plasma active renin levels after standing. A short Syn-
acthen test showed a normal cortisol response (baseline
cortisol level was 235 nmol/l, cortisol level one hour after
250 μg of Synacthen was 734 nmol/l.

A permanent ‘on-demand’ cardiac pacemaker was
inserted and oral calcium resonium and a low potassium
diet was continued. After 2 months, hypokalaemia
(potassium level 2.8 mmol/l) developed and the calcium
resonium and low potassium diet were stopped. On
further follow-up he remains well although a tendency to
hyperkalaemia persists (potassium levels = 5.0–5.1
mmol/l; reference range = 3.4–5.0 mmol/l).

Ibuprofen may have been implicated in the cardiac
dysrhythmias, by provoking hyporeninaemic hypo-
aldosteronism in a patient with underlying autonomic
dysfunction. We have not rechallenged the patient to
ibuprofen. The resulting hyperkalaemia in our patient led
to life-threatening dysrhythmias which required intracar-
diac pacing. Our case also demonstrates that regular
follow-up of potassium levels is necessary because the
hyporeninaemic hypoadosteronism caused by non-
steroidal anti-inflammatory drugs can be reversible, and
continued calcium resonium therapy may lead to
hypokalaemia.

T. Masud
P. Winocour
F. Clarke
Freeman Hospital,
High Heaton,
Newcastle-Upon-Tyne NE7 7DN, UK.

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Carcinoma of the pancreas in a young male

Sir,

Carcinoma of the pancreas is a disease of the elderly and is
rare in younger age groups. We report a 22 year old male,
the youngest patient to our knowledge with carcinoma of the
pancreas with associated chronic calcific pancreatitis.

A 22 year old male farm worker from North India
presented with constant pain in the epigastrium radiating
to the back of 6 months duration and progressive
cholestatic jaundice of 2 weeks duration. He had anorexia
and significant weight loss. He was found to have diabetes
5 years ago and was on insulin therapy. On examination
he was icteric and had a tender, firm well-localized mass in
the epigastrium and a smooth, non-tender gallbladder
lump. Investigations revealed haemoglobin of 10.4 g/dl
total leukocytoc count of 21 × 10³/l with 88% poly-
morphs, serum bilirubin 167 μmol/l, serum alkaline
phosphatase 607 IU/l (n = 35–125), transaminases 108/
261 U/l (n = 5–40) and serum amylase 24 U/l (n = 30–
110). Plain X-ray of the abdomen revealed speckled
calcification at L1–2 level. Ultrasonography and com-
puted tomographic scan of the abdomen revealed dilated
intrahepatic biliary radicles and a distended gallbladder;
the common bile duct measured 16 mm in width. Calcification was seen in the pancreatic tissue and a
hypoechoic mass was seen in the head of the pancreas.
The pancreatic duct measured 8.6 mm and had calculi in
it. Ultrasound-guided fine needle aspiration biopsy
revealed features suggestive of malignancy.

At laparotomy, there was a 8 × 9 cm hard mass in the
head of pancreas extending across into the neck. Vascular
planes posterior and inferior to the pancreas were
obliterated. Cholecystojejunostomy, gastrojejunostomy
and chemical coeliac plexus block was performed. Histo-
pathology of the intraoperative trucut needle biopsy from
the mass revealed a poorly differentiated adenocar-
cinoma. Postoperatively, his jaundice regressed and he
was relieved of pain. The final diagnosis was chronic
calcific pancreatitis with carcinoma of the pancreas and
diabetes mellitus.

Carcinoma of the pancreas is usually seen in the sixth
and seventh decades. In 1990 Hena et al. reported a 28
year old female as the youngest case of carcinoma of the
pancreas in the English language literature. To the best
of our information, our patient appears to be the
youngest patient reported to have carcinoma of the
pancreas.

Carcinoma of the pancreas is more frequent in a
population with chronic pancreatitis. The incidence of
carcinoma of the pancreas in association with chronic
pancreatitis is variable. In a study of 240 patients with
tropical pancreatitis, 22 (9.4%) developed carcinoma
over a follow-up period of 7 years. Maligancy as a
sequel of chronic pancreatitis has not been established but
the association between the two conditions is well
documented.

Prognosis of patients with carcinoma of the pancreas in
association with chronic pancreatitis is dismal as the
diagnosis is frequently delayed. Mean survival of these
patients after diagnosis is 2–3.5 months.

Wasif Ali
S.S. Sikora
S.P. Kaushik
Department of Surgical Gastroenterology,
Sanjay Gandhi Postgraduate Institute of
Medical Sciences,
Lucknow 226001,
India.

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Measurement of visual acuity by hospital physicians

Sir,

Ophthalmological disease is an important cause of morbidity in general practice and hospital in-patients. Assessment of visual health is therefore a vital part of patient care. It is particularly important when referring a patient with visual problems to an ophthalmologist that an assessment of visual acuity is included in the referral letter.1 This aids the ophthalmologist in deciding the degree of urgency with which a patient needs to be seen.

We report the results of a study carried out to assess whether hospital physicians were able to measure visual acuity and accurately record this information. A group of hospital physicians was randomly selected from four hospitals in the West Midlands region. The ability to assess visual acuity was determined using a standard four-part questionnaire:

1. What is the name of the chart used to assess distance visual acuity?
2. What is the usual correct distance between the chart and the patient?
3. If the patient usually wears spectacles, but has forgotten them, how can you get a rough assessment of their corrected visual acuity?
4. How would you record the visual acuity of this patient's right eye? (Shown a Snellen chart with patient able to read line indicated).

One hundred and two doctors of all grades were questioned. Only 25 (24.5%) doctors questioned were able to answer all four questions correctly. Ninety-five (93%) answered question 1 correctly but the correct response rates were 70%, 56% and 63% for questions 2, 3 and 4, respectively.

It is clear from these results that, although most doctors in our study group know the name of the chart used to measure distance visual acuity, many are not familiar with the practicalities of actually measuring visual acuity using it. Only 60% of doctors questioned who were of registrar level or below could accurately measure and document a patient's visual acuity so that the information would be of value to an ophthalmologist reading a referral letter. Another finding to emerge from this study was that Snellen charts were only generally available in accident and emergency departments, ophthalmology clinics and diabetic clinics/wards.

We feel that it is important that adequate time is allocated to the study of ophthalmology in the undergraduate curriculum so that all doctors can learn the basic examination skills necessary to assess ophthalmic problems.

P. Shah
S.J. Talks
F. Pochkhanawala
Department of Ophthalmology,
Birmingham and Midland Eye Hospital,
Church Street,
Birmingham, UK.

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