Sleeping eyes

O Vancollie, E Delgrange, J Donckier

Answers on p 312.

A 73 year old woman was admitted to hospital for weight loss, dysphagia with solids, and dyspnoea. She had suffered from Raynaud's phenomenon for 10 years. The main relevant findings are shown in the figures (figs 1–4). Erythrocyte sedimentation rate was normal and C reactive protein was 33 mg/l (normal <5 mg/l). White cell count was normal. Laboratory studies also revealed plasma lactate dehydrogenase of 1362 IU/l (normal 220–480 IU/l) and creatine phosphokinase of 1323 IU/l (normal 15–190 IU/l) consistent with myositis. Myoglobin was 1512 µg/l (normal <70 µg/l). Renal function was normal. Antinuclear antibodies were raised up to 1/2560 with a nucleolar staining pattern and extractable nuclear antigens were negative. Rheumatoid factor was negative. Plain chest radiography and lung function tests were normal. Doppler echocardiography demonstrated normal left ventricular function but severe pulmonary hypertension (pulmonary arterial systolic pressure was 56 mm Hg). Capillaroscopy showed dilated nailfold capillary loops.

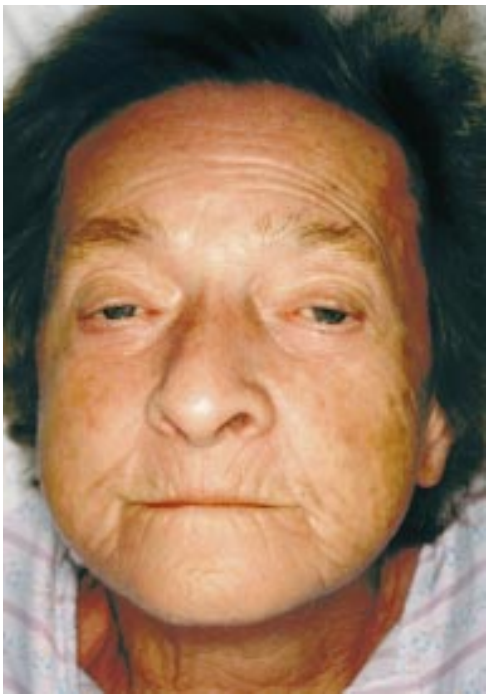

Figure 1 The patient's face (reproduced with her permission).

Figure 2 Photograph taken on examination.

Figure 3 Photograph of the patient's hand.

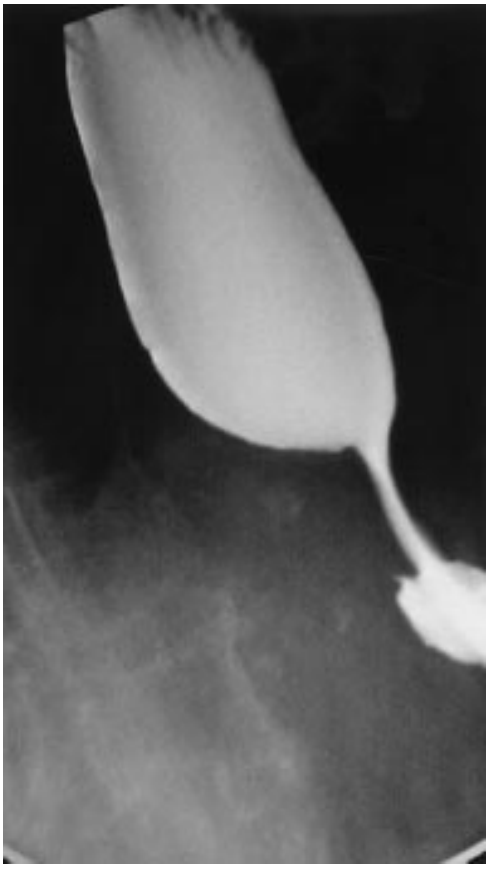

Figure 4 Barium swallow.

Questions

(1) What do the clinical photographs and radiograph show?
(2) What is the most likely diagnosis?
(3) What are the possible explanations for bilateral ptosis and myositis?

University Hospital UCL of Mont-Godinne, Department of Internal Medicine, 5530 Yvoir, Belgium
O Vancollie
E Delgrange
J Donckier

Correspondence to:
Professor Donckier
(e-mail: Julian.Donckier@mint.ucl.ac.be)

Submitted 19 April 1999
Accepted 5 July 1999

Answers on p 312.

Diffuse swelling of the penis in a young adult

N Sarath Krishna, E S Glen

Figure 1 Photograph of swollen penis (reproduced with the patient's permission).

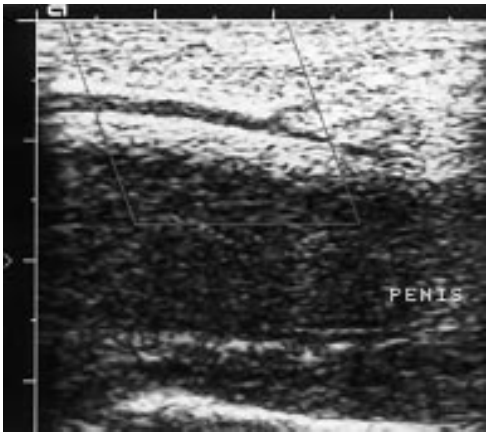

Figure 2 Doppler ultrasound scan.

A 25 year old man presented to our hospital with a seven day history of pain in the root of the penis and two day history of swelling of the penis. On questioning there was no history of prolonged intercourse, local trauma, insect bite, or infection. He had no relevant past medical history. General physical and abdominal examination were unremarkable. On local examination the penis was diffusely swollen-due to oedema. A long, thick, firm, and cord like structure was felt along the dorsal aspect of the penis. It was not tender. There was no evidence of venous thrombosis elsewhere. Urine microscopy, full blood count, and coagulation studies were all within normal limits. Colour Doppler ultrasonography of the penis showed a prominent superficial dorsal vein of penis with no evidence of spontaneous flow. A clinical photograph of penis and Doppler ultrasound scan of the penis are shown in figs 1 and 2 respectively.

Questions
(1) What is the probable diagnosis?
(2) What is the aetiology and pathology of this condition?
(3) How can this condition be managed?

Department of Urology, Southern General Hospital, 1345 Govan Road, Glasgow G51 4TF, Scotland, UK
N Sarath Krishna
E S Glen

Correspondence to:
Mr Sarath Krishna Nalagatla
(e-mail: sarath@rohini25.freeserve.co.uk)

Submitted 1 June 1999
Accepted 5 July 1999

Answers on p 313.

Hypercalcaemia in a 63 year old man

L Ranganath, M J Semple

A 63 year old man with IgG myeloma was found to have hypercalcaemia; specific hypocalcaemic measures such as intravenous fluids and pamidronate 60 mg followed by 1.6 g of oral sodium clodronate daily in addition to antimyeloma agents such as prednisolone, Adriamycin, and carmustine were unsuccessful in restoring eucalcaemia (fig 1).

Blood test results while on treatment with clodronate are shown in table 1.

Questions
(1) What is the cause of the apparent resistance to bisphosphonates?
(2) What further investigations for hypercalcaemia should be undertaken?
(3) What are the causes of hypercalcaemia in myeloma?

Epsom General Hospital, Epsom, Surrey UK: Department of Chemical Pathology
L Ranganath

Department of Haematology
M J Semple

Correspondence to:
Dr L Ranganath, Department of Clinical Chemistry, Royal Liverpool University Hospital, Prescot Street, Liverpool L7 8XP, UK
(e-mail: lrang@liverpool.ac.uk)

Submitted 1 June 1999
Accepted 12 July 1999