tachycardia and electrocardiogram confirmed atrial fibrillation with a ventricular rate of 170–180 beats/minute. Blood pressure remained stable. The dysrhythmia persisted and required treatment with amiodarone for 3 days before reverting to sinus rhythm. Serial electrocardiograms, and measurement of cardiac enzymes, urea and electrolytes were normal. There were no long-term sequelae.

Ventricular tachycardia associated with hyperkalaemia has been reported after ibuprofen overdose,³ although tachycardia and hypotension are more consistent features.² This is apparently the first report of atrial fibrillation occurring after an overdose of ibuprofen in a previously healthy individual. The presence of mild mitral regurgitation, and a possible hidden accessory pathway (as suggested by the short PR interval) may, however, have been predisposing factors in this case.

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Cerebellar haemangioblastoma in an octogenarian

Sir,

Sporadic cerebellar haemangioblastoma usually affects middle-aged individuals.¹ We recently excised this tumour in an 87 year old woman with subsequent rehabilitation to independence. The mean age at which this tumour presents is rising because a larger proportion of cases are occurring in older patients.² It is believed that during foetal development, a hamartoma forms in the cerebellum from the choroid plexus in the 4th ventricle. Cystic transformation then gives rise to the tumour.³ Why should such a transformation have occurred in our patient so long after the formation of a congenital lesion? Maher has recently provided an answer that requires an understanding of tumour suppresser genes.² Patients with Von Hippel–Lindau syndrome are heterozygous for a recessive tumour suppresser gene and require a single mutation for the formation of familial cerebellar haemangioblastoma. The sporadic tumour only occurs when two spontaneous mutations are acquired during life. This could statistically occur at any age after birth.

Although rare, cerebellar haemangioblastoma should be considered in the differential diagnosis of non-specific symptoms associated with acute cognitive impairment in old patients like ours. The usual physical signs of nystagmus, ataxia and papilloedema may not be elicited if patients are uncooperative in which case a computed tomographic scan of the head is necessary to exclude the diagnosis. A cystic low density mass is seen usually with an enhancing mural nodule. Cerebellar haemangioblastoma is more likely if papilloedema can be demonstrated as it occurs in up to 90% of cases.⁴ When senile miosis and cataract prevent adequate direct fundoscopy, referral to an ophthalmologist for examination by more sophisticated equipment could be valuable. With advances in neuroanaesthesia and a reduction in operative mortality,⁵ elderly patients should not be excluded from major surgery.

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Buerger's disease in Western India

Sir,

The predominant peripheral vascular disease seen in our busy surgical service is Buerger's disease (thromboangiitis obliterans). In 1988–1991 we treated 62 cases of Buerger's disease, all males below 42 years age (mean age 38 years). A total of 51 cases had peripheral gangrene with intractable pain, while the remaining 11 had non-healing ulcers with severe pain requiring narcotic analgesics in increasing doses. Lumbar sympathectomy (unilateral in 52, bilateral in 10 cases) was performed in all patients. Sympathectomy provided only temporary relief of the symptoms, 59 cases ended up in below-knee amputation, while the remaining two patients had minor amputations of the toes. The mean time interval between the onset of symptoms and the amputation was 22 months, while the mean time interval between sympathectomy and amputation was 6.4 months.