Dosage. In all patients, blood pressure, pulse pressure, and pulse rate remained essentially unchanged and thyroid function tests were confirmatory of drug compliance.

The very nature of this trial demands that the results be interpreted with caution. Nonetheless, certain observations lead us to believe that therapy with T3 was the factor responsible for the remissions experienced by our patients. In the first place, every one of them described a substantial, if not dramatic, improvement in their condition. Furthermore, this improvement occurred during the winter months when attacks would be expected to be most frequent and severe. Indeed, one patient (No 1) spontaneously commented that ‘this was the best winter she could remember’. Finally, there was coexistent biochemical evidence of strict compliance.

Our study was not designed to investigate how a T3 induced hyperthyroid state may relieve the symptoms of Raynaud’s phenomenon, and we are therefore not in a position to comment critically on the proposed mechanism—namely, thermoregulation reflex vasodilatation in consequence of resultant hypermetabolism.1 We should stress, however, that four of our patients had systemic sclerosis, a disease in which blood flow in the dorsum of the hand is believed to depend almost entirely on arterial perfusion pressure,2 yet in none was an increase in blood pressure or pulse pressure recorded.

Large dosages of T3 were found in this study to be a highly effective treatment for Raynaud’s phenomenon and one principally free from side effects. Whether such therapy confers advantages over more established remedies1 3-6 awaits the necessary, relevant comparisons in a double blind fashion.

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1Department of Internal Medicine and P H M C Desein1
2Division of Neurology, R F Gledhill2 *
Department of Internal Medicine, Pretoria and Kafafong Hospital,
Pretoria, South Africa
* Correspondence to Professor R F Gledhill, Kafafong Hospital,
Private Bag X396, Pretoria, South Africa.

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Effect of the calcium channel blocker nifedipine on Raynaud’s

Correspondence

Dermatomyositis/polymyositis and carcinoma of the ampulla
of Vater

Sur., 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 periorbital region were noticed.
Her temperature was 39°C, pulse 95 beats/min, and
the blood pressure 125/80 mmHg. The rest of the
systemic examination was unremarkable. A tentative clinical
diagnosis of dermatomyositis was made.

Laboratory investigations showed erythrocyte sedi-
mentation rate 100 mm/h, leucocytes 13-8×109/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 aspar-
tate transaminase 126 U/l (normal<27 U/l), serum alanine
transaminase 117 U/l (normal<50 U/l), lactic dehydro-
genase 290 U/l (normal<290 U/l), and γ-glutamyl trans-
ferase 224 U/l (normal<50 U/l). The following were
normal or negative: renal function studies, bilirubin,
hepatitis B surface antigen, heterophile agglutinins, creatine
phosphokinase, aldolase, amylase, thyroid function tests,
rheumatoid factor, antinuclear antibodies, antimitochond-
rial antibodies, smooth muscle antibodies, serum comple-
ment levels, cultures from throat, urine, and blood,
tuberculin skin test, stool specimen, chest x rays, electro-
cardiogram, electromyogram (EMG), upper gastrointes-
tinal 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 con-
dition 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. Pan-
creas 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 charac-
teristic skin findings of dermatomyositis with mainly the
cutaneous leucocytoclastic vasculitic lesions, a rare mani-
festation of DM/PM.2 Muscle enzymes and EMG were
normal. Other authors have also reported cases with
EMG or muscle enzyme changes, but with characteristic
histological changes of polymyositis.3 In a recent review2

4 Correspondence 945
the development of jaundice prevented us from establishing the diagnosis and undertaking radical treatment.

1st Department of Internal Medicine, Medical School of Athens, Laikon General Hospital, Goudi, Athens 115 27, Greece

G VAYOPOULOS C CONSTANTOPoulos C FOTOI PH KAKLAMANIS PH FE3AS

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