Bilateral fractures of the second metatarsals

Answers on p 805.

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Case history

A 45 year old housewife presented with bilateral painful feet. The pain was located over the metatarsals and was increased by walking and decreased on rest. The initial *x* ray was normal and the patient was sent home with advice to rest. A provisional diagnosis of metatarsalgia was made. The patient was reviewed after two months with persistent symptoms and a severe antalgic gait; *x* rays (fig 1) of both

feet revealed callus around both second metatarsals, indicating healing fractures.

Questions

- (1) What type of fractures are these and what is their aetiology?
- (2) Where are the other sites in the foot that stress fractures can occur?
- (3) What would be the best management at this stage?

Figure 1 *x* Ray of feet showing healing metatarsal fractures.

Thyrotoxicosis of a rare aetiology

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Answers on p 806.

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A 28 year old woman was admitted with an eight month history of menstrual irregularities and a four month history of weight loss, haemoptysis, and dyspnoea. She had had menorrhagia for six months, for which a dilatation and curettage was done. Following this, she developed amenorrhoea. Her obstetric history was unremarkable. She was a mother of two (the last childbirth was two years previously). Physical examination revealed bilateral exophthalmos, lid lag, fine tremors in the outstretched fingers, warm and moist skin, and pallor. She had resting tachycardia and tachypnoea. Temperature and blood pressure were normal. There was no goitre. Fine crepitations were heard throughout inspiration and expiration all over the thorax. Haematological studies showed a haemoglobin concentration

of 89 g/l, a leucocyte count of $10.9 \times 10^9/l$, and erythrocyte sedimentation rate of 70 mm/h. Thyroid function tests confirmed the diagnosis of thyrotoxicosis: thyroid stimulating hormone 0.01 mIU/l (reference range 0.35–5.5 mIU/l), T_4 22.4 $\mu g/dl$ (3.2–12.6), and T_3 2.54 ng/ml (0.6–1.81). The serum biochemical profile was in the normal range. Chest *x* ray showed multiple cannon ball opacities. An ultrasound study of the abdomen was normal. Further studies were performed to establish the aetiology.

Questions

- (1) What is the diagnosis?
- (2) What diagnostic procedure supports it?
- (3) What is the cause of the thyrotoxicosis?