Side effects of ecstasy

- hyperpyrexia
- rhabdomyolysis
- renal failure
- hyponatraemia
- convulsions
- death

Pseudohyperkalaemia associated with hereditary spherocytosis

Sir,

Aliani et al reported a case of hereditary spherocytosis complicated by thromboembolism, with typical perfusion defects on lung scanning. Indeed, in such cases, the differential diagnosis would include alternative causes of multiple perfusion defects, such as in situ thrombosis in the pulmonary circulation. The latter was the postulated cause of pulmonary hypertension in the patient with hereditary spherocytosis reported by Veresin et al with suggested that the patient's genesis was sequestration of erythrocytes in the pulmonary microcirculation, due to poor deformability resulting from spectrin deficiency.

This hypothesis lends credibility to the fact that poor deformability of erythrocytes has been validated in the underlying mechanism in the pathogenesis of pulmonary hypertension complicating sickle cell disease.

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Intestinal cytomegalovirus infection: a diagnostic problem in an HIV-positive patient

Sir,

Unexplained abdominal pain may be a problem in patients with AIDS. We report a 30-year-old woman infected with human immunodeficiency virus (HIV) through sexual contact about three years previously, who presented with intermittent and generalised abdominal discomfort. Examination was initially unremarkable and an abdominal X-ray showed her to have severe faecal retention but treatment with laxatives failed to relieve pain. Her CD4 lymphocyte count was 0.065 × 10⁹/l (range 0.5 – 1.5).

During the following three months a series of investigations yielded the following results: these included sigmoidoscopy, rectal biopsy, upper abdominal and pelvic ultrasonography, MRI abdominal scan and barium studies of the small and large bowel. Stool microscopy and culture failed to reveal relevant pathogens. Cultures for cytomegalovirus (CMV) were sterile in rectal biopsy, urine, throat swabs and blood. She had a 10% HIV indicative of infection at some time but titre were static and CMV IgM was not detected by immunofluorescence or enzyme immunoassay. The pain responded to symptomatic treatment but diffuse abdominal tenderness persisted. She remained afebrile throughout. Three months after presentation she unexpectedly collapsed and died. At post-mortem there was peritonitis and patchy ileal inflammation with a mid ileal perforation. The colon appeared normal macroscopically and histologically: examination of the infarcted ileal tissue showed changes diagnostic of CMV infection.

The investigation of abdominal pain in patients with HIV infection is often influenced by the site of pain and the presence or absence of diarrhoea; a diagnosis can be reached in most patients.

CMV infection of the gut is well recognised in AIDS patients (box). In our patient there was no pain localisation or other feature to suggest CMV; indeed CMV seemed to have been excluded. In patients with whom intestinal CMV infection has caused perforation, the site is usually between the distal ileum and splenic flexure and colonoscopy, which was not performed in our patient, would be preferable to sigmoidoscopy to discover affected gut mucosa (colonoscopy would have been normal in this patient).

This case highlights the fact that intestinal CMV infection may be difficult, indeed impossible, to diagnose without invasive investigation such as laparoscopy or laparotomy. Because ganciclovir may be effective in CMV colitis, any patient with CMV ileitis may benefit patients with CMV ileitis, we conclude that a diagnostic trial of anti-CMV treatment may have a role to play in CMV antibody positive AIDS patients with persisting abdominal pain of uncertain cause despite appropriate investigations.

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