A 48 year old man was admitted to the emergency department because of painful swelling of his right calf that had developed gradually during the previous week. He denied cough, dyspnoea, or chest pain. He had no history of a previous thromboembolic event, local trauma, or dehydration. Six months earlier he was diagnosed as suffering from psoriatic arthritis and treated with sulphasalazine, which was stopped after two months because of drug induced hepatitis.

On physical examination he was afebrile and without dyspnoea. His lungs were clear. The left knee was mildly swollen, with a full range of motion and no clear effusion. No palpable popliteal cyst was found. His left calf was tender, swollen, with erythematous skin (fig 1). Homans’ sign was positive. Pitting oedema of the foot, maximal in the medial malleolus area, with purple discoloration, were noticed. Venous duplex scanning performed in the emergency department excluded deep vein thrombosis (DVT).

The patient was discharged and referred for further follow up in the outpatient clinic.

QUESTIONS
(1) What is the likely diagnosis?
(2) What physical examination sign was the clue for the final diagnosis?
(3) What are the diagnostic modalities you would use to confirm the diagnosis?
(4) What treatment is indicated?

Postgrad Med J 2002;78:300

Authors’ affiliations
Y Berkun, K Sade, Y Naparstek, Department of Medicine, Clinical Immunology and Allergy Unit, Hadassah University Hospital, Jerusalem, Israel

A 16 year boy, resident of Bihar, presented to the emergency department with a history of generalised weakness for one month, and bleeding from his gums for eight days. There was no history of prolonged fever, haematemesis, haematuria, or haemoptysis. The patient had not taken any drug in the recent past. On examination he had severe pallor. Examination of the cardiovascular system revealed an ejection systolic murmur in the pulmonary area. The rest of the physical examination was normal. Laboratory examination showed a haemoglobin concentration of 20 g/l and total leucocyte count of $3.1 \times 10^9/l$ with differential leucocyte count of 19% neutrophils, 78% lymphocytes, 2% monocytes, and 1% eosinophils. Platelet count was $28 \times 10^9/l$. Anaemia was normocytic normochromic. No haemoparasites were seen in bone marrow. No abnormal cells were seen. In view of pancytopenia and relative decrease of myeloid cells and megakaryocytes in bone marrow, the possibility of toxic suppression of marrow was considered.

Pancytopenia
Young male with pancytopenia: an unusual cause
R Rajput, S B Siwach, S Singh, U Singh, Meena

Answers on p 304.
QUESTIONS
(1) What is the finding on slide of bone marrow examination (fig 1)?
(2) What are the causes of pancytopenia?
(3) How will you treat this patient?
Postgrad Med J 2002;78:301
A verrucous lesion of the palm
M Vijaikumar, D M Thappa, K Karthikeyan, S Jayanthi

Answers on p 305.

An unusual case of clinicoradiological dissociation
C Mahendran, N B S Mani, S Jogai, A N Aggarwal

Answers on p 306.
A previously fit 27 year old man presented to the gastroenterologists with a three month history of tiredness. There was no history of haematemesis, but he did complain of the passage of black stools on rare occasions. On examination temperature, pulse, and blood pressure were normal. There was no lymphadenopathy. Chest and abdominal examination were normal.

Laboratory investigations revealed a picture of iron deficiency with a haemoglobin concentration of 92 g/l, mean corpuscular volume 70.5 fl, mean corpuscular haemoglobin 21.8 pg, platelets $262 \times 10^9$/l, and an erythrocyte sedimentation rate of 13 mm/hour.

Upper gastrointestinal endoscopy revealed mild gastritis. He was negative for Helicobacter pylori and distal duodenal biopsies were normal. Chest radiography and colonoscopy were normal. He then underwent a barium follow through (see fig 1).

**QUESTIONS**

1. Describe the features on the barium follow through.
2. What is the differential diagnosis?
3. What is the diagnosis?

Postgrad Med J 2002;78:303

**Authors’ affiliations**

V A Shenoy, M P N Lewis, P Preston, Department of General Surgery, Norfolk and Norwich University Hospital NHS Trust, UK

P Preston, Department of Radiology

**Figure 1** Barium follow through.