Letters to the Editor

Oxidative stress in the development of diabetes during hyperthyroidism

Sir,

Elevated fasting plasma glucose levels and impaired glucose tolerance are common and observed as the most significant consequences of thyrotoxicosis. The prevalence of clinical diabetes mellitus is also increased in thyrotoxicosis.1 The diabetogenic/oxidative stress of thyrotoxicosis has variously been attributed to an increased rate of glucose absorption from the gastrointestinal tract, a decreased in the ability of the liver to store glucose as glycogen, increased liver glycogenogenesis, impaired release of pancreatic insulin, and to increased peripheral insulin resistance, as well as to a decreased plasma insulin half-life.1,2 Some reports have linked both hyperthyroidism and diabetes mellitus with underlying autoimmune mechanisms rendering cells more susceptible to damage. The development of diabetes mellitus during hyperthyroidism leads to an aggravation of both diseases, potentiating the development of complications such as ketoacidosis, and may result in increased daily insulin requirements.3 We report a patient who developed diabetes mellitus during hyperthyroidism, and suggest that increased oxidative stress during hyperthyroidism may be one of the pathogenetic abnormalities responsible for the development of diabetes.

Hyperthyroidism (toxic adenoma) was first diagnosed in a 35-year-old man at our hospital. The diagnosis was based on clinical evaluation, ultrasound scanning, and the following laboratory values: serum thyroxine 187.5 nmol/l (reference range 55–165 nmol/l), triiodothyronine 3.2 nmol/l (1.2–2.5), thyroid-stimulating hormone 0.12 mU/l (0.17–4.5 mU/l). He was prescribed propylthiouracil at a daily dose of 200 mg. Six months later he developed diabetes mellitus. On admission he was 180 cm tall (with a body mass index of 24.5 kg/m²). During the six months, he had poorly controlled diabetes mellitus with a fasting glucose level of 10.9 mmol/l while taking large doses of insulin (64 U/24 h in two daily doses). He also had an increased plasma fructosamine level of 0.28 μg protein (0.35–0.45 μg), while levels of fasting plasma triglycerides level (2.76 mmol/l), cholesterol (6.7 mmol/l) and LDL cholesterol (4.7 mmol/l) were slightly increased. The level of circulating immune complexes was almost double reference values (25.4 μU/ml vs 6–15 μU/ml), while plasma lipid peroxidation products were increased almost four-fold (38.72 μmol/ml vs 6–12 μmol/ml). The total plasma antioxidative capacity was decreased (64.6% vs 76–88% of control range), as was the level of reduced blood glutathione-GSH (0.70 μmol/ml vs 1.0–1.35 μmol/ml).

It was particularly interesting that the hyperthyroidism was accompanied by a significantly elevated level in the plasma concentration of lipid peroxidation products. It has recently been reported that levels of free radicals are increased in thyrotoxicosis, as a result of enhanced superoxide oxygen consumption as well as an increase in the activity of xanthine oxidase.3 Free oxygen radicals produced under conditions of increased oxidative stress are capable of decreasing insulin sensitivity and peripheral insulin effectiveness, as they are capable of interacting with the insulin-messenger system of NO-guanylate cyclase-cGMP.4 Glucose tolerance is dependant on the interaction of tissue sensitivity to insulin and the magnitude of pancreatic insulin secretion. Enhanced production of free oxygen radicals may also cause damage to β-cells, leading to decreased secretory potential of islet cells, which have a very low free-radical scavenging enzyme activity.1,4 These observations suggest that increased oxidative stress during hyperthyroidism is capable of promoting the onset of diabetes mellitus, favouring peripheral insulin resistance and exhaustion of β-cells. This finding could be of pathophysiological importance, not only in explaining some of the basic mechanisms behind the development of impaired glucose tolerance and diabetes during hyperthyroidism, but also in providing a rationale for the use of anti-oxidative drugs at the onset of hyperthyroidism, to prevent or decelerate the development of impaired glucose tolerance and diabetes.

R. KOVIC S. RADENKOVIĆ D. MIKIR
Endocrinology Clinic

G. KOVIC T. CVETKOVIĆ D. PAVLOVIĆ
Institute of Biochemistry, Faculty of Medicine University of Niš, Niš, Yugoslavia

Correspondence to Dr Radivoj Kovic, al Nikola Pašića 65, 18000 Niš, Yugoslavia

Accepted 16 December 1997


Methotrexate pneumonitis precipitated by NSAIDs – can fish oil help?

Sir,

We read with interest the article of Clearkin et al.1 which have methotrexate-induced pneumonitis presumably precipitated by concomitant use of diclofenac.2 Low-dose methotrexate has become a second-line treatment for patients with rheumatoid arthritis. Nonsteroidal anti-inflammatory drugs (NSAIDs) are frequently co-administered, notwithstanding the fact that such treatment in some cases leads to fatal aggravation of methotrexate toxicity. The mechanism of this is uncertain and may include either displacement of methotrexate from protein-binding sites, or an effect of NSAIDs on the kidney resulting in reduced methotrexate excretion, or both. Conflicting results have been reported with regard to safety of use of ketoprofen and naproxen with methotrexate,3 while it has been reported that flurbiprofen or piroxicam in clinically relevant doses do not affect methotrexate patients receiving low-dose methotrexate.2

Fish oil supplements have been found to reduce the need for NSAIDs in rheumatoid arthritis. Fish oils are rich sources of polyunsaturated fatty acids of the omega-3 series. Diets rich in omega-3 fatty acids appear to reduce inflammatory and immune response. Fish oils may be used in doses of 1–2 g daily without adverse effects.4 Encouraging results have also been reported on the beneficial effect of fish oils in diseases such as IgA nephropathy. We speculate that in systemic lupus erythematosus (which is also an extra-articular manifestation of rheumatoid arthritis), fish oils may also be beneficial. Clinical studies investigating the effects of fish oils in the prevention and treatment of cardiovascular diseases are beginning to emerge; it is likely that they can minimise the cardiovascular manifestation of rheumatoid arthritis.

We therefore suggest that, in patients with rheumatoid arthritis on low dose methotrexate who require NSAIDs, flurbiprofen or piroxicam may be preferred; further, the addition of fish oil supplements to this regimen may effectively reduce the dose of NSAIDs required and thereby minimise the additive effects of methotrexate, including pneumonitis. This regimen may also have a beneficial effect on many of the extra-articular manifestations of rheumatoid arthritis. Hence, we feel that a modified therapeutic regimen of low-dose methotrexate and low-dose flurbiprofen/piroxicam with fish oil supplementation, deserves a trial in rheumatoid arthritis.

Fish oil has constraints like higher cost and contains cholesterol. Therefore, alternate vegetable sources of omega-3 fatty acids, such as walnuts, wheat germ soybean lecithin, tofu, common beans, butternuts and seaweed, all of which are cost-effective and without cholesterol,1 could also be included in such a trial.

M THULUSIMANI
Department of Clinical Pharmacology, Madhava Gandhi Dental College and Hospital, Pondicherry 605001, India

S RAMASWAMY
Department of Clinical Pharmacology, Jambuwali Institute of Medical Education and Research, Pondicherry-605006, India

Accepted 19 November 1997

Sarcoidosis–lymphoma syndrome in a woman with acromegaly

Sir,

We read the article by Romero et al on sarcoidosis–lymphoma syndrome with great interest. We would like to report a case of a woman with acromegaly in whom non-Hodgkin’s lymphoma was diagnosed 6 years after sarcoidosis.

In 1979, a 38-year-old woman was admitted to our hospital with complaints of irregular fever and cervical lymphadenopathy. She had a history of active acromegaly which had been treated by local pituitary 19Co irradiation (3340 cGy in 20 fractions) two years earlier. At presentation she was in a good clinical condition. Physical examination revealed bilateral, movable cervical and supraclavicular enlarged lymph nodes without hepatosplenomegaly. Chest X-ray was normal. Lymphography showed retroperitoneal and bilateral inguinal lymphadenopathy. Full blood counts were normal; the erythrocyte sedimentation rate was 35 mm/h. After histological examination of two cervical lymph nodes, a diagnosis of sarcoidosis was established. She was put on 45 mg of prednisolone daily. After symptoms subsided, steroid therapy was continued for one year.

She remained asymptomatic for a follow-up period of 5 years. In 1986 she was again admitted to hospital with fever, weight loss, goitre and cervical lymphadenopathy. Her symptoms did not subside on 6 months ambulatory treatment with steroids. Other clinical examination findings were hilar enlargement, revealed on chest X-ray, and lymphatic infiltration of bone marrow (up to 20%). Histological examination of the cervical node demonstrated centroblastic lymphoma. The patient received six courses of CVP chemotherapy (cyclophosphamide, vincristin and predniolone). A reduction of symptoms, including a reduction of the enlarged lymph nodes and goitre, were noted. The patient remains asymptomatic.

Brincker, in his description of so-called sarcoidosis–lymphoma syndrome, pointed to three typical features: sarcoidosis preceding lymphoma by several years, the patients are on average 10 years older than other patients with sarcoidosis, and an association with Hodgkin's lymphoma is more frequent. Our patient met two of these three criteria. She was in her forties when she developed sarcoidosis. She had received steroid treatment and developed lymphoma 6 years after the diagnosis of sarcoidosis.

The immunologic abnormalities in our patient could have been initiated by radiotherapy. This might have provoked the development of sarcoidosis. Consequently an increased mitotic activity and dysregulation of lymphocytes observed in sarcoidosis, as well as steroid therapy, contributed to the development of lymphoma. We believe that our case supports the theory of non-random association between sarcoidosis and lymphoma and the existence of sarcoidosis–lymphoma syndrome.

M. SIEKIERSKA-HELLMANN
K SWORCZAK
Division of Endocrinology, 3rd Department of Internal Medicine, Medical University of Gdańsk, Poland

Accepted 21 January 1998


Understanding scientific papers

Sir,

We would like to offer an addendum to the articles published in recent years in various journals on how to read medical literature. This addendum, a translation of some of the phrases commonly used in scientific and clinical articles, has been gleaned from various sources and we have made some modifications of our own. We hope that readers will find it both instructive and amusing.

It has long been known that... = We haven't bothered to look up the relevant literature or the original reference.

While it has not been possible to provide definite answers to these questions... = The experiment did not work out, but we figured we could at least get a publication out of it.

Typical results are shown... = Only the positive results are shown.

It is suggested/believed... = We think.

It is generally suggested/believed... = A couple of other guys think so too.

It is clear that much additional work will be required before a complete analysis of the results... = We don't understand what happened.

Unfortunately, a quantitative theory to account for the results has not yet been formulated... = No one else understands it either.

Correct within an order of magnitude... = Wrong.

It is clear... = It is not clear.

It is obvious... = We think that is the way it should be, but we cannot explain why.

RAZ GROSS
The Chaim Sheba Medical Center,
Tel Hashomer, Israel

ALAN DEROWE
Meir Hospital, Super Medical Center,
Kfar Sava, Israel

Correspondence to Raz Gross, MD, 36 King David Blvd, Tel Aviv 64237, Israel

Accepted 19 November 1997
