Clinical Section

President Norman Tanner FRCS

Meeting February 9 1962
at Charing Cross Hospital, London

Cases

Myxœdema and Trauma (Two Cases)

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In the four months before this meeting, 4 myxœdematous patients were admitted to the wards from the Casualty Department after accidents. Myxœdema makes a person accident-prone. Two patients were demonstrated:

Case 1 F J, female, aged 66
This patient was admitted with a laceration of the scalp. She gave a two-year history of attacks of vertigo, and on the day of admission giddiness was followed by syncope; the duration of unconsciousness was not known. She was found to be drowsy and grossly myxœdematous.
Investigations: Serum cholesterol 378 mg/100 ml. Radioiodine uptake of five hours, 5% of the dose. Knee-jerk reaction time 190 msec (normal 40 msec). Serum protein-bound iodine (Dr Roger Bird): 3µg/100 ml (normal range 3·5 to 8·0 µg/100 ml).

Treatment was begun with 5 µg of triiodothyronine for five days and then changed to gr ½ thyroid, and this was increased to gr 1 after a further week. Five months later she had had no further syncopal attacks or falls and her attacks of giddiness were much less troublesome. She is now maintained on gr 2 thyroid daily.

Case 2 H S-A, female, aged 77
This patient was brought to the Casualty Department after falling on an escalator. There had been no loss of consciousness. She was very drowsy and appeared typically myxœdematous. During the previous six months she had become increasingly tired, deaf and lethargic.
Investigations: Serum cholesterol 365 mg/100 ml. Radioiodine uptake of four hours, 12% of the dose. Serum protein-bound iodine (Dr Roger Bird): 2·7 µg/100 ml. Thyroid antibodies present.

She was treated with L-thyroxine 0·05 mg daily, increased to 0·1 mg after one week. She has had no further falls and at present is maintained on 0·2 mg daily.

Neurological manifestations of myxœdema such as vertigo, deafness, paræsthesiæ and reflex changes are well recognized. Accidents in myxœdematous patients are probably due to drowsiness and delayed kinetic reactions rather than to more specific neurological symptoms such as vertigo. When the patient is admitted following head injury, the double diagnosis may be missed and mental change attributed to brain injury. If myxœdema is not recognized, surgical treatment may precipitate shock, as patients with hypothyroidism frequently have, in addition, adrenocortical insufficiency.

Epilepsy Due to Angioneurotic Œdema

P B S Fowler DM MRCP

The association of angioneurotic œdema and epilepsy has been thought rare. Batty Shaw & Finnegan (1952) reported one case and found only 9 others in the literature.

A total of 7 patients with cerebral disturbances associated with angioneurotic œdema have been seen (Table 1); Case 1 is reported below.

Table 1
Seven patients with cerebral disturbances associated with angioneurotic œdema

Case 1	M L H	female	aged 39	convulsions and vertigo
Case 2	V W	female	aged 59	loss of consciousness
Case 3	W W	female	aged 65	loss of consciousness
Case 4	M R	female	aged 57	right hemiparesis and slurred speech
Case 5	B A	female	aged 28	headache
Case 6	T A	female	aged 28	visual disturbance, headache and peripheral numbness
Case 7	MM	female	aged 55	recurrent exophthalmos and transient ophthalmoplegia

In all these patients, there is a history of angioneurotic œdema affecting the skin. The cerebral manifestations, transient, repetitive and with no sequelæ, tend to occur at the same time as the skin lesions.

Case 1 M L H, female, aged 39. Housewife
Referred to the Medical Out-Patient Department on November 15, 1961, with a history of recurrent attacks of urticaria for ten days. Large wheals would form over any part of the body or extremities during an attack. The face was spared. The rash would persist for about two hours and recur two or three times a day. She often felt faint at the height of an attack and with the two worst attacks lost consciousness and was incontinent of urine. Her husband witnessed both attacks and described a tonic phase followed by slight bilateral clonic movements. There was no past or family history of allergy. Clinical examination was essentially negative. EEG was normal. Skull and chest X-rays showed no abnormality.
Progress: She later complained of vertigo and nausea. This was thought to be due to angioneurotic œdema affecting the vestibular apparatus. An audiogram and caloric tests were normal. She was treated with Phenergan 25 mg *nocte* and ephedrine 25 mg *p.r.n.* and all her symptoms subsided.

Evidence derived from patients seen at Charing Cross Hospital, from the cases reviewed by Otteson (1943) and those reported by Kennedy (1926) suggests that varying cerebral disturbances are due to localized intracranial angioneurotic œdema.

REFERENCES
Batty Shaw A & Finnegan T R L
(1952) *Guy's Hosp. Rep.* **101**, 126
Kennedy F (1926) *Arch. Neurol. Psychiat.* **15**, 28
Otteson E (1943) *Acta psychiat., Kbh.* **18**, 487

Spontaneous Rupture of Œsophagus

A R Makey MS FRCS

A M, male, aged 41, after drinking rum and lemon, followed by several pints of ale, vomited suddenly and developed pain in the left lower chest posteriorly, which passed forward and upward into the left arm. The pain was severe and aggravated by breathing.
On admission (10.6.61): He was not shocked (pulse 72, blood pressure 120/80); his abdomen was rigid, especially in the left upper region; bowel sounds were normal. Chest X-ray showed elevation of the left diaphragm with some opacity at the left base. No free gas was present under the diaphragm (Fig 1). X-ray of the abdomen showed a normal gas pattern. He was admitted to a medical ward as a possible early case of pneumonia.

Deterioration occurred during the night despite the use of I.V. drip, hydrocortisone, erythromycin and an oxygen tent.

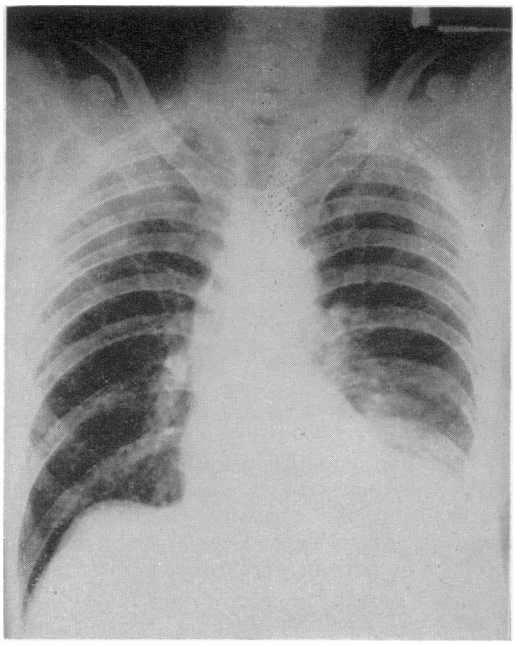

Fig 1 *A M, early pre-operative film*

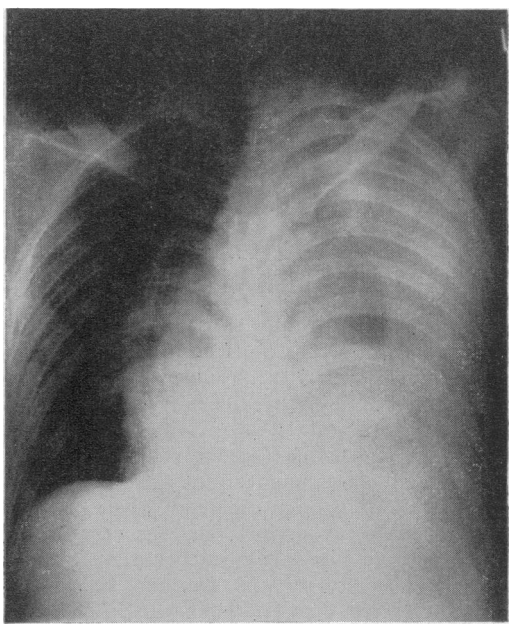

Fig 2 *A M, later film, showing large effusion*

11.6.61: He was shocked and ill with grunting respiration. Blood pressure 60 systolic. Pulse 160. Chest X-ray showed a left-sided pleural effusion (Fig 2). Aspiration of the effusion revealed the presence of food. In view of his very poor