Letters to the Editor

Epistaxis after prolonged water immersion in a hot Jacuzzi

Sir,

Water immersion up to the neck can cause many haemodynamic changes including increased central venous pressure and central blood volume as well as diuresis, natriuresis and decreased vasopressin levels.^{1–3} These effects have also been noticed after use of the Jacuzzi,^{4,5} especially one with water temperature over 39°C⁶. Vasopressin stimulates production of thromboxane,⁷ and vasopressin infusion is used in treatment of bleeding diathesis such as Mallory-Weiss syndrome.

A 39 year old businessman, in excellent health, stayed in a very hot Jacuzzi (approx. 41°C) for over 90 minutes, keeping only his head above water. About an hour after leaving the health club, he presented with a very copious epistaxis. He was treated at an outpatient clinic, and the epistaxis resolved. He claimed that he never had nosebleeds prior to this instance and that his usual stay in the Jacuzzi was for only 15 minutes.

Thus, it is possible that prolonged head-out water immersion in the hot Jacuzzi could affect platelet aggregation and induce bleeding in the susceptible.

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Autosympathectomy: a late complication of metastatic breast disease

Sir,

A 45 year old woman underwent simple mastectomy (with axillary node sampling) for carcinoma of the right breast. A single node contained metastatic disease.

Three years later a chest X-ray showed a raised right hemi-diaphragm, blunting of the right costophrenic angle and appearances suggestive of pleural thickening. A bilateral

oophorectomy was carried out. Six months later a symptomatic right sided pleural effusion developed but no malignant cells were seen in the aspirate. Tamoxifen was commenced.

During the next 3 year period pleural thickening was noted but there was no gross reaccumulation of fluid. The patient then developed postero-lateral chest pains on the right and a feeling of warmth in the right hand with a noticeable colour change (right more than left). The right hand was found on examination to be warm and dry and a diagnosis of auto-sympathectomy was confirmed by thermography. There was no evidence of Horner's syndrome.

Thermographic imaging (Novatherm Contact Thermography System, Novamedix, Ltd¹) which has previously been used to assess impaired sympathetic function,² confirmed a significant discrepancy between the temperature of the hands. The right hand was the hotter with most of it having a cutaneous temperature measuring 31°C. The left hand was markedly cooler with a mean temperature of 27°C.

The sympathetic supply of the hand is derived from the T1 to T5 segments of the sympathetic chain. In this case, the autotomectomy is assumed to have been caused by involvement of the T2 to T4 ganglia by tumour deposits on the pleura. The absence of Horner's syndrome suggests that the stellate and T1 ganglia were not involved.

The patient remains well with persistent denervation but no other signs of disease progression. This case, to our knowledge, demonstrates a previously undescribed complication of metastatic breast disease.

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Reversible hypothyroidism detected by normal ^{99m}Tc scan

Sir,

The existence of a reversible type of hypothyroidism sensitive to iodine restriction has been described in Japanese patients with dietary iodine intake of more than 1 mg daily.¹ In amiodarone-iodine induced hypothyroidism (AIH), ^{99m}Tc-pertechnetate and radioiodine uptake are normal.^{2,3} We describe a case of diiodohydroxyquinoline-induced hypothyroidism whose reversibility was suspected by the normal thyroid ^{99m}Tc-pertechnetate scan.

A 56 year old man had taken diiodohydroxyquinoline (Direxide) containing 63% iodine for one year, providing him with iodine intake of 210 to 420 mg/day. He presented with classic symptoms and signs of hypothyroidism, and serum concentrations of 18 mmol/l thyroxine (T₄),

1.11 mmol/l triiodothyronine (T3), and 43 mU/l thyroid stimulating hormone (TSH). Antithyroid and antimicrobial antibodies were negative and urinary iodine was >10 mg/l. A ^{99m}Tc -pertechnetate scan showed a normal gland.

The diiodohydroxyquinoline was discontinued, and L-thyroxine replacement therapy was instituted and continued for 18 months. One month after discontinuation of the thyroxine supplementation, the serum T4 was 136.74 mmol/l, serum T3 was 2.66 mmol/l and serum TSH was 1.76 mU/l.

Hypothyroidism in the presence of normal or elevated radioiodine or pertechnetate uptake has been described as a result of increased dietary iodine consumption^{1,4,5} and as a side effect of the iodine present in amiodarone.^{2,3} In many of these patients, the hypothyroidism was corrected by restriction of the excessive iodine source. The uninhibited ^{99m}Tc -pertechnetate and/or radioiodine uptake presumably reflects the uninhibited transport of iodine and the persistent decrease in iodine organification (the so-called Wolff-Chaikoff effect) which leads to hypothyroidism.^{2,3} The statement of the Japanese authors that normal or elevated ^{99m}Tc -pertechnetate and/or radioiodine uptake may suggest a reversible form of hypothyroidism seems valid whether iodine excessive consumption 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 man

Sir,

The acquired immunodeficiency syndrome (AIDS) is predominantly a condition of young sexually active homosexual men.¹ Most cases in patients aged over 70 years are related to blood transfusions.² Data from transfusion related cases suggest a mean incubation period from infection to overt clinical AIDS between 5 and 15 years.³ 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 $1.04 \times 10^9/\text{l}$, lymphocyte count $3.8 \times 10^9/\text{l}$ with atypical forms, platelet count $187 \times 10^9/\text{l}$ 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 polyclonal and in normal proportions, and that B- and T-cell markers were in normal proportions.

More detailed clinical history revealed that he had been a practicing bisexual until 1975. In 1971 a steady homosexual relationship in London had ended. He had casual homosexual 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 progression to AIDS in this patient in December 1987 at the age of 79⁴ followed by autonomic neuropathy. He died in March 1988.

Malaise, weight loss, lymphadenopathy, neutropenia, monoclonal gammopathy and autonomic neuropathy with postural hypotension are each recognized features of HIV infection,^{5–7} though many of these are commonly seen in elderly patients with other conditions. Extensive investigation failed to reveal additional lymphoma or other malignancy.

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.⁸ 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 performed on this patient when malaise, weight loss, lymphadenopathy and hepatomegaly raised the suspicion of abdominal neoplasm, before the true diagnosis had been