

An unusual palmoplantar pigmentation

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Figure 1 Palms showing progressive pigmentation.



Figure 2 Fingertips showing progressive pigmentation.



Figure 3 Discoloration of sclerae.

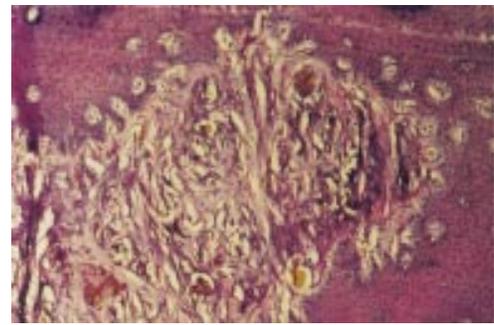


Figure 4 Histopathology of the skin lesion.

A 60 year old man had asymptomatic progressive pigmentation of the palms (fig 1), fingertips (fig 2), and soles for the last 20 years. Besides this, he had discoloration of his sclerae (fig 3). He was well but for low backache and joint pains of a few months' duration. Histopathological examination of the skin lesion was diagnostic (fig 4).

Questions

- (1) What is your diagnosis?
- (2) What are the bedside tests by which you can confirm your diagnosis?
- (3) What are the complications of this disease?

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An unusual cause of tremor in an elderly man

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Answers on p 277.

A 70 year old man presented with a two day history of coarse tremors of the head and upper limbs. The tremor was evident at rest and it became more obvious on movement. There were no symptoms of hyperthyroidism or history of a similar problem in the past. Apart from slight low back pain, he had been in good health. His urinary and bowel habits were normal. He denied taking any drugs. He was a non-smoker and a teetotaler.

On examination, the patient appeared pale. Coarse tremors of the head and upper limbs were evident at rest. The tremor of the head

consisted of vertical head nodding. The upper limb tremor was markedly accentuated during the finger-nose test and mildly accentuated by holding the arms outstretched parallel to the floor. Neurological examination otherwise showed no abnormality. There was mild prostatic enlargement noted on digital rectal examination. Chest and abdomen examination was unremarkable.

The haemoglobin concentration was 86 g/l with normal red cell indices, white cell count $2.3 \times 10^9/l$, and platelet count $88 \times 10^9/l$. Microscopic examination of the peripheral

blood did not reveal leucoerythroblastosis. The erythrocyte sedimentation rate was 102 mm in the first hour. Bone profile was recorded as calcium 2.9 mmol/l (normal range 2.2–2.6), phosphorus 1.2 mmol/l (0.8–1.4), and alkaline phosphatase 678 IU/l (40–120). The thyroid, renal, and liver profiles were within normal limits. The radiograph of the lumbar spine is shown in fig 1. Chest radiography and contrasted computed tomography of the brain

did not reveal any abnormality. An aspirate of the bone marrow is shown in fig 2.

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Figure 1 Radiograph of the lumbar spine showing sclerotic lesions of the lower lumbar vertebrae.

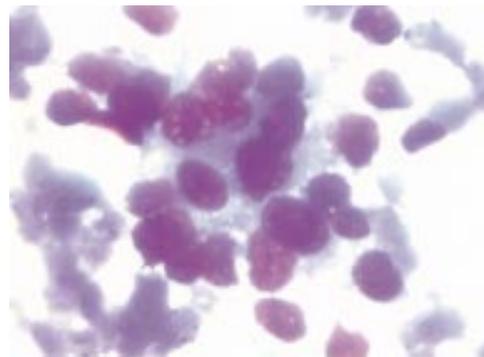


Figure 2 Aspirate of the bone marrow showing a clump of neoplastic cells infiltrating the marrow (May-Grunwald-Giemsa $\times 400$).

A 35 year man with acromegaly and neck stiffness

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A 35 year old man was referred for acromegaly by primary physicians. He complained of mild diffuse headache and easy fatiguability. Clinically he had somatic features of acromegaly and his visual acuity was reduced (6/30: left eye, 6/36 right eye) with a bitemporal superior quadrantanopia. Fundi were normal. He was normotensive and the rest of the clinical examination was normal. His basal hormone concentrations were: growth hormone (random) >25 mU/l (reference range <10), insulin like growth factor-1 level 210 nmol/l (14–45), serum alpha subunit not raised (<0.3 IU/l), prolactin 450 mU/l (60–390), luteinising hormone 8.0 U/l (2.5–9.0), follicle stimulating hormone 7.5 U/l (1.5–9.0), thyroid stimulating hormone 2.5 mU/l (0.5–4.5), free thyroxine 18 pmol/l (10–27), serum cortisol 8 am (basal) 500 nmol/l (160–565), and testosterone 20 nmol/l (10–30). Cranial contrast enhanced computed tomography demonstrated an enhancing sellar mass with suprasellar extension (fig 1). The patient was advised

to have surgery and in the interim period was put on octreotide 100 μ g subcutaneously eight

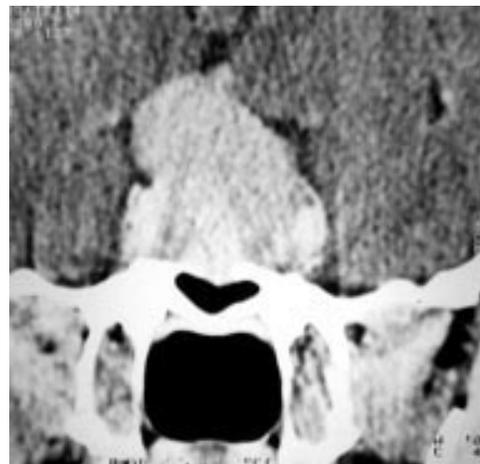


Figure 1 Computed tomogram showing an enhancing sellar mass with suprasellar extension.