

therapy, she made a good recovery, though still had some permanent disability.

Spontaneous dissection of the carotid artery was first described in 1959,³ though traumatic dissection has been known for longer.¹ Common presenting features are abrupt unilateral pain in the neck, face or head, hemiparesis, ipsilateral Horner's syndrome, pulsatile tinnitus, and bruit. Angiographically there is irregular narrowing of the cervical carotid artery ('string sign'). Although the overall prognosis is good,^{1,4} diagnosis is important as outcome is improved with anticoagulation. In our patient, coughing appears to have precipitated the dissection. The considerable diagnostic delay was largely due to inadequate history-taking, and the possibility of carotid dissection not being considered.

Carotid dissection is probably underdiagnosed, and may indeed be one of the commonest causes of stroke in young patients.⁵ The condition is well recognized by neurologists, but often not by physicians, even though it is these latter doctors who deal with most stroke disease. Carotid artery dissection should therefore be suspected especially in younger patients presenting with transient cerebral ischaemia or stroke, associated with unilateral facial, neck pain or headaches. A history of even trivial trauma such as coughing, vomiting or sneezing should further alert the physician, as should the lack of other obvious causes.

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Rare presentation of gastric leiomyosarcoma

Sir,
Gastric leiomyosarcomas are rare tumours and account for 1-3% of all gastric cancers.¹ The presenting features are non-specific and these tumours often present at an

advanced stage.² We describe a patient with gastric leiomyosarcoma whose main presenting feature was a pyrexia of unknown origin.

A 47 year old male presented with a 2-week history of left sided neck pain, tiredness, headaches, sweating and rigors. His temperature on admission was 40.5°C and physical examination demonstrated no obvious focus of infection. The positive findings on routine blood tests were mild anaemia (haemoglobin 10.8 g/dl), a platelet count of $638 \times 10^9/l$, a white cell count of $13.5 \times 10^9/l$ (70% polys), and an ESR of 54 mm/h. Chest X-ray revealed consolidation in the left lower lobe with slight elevation of the diaphragm. A computed tomographic (CT) scan of the brain was normal, as was lumbar puncture. Blood cultures, however, grew an anaerobic streptococcus and the patient was commenced on intravenous erythromycin. His temperature settled and he was discharged home 3 weeks later.

He was admitted 6 days later with a pyrexia, sweating and rigors. Blood cultures were negative on this occasion. Abdominal examination was unremarkable but ultrasound revealed a mass in the left hypochondrium. CT scan confirmed the presence of a 12 cm mass lying above and medial to the spleen extending to the left hemidiaphragm. Ultrasound guided needle biopsy of the left upper quadrant mass revealed clusters of spindle-shaped cells suspicious of malignancy.

A laparotomy was performed and revealed a large inflammatory mass in the left upper quadrant. This was adherent to the dome of the diaphragm, the spleen, the tail of the pancreas and originated from the fundus of the stomach. The mass was excised with the attached stomach wall, the tail of the pancreas and the spleen. Histology showed that the mass had a necrotic centre with malignant spindle-shaped cells, diagnostic of gastric leiomyosarcoma. His post-operative recovery was complicated by a left basal pneumonia which settled on antibiotic therapy. At discharge he was afebrile and was well at follow up 4 weeks later.

This is the first reported case of a gastric leiomyosarcoma presented with a pyrexia of unknown origin.³ The commonest presenting features in patients with gastric leiomyosarcoma are gastrointestinal bleeding, abdominal mass and weight loss. Septicaemia may complicate peptic ulceration due to venous invasion and it is possible that the same mechanism was responsible for the pyrexia in the present case.⁴

The initial presenting symptoms in this case were non-specific and did not implicate the gastrointestinal tract. This resulted in a delay in diagnosis. Preoperative diagnosis is unusual and histological confirmation of gastric leiomyosarcoma was made in only 8% of cases in a recent review.³ We suggest that a diagnosis of gastric leiomyosarcoma should be considered in patients with a Gram-positive septicaemia and a solid mass in the left upper quadrant.

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Mitral valve prolapse – do all patients need an echocardiogram?

Sir,

Mitral valve prolapse (MVP) is one of the commonest cardiac abnormalities and yet confusion still exists as to its diagnostic criteria.¹ The diagnosis can be made by several methods. Clinical criteria include auscultation of midsystolic clicks and late systolic murmurs. Echocardiography has played an increasingly important role in diagnosis and is currently the most commonly used method of diagnosis because it is non-invasive and, if strict criteria are followed,^{2,3} accurate. However, in developing countries, echocardiographic facilities are not easily available and are relatively expensive when compared with clinical methods.

The purpose of this study was to assess the usefulness of performing echocardiographic examinations on patients with a clinical diagnosis of MVP.

Thirty six consecutive outpatients (male: 10) had been referred for an echocardiogram from the outpatient clinics (non-cardiological) of the University Hospital, Kuala Lumpur, with a clinical diagnosis of probable or definite mitral valve prolapse. By the nature of this study, referring doctors were unaware that such a study was taking place and hence, no uniform diagnostic criteria were used. Their ages ranged from 13–65 years (mean 29.3 years).

All patients underwent a Doppler echocardiogram examination (Toshiba colour Doppler ultrasonograph SH 65 A). Interpretation of the examination was based on established criteria.^{3,4} Mitral valve prolapse was deemed present if it was detected on at least 2 views, one of which included the parasternal long axis view.² Statistical analysis was performed using the chi-square test.

Of the 36 patients, 24 had a clinical diagnosis of definite MVP while 12 had a clinical diagnosis of probable MVP. In the former group, 12 patients (50%) had MVP on echocardiogram and in the latter group, 7 patients (58.3%) had MVP. There was no significant difference in prevalence of MVP between patients with a clinical diagnosis of definite or probable MVP.

It is well known that prevalence rates of MVP based on auscultatory criteria vary depending on the examiner's skill.¹ However, it cannot be expected that all patients in the community will be screened by a skilled cardiologist. The question therefore arises among doctors concerned with health economics, as to whether or not all patients with a possibility of MVP should be submitted to an echocardiographic examination.

The author would submit that, based on this study, echocardiography is justified. Specificity of auscultatory criteria was low. The pool of referring doctors was not preselected and these doctors referred patients in the course of their usual clinical practice. If an echocardiogram was not available, nearly half the patients would have been misdiagnosed as having MVP with its many medical, social and financial implications.

Echocardiography is currently the most widely accepted diagnostic test for MVP and is used to predict prognosis and plan further management.^{2,5} It would not be unreasonable to suggest that this non-invasive test be made freely available to all patients when a diagnosis of MVP is suspected clinically.

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Myasthenia gravis and reversible pyramidal tract signs in a thyrotoxic patient

Sir,

A 33 year old Indian male was admitted with a 3 year history of easy fatigability, tremulousness, weight loss and heat intolerance. Six months previously he had developed protrusion of the eyes, ptosis and diplopia. Later he noticed weakness in both lower limbs, predominantly distal and especially after exertion, which spread to involve the upper limbs, muscles of mastication, swallowing and also the bladder for he started having hesitancy of micturition.

Physical examination revealed bilateral ptosis with restricted ocular movements in all quadrants, with normal vision and fundus, weakness of facial and limb muscles (distal more than proximal), normal tone, generalized hyperreflexia and absent abdominals, cremasterics and bilateral extensor plantar responses.

His neostigmine test and electromyography confirmed the diagnosis of myasthenia gravis. His chest X-ray was normal but computed tomographic scan showed thymic