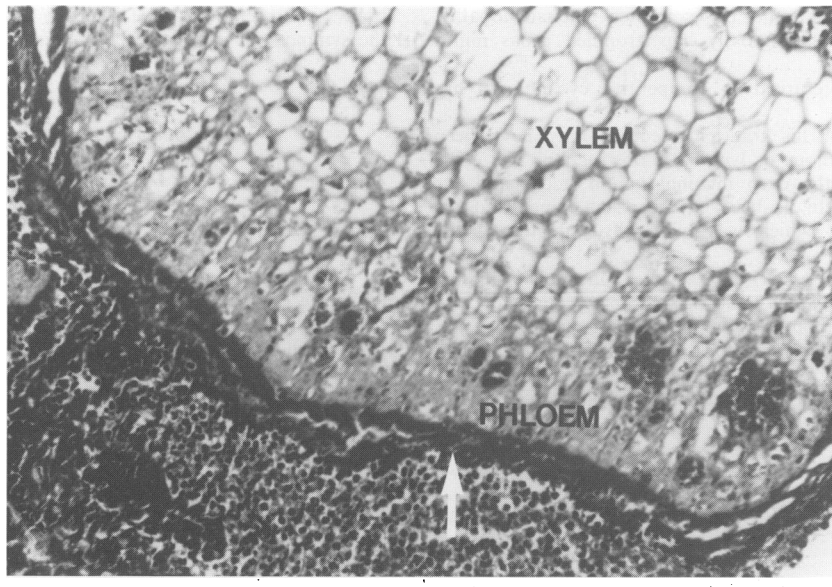

Figure 1 High power photomicrograph in which the plant wall is clearly seen (arrow). Xylem and phloem elements are present. Neutrophils and macrophages surround the plant. Magnification ×100. Haematoxylin and eosin.

association of a scalp lesion and neurological signs should prompt urgent neuroradiological investigations, no matter how superficial the former may look. Second, in dermatitis artefacta one should always remember that 'anything is possible'.[3]

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Bilateral pelvic masses in a longdistance cyclist

Sir,

A 37 year old man presented with a two week history of bilateral pitting oedema of the legs. He had previously given up longdistance running due to 'jogger's trots' and had taken up competitive cycling. Just prior to presentation he had competed in a 150 km cycling race.

Physical examination showed a very fit man with mild ankle oedema. Blood count, ESR, urinalysis, serum biochemistry and chest radiograph were normal. Computed tomographic (CT) scan of the abdomen was reported as showing bilateral massive pelvic lymphadenopathy (Figure 1).

Because of the patient's clinical history and wellbeing and the symmetrical nature of the 'pelvic lymphadenopathy', a lymphangiogram was performed; this showed no evidence of lymphadenopathy. On review of the CT scans,

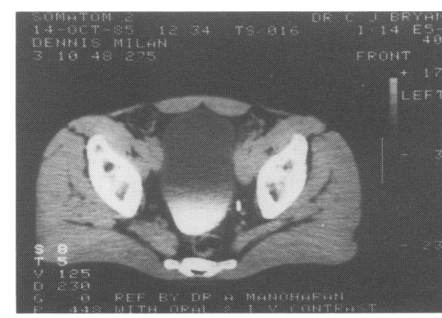

Figure 1 Computed tomographic scan with oral and I.V. contrast showing bilateral, symmetrical pelvic 'masses' impinging on the urinary bladder.

it was realised that the 'pelvic masses/lymphadenopathy' were no more than grossly hypertrophied psoas minor muscles.

The patient returned to competitive cycling and has remained well.

The cause of his transient oedema may have been secondary to venous or lymphatic obstruction. The efferent vessels of the deep inguinal lymph nodes and the external iliac vein lie between the psoas minor and the urinary bladder which was bilaterally indented in the patient.

It is of interest to note that he had previously had 'jogger's trots' which has been recently attributed to passive colonic compression by the hypertrophied psoas muscles;[1] and that his psoas minor was now hypertrophied out of proportion with the psoas major probably because of his switch from running to cycling. The clue to proper interpretation of CT scans in such 'patients' lies in the symmetrical nature of the 'masses'.

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