hyperplasia. Thyroid function tests confirmed thyrotoxicosis. He was treated with carbimazole and neostigmine and within 4 days his upper motor neurone signs reverted to normal.

Of interest is the hyperthyroidism which has been reported in 5–10% of cases of myasthenia gravis.1 Thymic hyperplasia is seen in 75% of patients with myasthenia gravis2 and has been noted with myasthenia gravis associated with thyrotoxicosis.3 Distal limb weakness was more marked in our patient though the literature scanned mentions predominant ocular and proximal involvement. Finally, the most uncommon and interesting association was the transient corticospinal involvement, signs of which reversed in a few days of hospitalization, possibly on the basis of reversible corticospinal tract changes with thyrotoxicosis and their improvement with antithyroid drugs.4 The pathophysiological basis of pyramidal tract dysfunction in hyperthyroidism which is reversible5 is not known and no histopathological studies have been reported.

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References

Pericardial tamponade resulting from changing a central venous catheter over a guide wire

Sir,

Pericardial tamponade resulting as a complication of central venous cannulation is well recognized. In renal dialysis units it is routine practice to replace central venous catheters using guide wires. I report a case of haemopericardium in a dialysis patient who followed replacement of a subclavian vein catheter over a guide wire which was inserted through a catheter already in the vein.

A 42 year old female with renal failure secondary to systemic lupus erythematosus was being temporarily haemodialysed via a single lumen 20 cm 8F central venous catheter which had been inserted into the left subclavian vein infraclavicularly using the Seldinger technique. A chest radiograph after insertion of the catheter showed a normal cardiac outline.

On the fifth dialysis session, 9 days after insertion of the catheter, it was decided to change the catheter due to poor blood flows. A straight uncoated 70 cm × 0.038 in. guide wire (Vas-Cath Inc) was easily inserted through the catheter lumen and the catheter was removed. A new 20 cm 8F catheter with a single lumen was inserted over the guide wire which was then removed.

A chest radiograph following catheter replacement confirmed satisfactory positioning of the catheter in the superior vena cava and showed a normal cardiac outline. The patient was commenced on haemodialysis with a continuous infusion of heparin at a rate of 1500 units/h. Ninety minutes later she became unwell with a sinus tachycardia and hypotension. An echocardiogram confirmed a large collection in the pericardial space and showed right ventricular diastolic collapse confirming tamponade. After unsuccessful attempts at subxiphisternal pericardial aspiration she underwent emergency thoracotomy.

At operation 300 ml of blood with a haematocrit of 0.27 was removed from the pericardial sac. The peripheral blood haematocrit was 0.24. A drain was left in situ and a subsequent chest radiograph did not show any change in the position of the catheter. This was later removed and the patient made an uneventful recovery.

We believe that the haemopericardium resulted from a combination of anticoagulation and breaching of the wall of the superior vena cava or right atrium.

The use of a J shaped instead of a straight guide wire may have prevented this complication. This case illustrates that patients requiring anticoagulation are at particular risk of complications related to central venous catheterization.2,3 It also shows that a satisfactory chest radiograph following cannulation does not exclude the possibility of serious late complications.

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References

Leukopenia and thrombocytopenia due to fusidic acid

Sir,

Fusidic acid is increasingly used especially for methicillin-resistant staphylococci. Side effects are limited to gastrointestinal upset,1 skin rashes,1 impaired liver function1 and, rarely, granulocytopenia.2,3 We report here leukopenia and thrombocytopenia in association with fusidic acid.

References
A 49 year old patient, after mitral valve replacement, developed a methicillin-resistant staphylococcus sternal wound infection. She received fusidic acid, at the dose of 1.5 g daily. The only other medications were warfarin and diuretics she had been taking for years. After 2 weeks on fusidic acid, a routine blood count revealed leukopenia of $1.2 \times 10^9/l$ with $60\%$ granulocytes, and thrombocytopenia of $22 \times 10^9/l$, with no bleeding diathesis. Her previous blood counts had been normal except for anaemia. Both the leukopenia and the thrombocytopenia promptly resolved upon discontinuation of fusidic acid. The time correlation between initiation of fusidic acid and the development of leukopenia and thrombocytopenia, and between discontinuation of the drug and normalization of the blood count is strongly suggestive of a cause and effect relationship between the two.

Although granulocytopenia has been recorded in three patients treated with fusidic acid,\(^2,3\) thrombocytopenia has not been previously documented to our knowledge and should be added to the potential side effects of this drug.

**References**


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