A 42 year old woman presented with ischaemic left leg pain. There had been a right above knee amputation two years previously when Buerger’s disease was diagnosed. However, on review of the arteriogram there was proximal disease in the superficial femoral artery suggesting atherosclerotic disease, and typical arteriographic features of Buerger’s disease were absent. She had been a smoker of 30 cigarettes per day since age 16 years. At presentation two years after the right above knee amputation, the posterior tibial and dorsalis pedis pulses were absent in the left foot but there were no ischaemic ulcers in the toes. The following investigations were normal or negative: fasting blood sugar, lipid profile, C reactive protein, antinuclear antibody, rheumatoid factor, complement, anticientromere antibody, anti-Scl-70, anticardiolipin antibody, and thrombophilia screen. An echocardiogram was also normal.

Serum homocysteine was 117.9 µmol/l (5.5–13.6), serum methionine was 16 µmol/l (22–32), serum folic acid was 3.5 ng/ml (3.2–12.4), serum vitamin B12 was 225 pg/ml (158–1050), and serum vitamin B6 was 45 nmol/l (15–73).

Genetic testing revealed the patient was homozygous (TT) for the C677T polymorphism of methylenetetrahydrofolate (MTHFR).

QUESTIONs
(1) Which conditions should be excluded before making a diagnosis of Buerger’s disease?
(2) What are the causes of a raised serum homocysteine?
(3) What is the appropriate treatment for this patient?
A 15 year old boy presented with a four month history of intermittent claudication of right calf at 500 yards, which gradually got worse and he subsequently developed numbness and discoloration of the right foot. He was a non-smoker, non-diabetic, and there was no history of cardiovascular, respiratory, or haematological disorders. There was no history of trauma, burns, or radiotherapy. His height was 1.88 m and weight 92.4 kg (body mass index = 26). On examination he was normotensive with normal heart sounds and in sinus rhythm with no carotid bruit or aneurysm of the aorta or peripheral arteries. He had a full complement of pulses on the left leg. On the right leg popliteal and foot pulses were not palpable. The right leg was cold below the mid-calf. There was no neurological deficit and no tissue loss. Ankle brachial pressure index of the right dorsalis pedis was 0.28 and left dorsalis pedis was 1. Blood tests including full blood count, clotting time, C reactive protein, liver function test, thyroid function test, rheumatoid factor, autoimmune antibodies, and cholesterol were all within the normal range. The Duplex scans of his right leg arteries are shown in figs 1 and 2. A magnetic resonance angiogram (MRA) is shown in fig 3.

**QUESTIONS**

(1) What do the Duplex scans show?
(2) What does the MRA show?
(3) What are the causes of ischaemic foot?

Postgrad Med J 2002; 78:501

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Submitted 30 October 2000

Accepted 3 April 2001
The patient was weaned off the ventilator, but died nine days after his second laparotomy of an extensive myocardial infarction.

Histology of the excised colon showed attenuation of the muscularis propria with no evidence of active colitis, confirming that the spontaneous perforation was due to Ehlers-Danlos syndrome and not the result of ulcerative colitis.

**Galactorrhoea**

**Galactorrhoea in a 16 year old girl with a large sellar mass**

I Ilias, E Zapanti, G Philippou, M Alevizaki

**Answers on p 506.**

A 16 year old girl was admitted because of low grade fever, headache, and nuchal rigidity. She complained of galactorrhoea during the preceding year and irregular menstruation since menarche at 13 years old.

Physical examination was unremarkable except for the galactorrhoea.

The diagnostic work-up for meningitis was negative. Cranial computed tomography and subsequent magnetic resonance imaging showed a large, possibly cystic, pituitary lesion (fig 1). The laboratory work-up showed a mild elevation of basal prolactin levels, 1.05 IU/l; evaluation of pituitary reserve showed normal thyrotrophin, luteinising hormone, and follicle stimulating hormone responses after stimulation. The α-subunit levels were 0.1 mIU/ml. Mild bilateral superior constriction was found on Goldman visual field examination. There were no findings suggestive of sarcoidosis (normal chest radiography, normal serum angiotensin converting enzyme levels).

**QUESTIONS**

(1) What is the differential diagnosis for this patient?
(2) Which specific work-up should the follow up include?

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Submitted 17 September 2001

Accepted 21 May 2002
A 48 year old man presented with cough, purulent sputum production, wheeze, and reduced exercise capacity. He described rapid weight loss of 9 kg over six months, associated with night sweats. He denied chest pain or haemoptysis. He had a 30 pack year cigarette habit and previously worked as a glazier.

Ulcerative colitis had been diagnosed 25 years previously, with rapid disease progression despite sulphasalazine treatment. This resulted in a panproctocolectomy the next year with a postoperative period complicated by a subphrenic abscess and wound dehiscence. There was no recurrence of gastrointestinal symptoms.

On examination he was cachectic with finger clubbing. There was a low grade pyrexia and functioning ileostomy. Chest auscultation revealed scattered coarse rales.

The neutrophil count was $16.5 \times 10^9/l$, the C reactive protein was 121 mg/l, and the erythrocyte sedimentation rate was 70 mm/hour. IgE was 154 U/l (normal <100), autoantibody screen was negative, and p-antineutrophil cytoplasmic antibody (ANCA) was borderline positive with MPO-ANCA titre 27 EU/ml.

QUESTIONS

1. What do the chest radiograph (fig 1) and computed tomogram of the upper thorax (fig 2) show?
2. What is the likely diagnosis and what further investigations should be performed to confirm this?
3. What treatment should the patient be given?
4. What are the pulmonary complications of ulcerative colitis?

Answers on p 507.

Figure 1 Chest radiograph.

Figure 2 Computed tomogram.
Ischaemic foot: an unusual cause

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Postgrad Med J 2002 78: 501
doi: 10.1136/pmj.78.922.501

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