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Letters to the Editor

Sleep apnoea syndrome – a too frequent misdiagnosis

Sir,

A 45 year old woman, experienced progressive deterioration of memory, loss of concentration, anxiety, tiredness, insomnia with nightmares and arousals characterized by unexplained fear and, rarely, thoughts of suicide. She developed a profound depression, so that 2 months later in November 1987 she decided to discontinue her job in the stock market. A diagnosis of menopausal-related anxious depressive syndrome was made by her general practitioner and confirmed by two psychiatrists. However neither ethynyl oestradiol, imipramine or diazepam relieved her symptoms. From January to April 1988 two further therapeutic trials with trazodone and tranylcypromine were unsuccessful. In January 1988, she consulted an internist who noticed that her voice had a peculiar timbre, consistent with upper airway obstruction. Examination revealed narrowing of the oropharyngeal airway by excessive folds of the soft palate: fibreoptic examination excluded any coexistent hypopharyngeal or laryngeal obstruction. Polysomnography demonstrated a typical pattern of obstructive apnoea,[1] with 49 obstructive episodes per hour characterized by arterial oxygen desaturation up to 35%. The most severe of these episodes were terminated by sudden arousal and the presenting symptoms. Application of continuous positive airway pressure[2] resulted in a dramatic decrease of both frequency and severity of desaturation episodes. The patient recovered her sense of well-being and resumed her job. Uvulopalatopharyngoplasty[3] resolved her problem definitively.

In the last year, we have observed three further cases of misdiagnosed sleep apnoea syndrome with various clinical presentations. Unfortunately, medical textbooks do not reflect the increasing interest in this subject in medical journals. Thus only half a page is given up to the sleep apnoea syndrome in the last edition of probably the most authoritative textbook of internal medicine.[4] Owing to the high prevalence of this syndrome in the general population, both general practitioners and specialists should become familiar with its multiform clinical presentation.

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Psoas abscess in a drug addict

Sir,

Common sites of abscesses from heroin abuse include the antecubital fossa, deltoid region of the arm and the buttock.[1] As most intravenous drug addicts choose veins in the antecubital fossa as the preferred route of administration, abscesses described are usually in the upper extremities. They are found at the puncture site, along fascial planes when necrotizing fasciitis sets in, or elsewhere as metastatic abscesses.[2] When the veins of the upper extremities are used up, the femoral region provides an alternative venous access. However psoas abscess formation in an addict using femoral venepuncture has not been reported.

A 52 year old heroin drug addict was admitted with a 2 cm diameter subcutaneous left groin abscess which was incised and drained. *Staphylococcus aureus* was cultured from the pus. He had been an addict for 30 years and had changed to femoral venepuncture when his upper limb veins were no longer usable. Systemic antibiotics were considered unnecessary and he was discharged. He returned for wound dressing daily as an outpatient. The patient was readmitted 25 days later with a history of increasing right iliac fossa pain for one week. Signs of focal peritonitis in the right lower quadrant of the abdomen with psoas muscle irritation were present. A temperature of 37.8°C and leucocytosis of $14.3 \times 10^9/l$ were recorded. Plain abdominal X-ray revealed blurred psoas shadows on both sides. Because acute appendicitis could not be excluded, the right iliac fossa was explored through a grid-iron incision. The appendix was confirmed to be normal. A huge abscess was palpable in mid right psoas. The fascia over the lower third of the right psoas muscle was rendered hard by inflammation. Appendicectomy was performed and the peritoneum closed. The abscess was explored extraperitoneally and 200 ml of pus was drained. A tube drain was left in the abscess cavity. The wound was not closed because of marked contamination. The same strain of *S. aureus* was again cultured from the pus. The drain was removed after 7 days when discharge was minimal and the wound healed by second intention.

The psoas abscess of this patient appears to be the result of necrotizing fasciitis along the psoas fascia rather than metastatic abscess because inflammation was demonstrable from the groin upwards. It is also of interest because it mimicked an intra-abdominal condition.

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