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In

many of these patients, the

hypothyroidism was corrected by restriction of the

excessive iodine source. The uninhibited 99mTc-

tepertechnetate and/or radiiodine uptake presumably reflects the

uninhibited transport of iodine and the persistent decrease in

iodine ofumentation (the so-called Wolff-Chaikoff effect)

which leads to hypothyroidism. The statement of the

Japanese authors that normal or elevated 99mTc-per-
technetate and/or radiiodine uptake may suggest a reversible form of

hypothyroidism seems valid whether iodine excessive con-

sumption results from diet or from drugs such as amiodarone and
diiodohydroxyquinoline.

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Lengthy incubation for homosexual transmission of
acquired immunodeficiency syndrome in a 79 year old

Sir,

The acquired immunodeficiency syndrome (AIDS) is
predominantly a condition of young sexually active
homosexual men. Most cases in patients aged over 70 years
are related to blood transfusions. Data from transfusion
related cases suggest a mean incubation period from infection
to overt clinical AIDS between 5 and 15 years. It seems
possible, therefore, that sexually transmitted AIDS may
present many years after the cessation of sexual activity in
elderly patients.

Many of the features of human immunodeficiency virus
(HIV) infection are not uncommon in elderly patients in
whom other diagnoses will probably be considered before
AIDS. We describe an elderly patient who developed AIDS
12 years after his last exposure to recognized risk factors.

A 79 year old West Indian man presented in June 1987 with
malaise and weight loss. He denied sexual activity over the
preceding 12 years. He had received no blood products, and
did not use intravenous drugs.

Between January and May 1987, whilst visiting Trinidad,
he developed pharyngitis and pyrexia, with anorexia, weight
loss and constipation. In June 1987 he presented to this
department. He weighed 65 kg, there were bilateral axillary
and groin lymph nodes up to 1 cm diameter, and a palpable
liver edge.

There was a neutropenia of 1.04 × 10^9/l, lymphocyte count
3.8 × 10^9/l with atypical forms, platelet count 187 × 10^9/l and
haemoglobin concentration 125 g/l. The erythrocyte
sedimentation rate was 58 mm in the first hour. Serum
electrophoresis showed a polyclonal increase in gamma-
globulins, and also a single paraprotein in the gamma region of
3.6 g/l, comprising IgG with lambda light chains only. Urine
was negative for Bence Jones proteins. Bone marrow
aspirate and trephine were not diagnostic. Biopsy of a lymph
node from the left groin, and subsequently of an enlarging
node in the left axilla showed reactive changes only.

Immunostaining showed that the plasma cells were poly-
clonal and in normal proportions, and that B- and T-cell
markers were in normal proportions.

More detailed clinical history revealed that he had been
practicing bisexual until 1975. In 1971 a steady homosexual
relationship in London had ended. He had casual homosex-
ual relationships in New York in 1974 and Jamaica two years
later. He denied subsequent sexual contacts. Antibodies to
HIV were detected by enzyme-linked immunosorbent assay
(ELISA) at Chelmsford Public Health Laboratory (PHL), and
confirmed on a separate serum sample by ELISA and
fluorescent antibody test at Oxford PHL.

The onset of oesophageal candidiasis heralded the progres-
sion to AIDS in this patient in December 1987 at the age of
79 followed by autonomic neuropathy. He died in March

Malaise, weight loss, lymphadenopathy, neutropenia,
monoclonal gammopathy and autonomic neuropathy with
postural hypotension are each recognized features of HIV
infection, though many of these are commonly seen in
elderly patients with other conditions. Extensive investi-
gation failed to reveal additional lymphoma or other mali-
gnancy.

This patient reported no sexual contacts during the
preceding 12 years and denied other risk factors for AIDS.
O’Neill et al. have recently emphasized that sexual histories
should not be omitted in elderly patients. Our case confirms
that incubation periods for sexually transmitted AIDS may
be long in elderly patients and that distant sexual histories
may be relevant in reaching the correct diagnosis in patients
with compatible clinical features. Gastroscopy was per-
formed on this patient when malaise, weight loss, lymph-
adenopathy and hepatomegaly raised the suspicion of
abdominal neoplasm, before the true diagnosis had been
suspected. Strict precautions should be employed during invasive procedures even in patients not suspected of being at high risk of HIV infection.

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Carcinoma of the gall bladder – can we do anything?

Sir,

Chattopadhyay et al. concluded that the diagnosis of gall bladder carcinoma was clinical in the majority of cases and the investigations merely confirmatory. We would like to report a case where repeated investigations simply delayed a diagnosis which was eventually made by laparotomy.

A 72 year old female was admitted with a short history of anorexia, nausea, vomiting, weight loss and low back pain with urinary frequency. On examination she was pyrexial 38.4°C, icteric and had hepatomegaly with a tender right lumbar mass. Liver function tests showed an obstructive picture and urinalysis showed evidence of infection.

Clinically it was thought she had a pancreatic carcinoma and possibly a right pyonephrosis. The ultrasound scan suggested a 5 cm mass in the head of the pancreas and a dilated common bile duct, a thick walled gall bladder containing several calculi, a right hydronephrosis and a suspicion of metastases in the right lobe of the liver. Endoscopic retrograde cholangiopancreatogram (ERCP), performed at another hospital, showed multiple stones in the common bile duct some of which were extracted after sphincterotomy. Arrangements were made for repeat ERCP in 4 weeks.

The patient had improved both clinically and biochemically. Because of the strong suspicion of malignancy the ultrasound scan was repeated. This time it failed to show any pancreatic mass, but the report was otherwise similar to the first. An outpatient computed tomographic (CT) scan showed generalized pancreatic atrophy, gas in the biliary tree and a right hydronephrosis. Two weeks later the patient deteriorated and an exploratory laparotomy was performed. This revealed an intraperitoneal malignant gall bladder infiltrating the liver in addition to stones in the common bile duct. Gall bladder and liver biopsy confirmed an undifferentiated large cell carcinoma infiltrating into liver tissue. The patient died 9 days postoperatively with broncho-pneumonia.

Our patient had endured 6 weeks of tests involving 2 ultrasounds, 1 ERCP and sphincterotomy, 1 CT scan and was awaiting a repeat ERCP when her diagnosis was made by laparotomy. The estimated cost of these tests would be over £1000.

We feel this case highlights some of the problems of modern technology where tests are performed one after another to try and establish a precise ‘medical’ diagnosis, when a simple good old fashioned laparotomy will very quickly establish the diagnosis and modern clinicians should not forget this very basic fact.

With reference to gall bladder carcinoma in particular, there is a very low preoperative diagnosis of 5–8.6% with a correspondingly poor prognosis. Ultrasound scans claim diagnostic successes of 88–100% for early detection. ERCP is acclaimed by some, CT scans by others. A drip infusion cholangiography, percutaneous transhepatic cholangiography and coeliac axis angiography are also considered contributory. Gall stones coexist in 54–75% of cases, and interpretation of the diagnostic features becomes difficult and unreliable. The list of investigations grows longer and longer as does the costs and time taken to do them. A ‘simple old fashioned’ laparotomy remains the quickest and most reliable ‘test’.

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Lengthy incubation for homosexual transmission of acquired immunodeficiency syndrome in a 79 year old man.

D. A. Walsh and T. C. O'Shaughnessy

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