Letters to the Editor

Pituitary apoplexy after stimulation tests

Sir,
We read with interest the recent report by Vassallo, Rana, and Allen of a case of pituitary apoplexy following stimulation tests.¹ We report a similar case of pituitary apoplexy following medical intervention, although in somewhat different circumstances.

A 53-year-old woman presented with acute right iliac fossa pain associated with anorexia, nausea and vomiting. On examination, the patient was pyrexial (38°C) with right iliac fossa tenderness. At surgery, a right paratubal abscess was identified which involved the caecum and proximal ascending colon. A modified right hemicolectomy and right salpingectomy were performed. Suppurative paratubal abscess with culture of *Streptococcus faecalis* was confirmed by histopathological examination.

Thirty-six hours post-operatively the patient complained of sudden onset frontal headache and, on examination, right-sided ptosis and inability to laterally deviate the right eye was noted. Visual acuity was normal and no gross visual field defect was detected. Over the next day a complete right sixth cranial nerve palsy and partial right third cranial nerve palsy developed along with a minor deterioration in visual acuity and a temporal hemianopia. Computed tomographic (CT) scan of brain and pituitary fossa revealed a pituitary lesion of mixed density with some haematoma and zones of infarction in a probable pituitary adenoma. The patient was commenced on intravenous dexamethasone.

Two weeks later, a 75% improvement in the third cranial nerve function was recorded but the sixth nerve palsy was still complete. Over the next six months, the visual field defect and all cranial nerve palsies completely resolved. Investigations of pituitary endocrine function revealed normal levels of prolactin, thyroid stimulating hormone and adrenocorticotid stimulating hormone, with reduced levels of growth hormone, follicle-stimulating hormone and luteinising hormone. Hormone replacement therapy has not, as yet, been required.

Pituitary apoplexy has been reported on seven occasions following cardiopulmonary bypass surgery, but we have identified only one other case of pituitary apoplexy occurring after non-cardiac surgery which was in a Japanese man after cholecystectomy.³ The incidence of neurological dysfunction following extracorporeal cardiopulmonary bypass has been estimated to range from 7 to 44% for transient and 1.6 to 23% for persistent sequelae.⁴ Impairment of cerebral function following surgery may result from cerebrovascular damage, coagulation distur-

bances, thrombosis, and embolism of particulate matter. Per-operative hypotension has not been shown to correlate well with post-operative neurological dysfunction.⁴ However, in the case of pituitary apoplexy following non-cardiac surgery, catecholamine release secondary to intra-operative hypotension was suggested as a possible causative factor.³ Thus, techniques resulting in hypotension or increased cerebral venous pressure such as jugular venous or abdominal compression, should be avoided in patients with suspected pituitary adenoma. However, as is commonly the case, pituitary adenoma was not suspected in our patient prior to onset of symptoms.

This case demonstrates the necessity for thorough investigation of all patients who develop unusual neurological symptoms following general anaesthesia and serves to heighten clinical awareness of this potentially life-threatening complication of surgery.

ST O'SULLIVAN
CJ VAUGHAN
RJ GALVIN
WO KIRWAN
*Cork Regional Hospital,
Wilton, Cork, Ireland*

Correspondence to Mr ST O'Sullivan, 28 Rossbrook, Model Farm Road, Cork, Ireland

- 1 Vassallo M, Rana Z, Allen S. Pituitary apoplexy after stimulation tests. *Postgrad Med J* 1994; 70: 444–5.
- 2 Shapiro LM. Pituitary apoplexy following coronary artery bypass surgery. *J Surg Oncol* 1990; 44: 66–8.
- 3 Yahagi N, Nishikawa A, Matsui S, Komoda Y, Sai Y, Amakata Y. Pituitary apoplexy following cholecystectomy. *Anaesthesia* 1992; 47: 234–6.
- 4 Slogoff S, Girgis KZ, Keats AS. Etiologic factors in neuropsychiatric complications associated with cardiopulmonary bypass. *Anesth Analg* 1982; 61: 903–11.

Guidelines for the clinical use and dispensing of thalidomide

Sir,
Formal guidelines for the use of thalidomide are welcome and long overdue. Thalidomide is rightfully regarded as a potentially dangerous drug but we recognise that it has a role in the treatment of certain rare and severe skin diseases that have failed to respond to all other available therapies.

In our Institute, over a three-year period, 28 patients were treated with thalidomide (box). Patients' ages ranged from 7–68 years; 21 were female and seven male. The dose range of thalidomide was wide, varying from 50 mg on alternate days to 300 mg daily. Duration of treatment ranged from three weeks to 66 months, but the patients with the photosensitivity disorder, actinic prurigo, usually had defined courses lasting 3–6 months in the spring and summer seasons.

Side-effects necessitating discontinuation of treatment occurred in 11 of the 28 patients. Of these, eight had symptoms of possible sensory neuropathy and three had abnormal electrophysiological studies (so-called reduced SNAP). Paraesthesiae persisted for some months after cessation of therapy. The

Thalidomide indications

severe actinic prurigo	16
nodular prurigo	4
lupus erythematosus	4
Behçet's disease	1
major aphthosis	1
mucosal lichen planus	1
epidermolysis bullosa	1

occurrence of neuropathy was not related to the dose or duration of treatment and seemed less likely to occur in the actinic prurigo patients. One patient with discoid lupus erythematosus developed unequivocal neuropathy after three weeks (total dose = 2 g) while another with lupus erythematosus profundus had no evidence of it after 28 months (total dose = 174 g).

Of the 14 potentially fertile female patients, four were thought not to be at risk of pregnancy, because they were not sexually active or their partner was sterilised. The others were verbally counselled regarding the risks (six signed a consent form acknowledging their understanding of the risk of teratogenicity). There were no pregnancies during therapy or within the three-month period after its cessation. Apart from the drug dispensing details, the containers were labelled with a warning that it should only be taken by the named patient.

Following this review, we drew up guidelines and a consent form for the use of thalidomide in our department similar to those suggested by Powell and Gardner-Medwin,¹ and we congratulate them on drawing these matters to the attention of a wider audience.

MR JUDGE
A KOBZA-BLACK
JLM HAWK
*St John's Institute of Dermatology
St Thomas' Hospital,
London SE1 7EH, UK*

- 1 Powell RJ, Gardner-Medwin JMM. Guideline for clinical use and dispensing of thalidomide. *Postgrad Med J* 1994; 70: 901–4.

Changing clinical spectrum of liver abscess

Sir,
It is perhaps misleading to suggest, as Yinnon *et al* have done,¹ that ultrasonography and computed tomography (CT) possess comparable sensitivity in the diagnosis of liver abscess. The retrospective analysis by Rubinson *et al* suggests that CT scanning has a sensitivity of 95–100% *vs* a sensitivity of 85–95% for ultrasonography.² Furthermore, multiple liver abscesses are more easily detected by CT scanning than by ultrasonography.^{3,4} CT scanning has the additional advantage of depicting the anatomical relationships with other abdominal viscera more accurately.⁵ Because of the superior specificity of ultrasonography, however,⁵ the complementary nature of these two imaging

Post-operative pituitary apoplexy

- cardiopulmonary bypass surgery
- cholecystectomy
- salpingectomy