rather than elderly. Our lady of 48 years had a physical state considerably more advanced than her years and not typical of others of her age. Although our unit has a paediatric interest, we continue to have a practice involving all ages, and two of the authors consider themselves 'middle aged'.

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References

Treatment of Raynaud’s phenomenon with large doses of triiodothyronine: a pilot study

Sir, The use of triiodothyronine (T3) in doses sufficient to induce a hyperthyroid state has been advocated as a novel form of treatment for Raynaud’s phenomenon.1 An extensive search of the English language literature failed to uncover a single descriptive account of the use of such therapy, however. This apparent lack of recorded data prompted us to report our experience with T3 in the treatment of Raynaud’s phenomenon accompanying various connective tissue diseases.

The study group comprised nine subjects, this being the total number of patients with Raynaud’s phenomenon under our care when the trial was begun and who had no clinical evidence of cardiovascular disease and were not taking vasoactive drugs. A summary of the relevant personal characteristics and clinical features of these patients is presented in Table 1. All were non-smokers and none consumed alcohol.

The trial was open and uncontrolled. At the time of enrolment, and after giving informed consent, each patient was asked to record the average number of attacks they were currently experiencing each week and the average duration of the attacks. For duration, figures of 5, 10, 15, 20, or more than 20 minutes were offered as examples. Measurements of (sitting) blood pressure and pulse rate were also recorded. Triiodothyronine was prescribed at a dosage of 80 μg/day (in accordance with recommendations¹), and each patient was reassessed at intervals of four weeks for the next 12 weeks. At every visit the patients were questioned about the development of side effects of therapy; specifically, the occurrence of nervousness, palpitations, or heat intolerance. Also, the blood pressure and pulse rate were measured. Compliance was assessed by regular estimations of a battery of thyroid function tests.

All the patients experienced remission of their Raynaud’s symptoms (Table 1). During the trial period the mean minimum daily temperature fell from 12-3 to 4-6°C (Pretoria Weather Bureau). One patient (No 3) experienced heat intolerance and palpitations during the seventh week of therapy, which resolved when the dosage was decreased to 40 μg/day. A further patient (No 4) reported episodic palpitations at the first follow up visit; these remitted after a dosage reduction to 60 μg/day. Neither patient experienced a relapse while taking the lower dosage of T3.

### Table 1 Patient characteristics, clinical features, and responses to therapy

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Race</th>
<th>Time since onset of symptoms (years)</th>
<th>Before treatment</th>
<th>After 12 weeks' treatment</th>
<th>Underlying disease</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number of attacks (per week)</td>
<td>Average duration of attack (min)</td>
<td>Number of attacks (per week)</td>
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<td>1</td>
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<td>F</td>
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<td>4</td>
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<td>44</td>
<td>F</td>
<td>B</td>
<td>3</td>
<td>21</td>
<td>20</td>
<td>7*</td>
</tr>
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<td>35</td>
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<td>37</td>
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</tbody>
</table>

B=black; W=white; SLE=systemic lupus erythematosus; SS=systemic sclerosis; OS=overlap syndrome; RA=rheumatoid arthritis.

*No longer painful.
Dermatomyositis/polymyositis and carcinoma of the ampulla of Vater

Sir., The association of dermatomyositis/polymyositis (DM/PM) with malignancy has been recorded in several reports and reviews. Although cases of carcinoma of the pancreas and dermatomyositis have been reported, we have found no report of carcinoma of the ampulla of Vater with DM/PM. We wish to report such an association.

A 62 year old woman was admitted to hospital because of fever and chills. Two weeks before admission she developed increasing fatigue, persistent sore throat with chills and fever reaching 39-4°C, night sweats, malaise, weight loss, pain in her left knee, and a morbilliform rash which in five days assumed an urticarial appearance. On admission, a painful tender left knee and oedematous dusky erythema on the periobital region were noticed. Her temperature was 39°C, pulse 95 beats/min, and the blood pressure 125/80 mmHg. The rest of the systematic examination was unremarkable. A tentative clinical diagnosis of dermatomyositis was made.

Laboratory investigations showed erythrocyte sedimentation rate 100 mm/h, leucocytes 13-8x10⁹/l with a shift to the left (total granulocytes 90% and lymphocytes 10%), and packed cell volume 40%. Alkaline phosphatase was more than 200 SIU (normal<75 SIU). Serum aspartate transaminase 126 U/l (normal<27 U/l), serum alanine transaminase 117 U/l (normal<30 U/l), lact dehydrogenase 290 U/l (normal<290 U/l), and γ-glutamyl transferase 224 U/l (normal<30 U/l). The following were normal or negative: renal function studies, bilirubin, hepatitis B surface antigen, heterophil agglutinins, creatine phosphokinase, aldolase, amylase, thyroid function tests, rheumatoid factor, antinuclear antibodies, antiphospholipid antibodies, smooth muscle antibodies, serum complement levels, cultures from throat, urine, and blood, tuberculin skin test, stool specimen, chest x rays, electrocardiogram, electromyogram (EMG), upper gastrointestinal study, intravenous pressure, ultrasonographic study, and the computed tomographic scan of the abdomen. A muscle biopsy showed typical changes of fragmented and degenerated muscle fibres in a background of fibrous tissue heavily infiltrated by leucocytes (Fig. 1).

Three weeks later pyrexia continued and the patient developed jaundice with pruritus and ascites. Her condition deteriorated, she had a massive haematemesis, and died. The postmortem examination showed an anaplastic adenocarcinoma of the ampulla of Vater (diameter 1-5 cm). Liver histology showed acute cholestasis. Pancreas and spleen were normal. No metastases or other primary tumours were found.

This case represents an example of DM/PM satisfying the proposed criteria.¹ The patient developed the characteristic skin findings of dermatomyositis with mainly the cutaneous leucocytoclastic vasculitic lesions, a rare manifestation of DM/PM.² Muscle enzymes and EMG were normal. Other authors have also reported cases without EMG or muscle enzyme changes, but with characteristic histological changes of polymyositis.³ In a recent review²

References


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P H Dessein and R F Gledhill

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