are used excessively to treat diarrhoea when adequate hydration or, if occurring after antibiotic use, metronidazole would be more appropriate. We report a case where loperamide, used inadvertently to treat *Clostridium difficile* colitis, may have precipitated toxic megacolon.

A 68 year old woman was given courses of amoxicillin, clindamycin and flucloxacillin for a dental abscess. She developed frequent watery bowel motions for which she was prescribed loperamide 2 mg eight hourly. The diarrhoea eased but after 2 weeks' treatment, she started to vomit repeatedly and became dehydrated and confused, requiring hospital admission. She was pyrexial, and had a soft, distended abdomen. X-ray showed dilatation (> 10 cm) of the transverse and descending colon. A toxic megacolon was diagnosed. Sigmoidoscopy showed inflamed rectal mucosa but no pseudomembrane. A cytopathogenic toxin, neutralized by *Cl. sordelli* antitoxin,

was found in the faeces, which also grew *Cl. difficile*. She was treated with intravenous fluids and metronidazole, and later with vancomycin by nasogastric tube and sigmoidoscopic decompression of the colon. Despite 3 days' intensive medical therapy, the abdomen became more distended and signs of peritoneal irritation developed. A laparotomy was performed, but no colonic perforation was found, and the colon was decompressed by a transverse colostomy. After this, she improved steadily and made a full recovery. The colostomy was later reversed.

Toxic megacolon may complicate inflammatory bowel disease, and *Cl. difficile* has sometimes been implicated.¹ Toxic megacolon is a rare complication of *Cl. difficile* colitis. In only one previous case has a clostridial cytotoxin been found.² The use of opiates or diphenoxylate may have precipitated some cases.^{2,3} There is one report of loperamide associated toxic megacolon in a patient with ulcerative colitis,⁴ but none in *Cl. difficile* colitis. The data sheets for diphenoxylate and loperamide recommend that they should not be used in inflammatory bowel disease, nor in antibiotic induced colitis. Antidiarrhoeal drugs may prolong the toxic manifestations of bacterial bowel infections although improving the diarrhoea. The delayed transit may encourage bacterial epithelial penetration and local microbial proliferation. Diarrhoea in such patients appears to be protective, and antidiarrhoeal drugs should be used with great caution if at all.⁵

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Silent nocardia cerebral abscesses in treated dermatomyositis

Sir,

The difficulties presented by opportunistic infections in immunosuppressed patients are well known. We report a