A vanishing pituitary mass

Answers on p 729.

N Norman Chan

A 26 year old music composer presented with sudden onset of frontal headache followed by an episode of witnessed tonic-clonic convulsion which lasted 10 minutes. He had bitten his tongue and was confused for 20 minutes. There was no visual disturbances. He was previously in good health without a history of epilepsy or other illnesses. There was no family history of epilepsy. His alcohol intake had been 5–10 units per week for the past eight years.

The patient had a normal BM of 6.8 when checked by the ambulance crew. On arrival in the accident and emergency department, physical examination was unremarkable. The patient became more alert and his Glasgow coma scale score was 15/15. His vital signs were normal with a blood pressure of 150/84 mm Hg. There was no focal neurology or signs of meningism. Fundoscopy was normal and visual field was full on direct confrontation. Blood tests including blood glucose (5.0 mmol/l), electrolytes, liver function, and full blood count were all normal. A magnetic resonance imaging (MRI) scan of the skull was performed (fig 1, left). He did not receive any treatment and a repeat MRI scan was performed seven months later (fig 1, right).

Questions

(1) Describe the initial abnormality shown by the MRI scan (fig 1, left).
(2) What does the follow up MRI scan show (fig 1, right)?
(3) What is the most likely diagnosis?

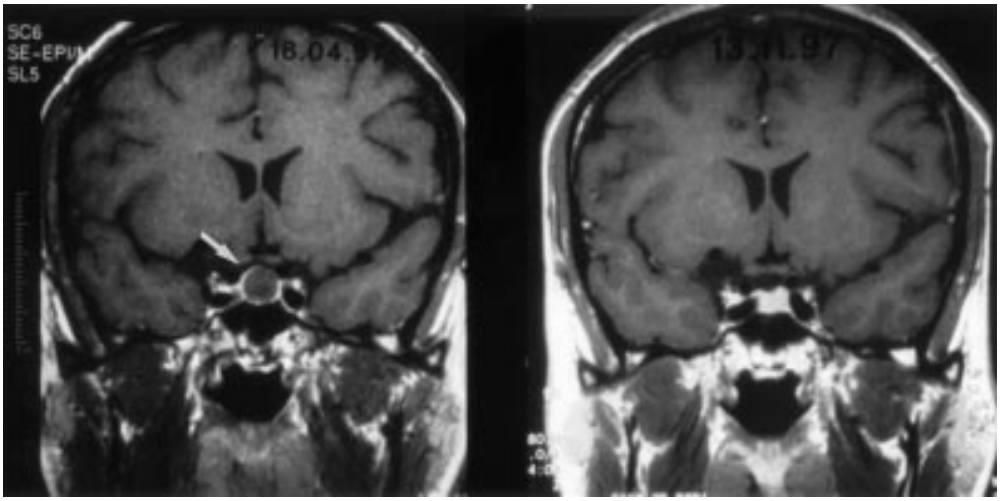

Figure 1 MRI scan on admission (left) and after seven months (right).

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Shortness of breath and diffuse chest pain

Answers on p 731.

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A 60 year old man presented to the emergency medicine department of Sher-i-Kashmir Institute of Medical Sciences, Srinagar with a one day history of shortness of breath and diffuse chest pain aggravated by breathing. He had no history of trauma, fever, altered sensorium, syncope, cough, haemoptysis, weakness, or oliguria. He had a three month history of generalised aches and pains and easy fatigability for which he had received non-steroidal anti-inflammatory drugs and was not evaluated.

Clinical examination revealed moderate pallor, tachycardia, tachypnoea, a depressed anterior chest wall with sharp indentations around the mid-clavicular line on both sides, paradoxical motion of the anterior chest wall, and diffuse bone tenderness. There was no cyanosis, oedema, lymphadenopathy, or organomegaly, and cardiovascular and neurological variables were normal.

Preliminary investigations revealed a haemoglobin concentration of 80 g/l, a normocytic normochromic peripheral smear, total leucocytic count 5.5×10^9/l, and platelet count 200×10^9/l. Erythrocyte sedimentation rate was 65 mm/hour (Wintrobe's), serum urea nitrogen 26.5 mmol/l, creatinine 194.5 μmol/l, calcium 2.9 mmol/l with a normal blood glucose, electrolytes (sodium, potassium), liver profile, alkaline phosphatase, and routine urine examination. Chest radiography revealed double fractures in the 4th, 5th, 6th, and 7th ribs and osteoporosis. Arterial blood gas analysis showed a pH of 7.45, carbon dioxide tension 4.67 kPa, oxygen tension 9.33 kPa, and bicarbonate 19 mmol/l with a saturation of 90%. Further evaluation of the patient revealed presence of Bence Jones protein in the urine (Kappa), presence of M band (quality not determined) on serum and urine electrophoresis, and serum immunoglobulin concentrations of IgG 36 g/l (normal 8–15 g/l), IgA 1.3 g/l (0.9–3.2 g/l), and IgM 0.8 g/l (0.45–1.5 g/l). A skeletal survey revealed multiple lytic lesions in the skull, diffuse osteoporosis, and compression fracture at T4, T5, L4, and L5 vertebrae. Bone marrow examination revealed 35% plasmacytosis.

Questions
(1) What is the diagnosis?
(2) What is the primary disease?
(3) What are the causes of flail chest?
(4) What are the treatment options?

Answers on p 731.

An elderly man with muscle cramps

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A 60 year old man presented to the emergency department with slurring of speech and generalised weakness associated with cramps affecting his hands. He had no medical illnesses apart from a left sided cataract removed a year ago. A 12 lead electrocardiogram was performed.

Questions
(1) What is the abnormality on the 12 lead electrocardiogram (fig 1)?
(2) What are the possible causes of the abnormality of the electrocardiogram?
(3) What is the likely diagnosis?

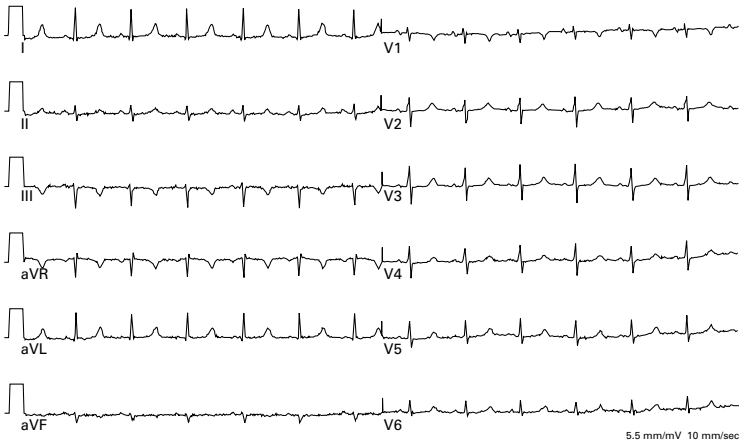

Figure 1 Electrocardiogram.