Letters to the Editor

Lymphoma presenting with Addison’s disease

Sir,

Several large autopsy series have shown that the adrenal glands are commonly involved in carcinomatosis.¹ Metastatic cancer presenting with Addison’s disease is, however, rare.² In one series, 5 of 15 patients with bilateral adrenal involvement at computed tomography (CT) had subnormal Synacthen tests.³ In another, 4 of 21 patients with adrenal masses at CT developed Addison’s disease at some point in their illness.⁴ In another, 7 of 173 cases of lymphoma had adrenal masses. Of these, 3 were detected at presentation. Three were bilateral, of which 2 were detected at presentation and the third at relapse.³ In another, 7 of 257 cases of non-Hodgkin’s lymphoma had adrenal masses, of which 3 were bilateral. In these 7 the other organs involved were: none (3); kidneys (2); gut (1); kidneys, gut and pancreas (1); and retroperitoneal nodes (6).³ Cases of lymphoma presenting with Addison’s disease due to adrenal involvement, but without evidence of dissemination, are very rare.⁵–¹⁰ We present one such case.

A 68 year old white male presented with a 9 month history of weakness, faintness, anorexia, dysgeusia and weight loss of 20 kg. The skin was pigmented on light-exposed areas, the palmar creases were dark and the nail beds pale. The pulse was 72 beats/min and the blood pressure 145/90 mmHg with no postural drop. There were no other abnormalities to find. There was a mild normochromic, normocytic anaemia. The erythrocyte sedimentation rate was 42 mm in the first hour. Plasma sodium was 132 mmol/l, potassium 4.2 mmol/l, urea 12.3 mmol/l and creatinine 190 μmol/l. Liver function tests and calcium were normal. The chest X-ray was clear. Pre-prandial blood sugar levels were in the range 1.9 to 3.8 mmol/l. The serum cortisol at midnight was 178 nmol/l, and at 9 a.m. 190 nmol/l. A short Synacthen test using 250 μg gave these results: serum cortisol at 0 min 199 nmol/l, at 20 min 203 nmol/l; and at 60 min 217 nmol/l. CT showed a smooth mass 10 cm across in the position of the right adrenal, and another a similar 8 cm across on the left. There were no other abnormalities seen in the abdomen or chest. A percutaneous needle biopsy of the right adrenal was done under ultrasound guidance. Microscopy showed tissue infiltrated by a high grade lymphoma of centroblastic type. Immunocytochemical studies confirmed a B cell immunotype. Trehpine biopsy of iliac crest revealed normal bone marrow. Serum immunoglobulins were normal.

Treatment comprised saline, steroid replacement and entry into a trial of the chemotherapy regimen CAPOMET, in which drugs are given in pairs at weekly intervals; cyclophosphamide with Adriamycin, prednisolone with vincristine, methotrexate with folinic acid rescue and etoposide. His health improved. Four months later CT showed considerable reduction in size of both adrenal masses and no other deposits. He then received radiotherapy to both adrenal beds. A further scan at 9 months showed no change in size of the adrenal masses, but multiple deposits in the lungs.

The commonest cause of primary adrenal failure and shrunken adrenals is autoimmune adrenalitis. The same clinical picture with adrenal masses is nowadays most commonly due to carcinomatous spread. Our case emphasizes the importance of obtaining tissue from patients such as these, where no primary lesion is apparent, as occasionally a treatable lymphoma will be found.

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References

Herpes simplex encephalitis without CSF leucocytosis

Sir,

Herpes simplex encephalitis (HSE) must be considered in the diagnosis of any acute encephalopathy, particularly if a fever or focal signs are present. Examination of the cerebrospinal fluid (CSF) is particularly important; a lymphocytic pleocytosis is a nearly constant feature of HSE¹ and strongly supports the diagnosis. Rare instances of HSE without a CSF pleocytosis have been explained by examination of the CSF at too early a stage of the illness.² However, we have observed a case of proven HSE in which no CSF leucocytosis was observed even at an advanced stage.

A 65 year old diabetic woman presented with a 2 week history of malaise and progressive sensory disturbance of the right arm. For 5 days there had been increasing confusion, drowsiness, right-sided limb weakness and involuntary jerking of the right arm. On examination,