an abnormal TFT that has not been acted upon within a specified time.

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Cytomegalovirus colitis in an elderly patient

Sir,

We report a patient with severe cytomegalovirus (CMV) colitis, in association with *Clostridium difficile* infection.

An 83 year old previously fit woman was admitted with collapse. She was confused and chest X-ray confirmed left basal pneumonia. She was treated with intravenous ampicillin but next day she became pyrexial, with vague abdominal pain and was noted to have diarrhoea. Sigmoidoscopy revealed inflammatory changes up to 15 cm. Stool culture showed a significant growth of *Clostridium difficile*. Oral vancomycin rendered her stool culture negative but the diarrhoea continued sometimes mixed with blood. Barium enema showed some irregularity in the sigmoid colon confirmed to be gross sigmoid colitis by colonoscopy. She was treated with prednisolone and olsalazine which were stopped when the biopsies reported a large number of cytomegalovirus-infected cells with inclusion bodies. Treatment with intravenous ganciclovir was commenced. Human immunodeficiency virus (HIV) test was negative, serum electrophoresis excluded gammopathy and CMV IgM titres were significantly raised. She failed to improve and subsequently died. Postmortem examination revealed no evidence of ulcerative or ischaemic colitis, no CMV inclusion bodies were seen in the colonic mucosa which was denuded and inflamed and her lungs were severely bronchopneumonic.

Although detecting CMV inclusions by cytologic or histologic methods is diagnostic. It is not considered a sensitive means of diagnosis.¹ It reflects activity of infection and could be a useful marker to guide antiviral therapy.²

There is a high prevalence of CMV IgM antibodies among elderly patients despite the lack of obvious evidence of clinical sign or viral shedding. This might be attributed to the progressive decline of the immune system in old age; however the exact reasons are still unknown.³

CMV colitis is a recognised complication in severe immunodeficiency states but it is also reported to occur as an isolated phenomenon. The associations with ulcerative colitis and colonic adenocarcinoma have been reported, but it remains unclear as to how significant these associations are.⁴ In ulcerative colitis the susceptibility to CMV infection may be attributed to either steroid treatment or the growth of readily infected granulation tissue as a result of tissue damage.⁴ In our case CMV colonic biopsies were taken before starting steroid therapy. It is possible that the tissue damage associated with the *Clostridium difficile* colitis increased the patient's susceptibility to CMV colitis as ulcerative colitis may do. This hypothesis requires further studies for confirmation.

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Monozygotic twins concordant for both open-angle glaucoma and bronchospasm induced by beta-blockers

Sir,

A female monozygotic twin pair, born in 1914, is reported which demonstrates concordance for both open-angle glaucoma and bronchospasm precipitated by beta-blockers. The monozygosity of the twin pair was inferred by their morphological identity and homologous blood group antigens. There was no personal or family history of bronchospasm, atopy, or glaucoma; neither twin was a tobacco smoker.

Primary open-angle glaucoma was diagnosed in one twin at the age of 67 years and treated with pilocarpine eyedrops. Propranolol was subsequently prescribed for angina pectoris and bronchospasm developed which resolved upon withdrawal of the propranolol. Ten years later, an incidental diagnosis of advanced open-angle glaucoma was made in her asymptomatic co-twin. Treatment was commenced with betaxolol eyedrops but after 6 weeks, she developed bronchospasm. The betaxolol eye-