ADDENDUM.—Since this paper was written a case of this syndrome associated with hypertrophic pyloric stenosis has been recognized in a 2-months-old infant (Keay and Lewis, 1954). These authors, however, described the oedema of the extremities in their patient as non-pitting in character.

We are indebted to Dr. J. D. Allen, superintendent of the Baragwanath Hospital, for permission to publish this report. We wish to thank Dr. E. Kahn, under whom the patient was admitted, for his encouragement and advice.

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Medical Memoranda

"Primary Myxoedema" in a Man of 30

Myxoedema was first described by Gull (1874) when he wrote "On a Cretenoid State Supervening in Adult Life in Women." It was Ord in 1878 who first used the term "myxoedema" to describe these cases of hypothyroidism. It is well known that myxoedema generally occurs in middle-aged and elderly women. Myxoedema in young males is uncommon, and so far as can be ascertained is either due to "pituitary myxoedema" as described by Means *et al.* (1940) or present as a true myxoedema following total thyroidectomy. It is therefore most unusual to find a case of "primary myxoedema" in a man of 30.

FIG. 1

FIG. 2

FIG. 1.—Photograph taken on October 23, 1953. FIG. 2.—Photograph taken on November 28, 1953.

CASE REPORT

A gardener aged 30 was first seen in consultation in October, 1953. He complained of a rash on the hands and forearms which was due to a plant-contact eczema. His general appearance was most striking, as shown in Fig. 1. On further questioning he admitted to the following symptoms: (1) the gradual onset during the past two years of increasing weariness, which was now extreme towards the end of the day; (2) increase in weight; (3) a preference for hot weather and a feeling of the cold "right through him"; (4) a deepening of his voice and a slowing and hesitant speech; (5) a drying of the skin—"he had not sweated for months"; and (6) his hair was becoming coarse and lifeless.

On examination there were no physical abnormalities apart from a bradycardia of 50. The serum cholesterol was 400 mg. per 100 ml. and the blood urea 67 mg. per 100 ml. of serum. Examination of the urine showed: sp. gr. 1009, sugar, nil; albumin, slight trace; no casts or red blood cells. X-ray examination of the pituitary fossa was normal.

Treatment with L-thyroxine sodium 0.1 mg. daily for a week, then 0.1 mg. twice a day, was started on October 23. Improvement was most dramatic, both in his appearance as shown in Fig. 2, taken five weeks after Fig. 1, and in the blood chemistry as shown in Fig. 3, the serum cholesterol and the blood urea returning to normal within twenty-eight days.

He felt perfectly fit and all his symptoms had disappeared. His voice was now normal, he could sweat, his hair was improving in texture, he had lost weight, and he was no longer weary.

COMMENT

This record is of particular interest as it describes a case of "primary myxoedema" in a young man which responded dramatically to a relatively small dose of thyroxine and showed a fall, not only of the serum cholesterol as would be expected, but also of the blood urea. The fall in the blood urea was presumably due to the increased metabolism. Or could it have been due to a clearing of "cholesterol-clogged" arterioles in the kidneys?

I am grateful to Dr. C. A. K. Bird, of Macclesfield Hospital, for his advice and help with the blood chemistry in this case.

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Ventricular Tachycardia following Exercise in a Case of Angina Pectoris

It is felt that the following case is interesting enough to be placed on record.

CASE REPORT

A man aged 46 attended the out-patient department giving a history typical of angina pectoris of four months' duration. The attacks had never occurred before this, had on no occasion lasted longer than 10 minutes, and had never been severe enough to cause absence from work. Apart from "pleurisy" 10 years previously, no history of any past

FIG. 3.—Showing improvement in blood chemistry.

illness was obtained. He worked as a light machinist at a lathe in a nearby factory. He was married and had a family of four sons. No familial history of any ailments was obtained.

FIG. 1.—Standard leads taken at 11 a.m. Normal.

FIG. 2.—Standard leads taken at 11.15 a.m. The tracings show ventricular complexes which vary in size and which are deformed, the appearances being those of ventricular tachycardia or ? flutter. Rate 330 a minute.

FIG. 3.—Standard leads taken at 2.15 p.m. Normal.

Little of significance was found in the various systems, but examination of the cardiovascular system revealed: pulse, 70, regular, good volume and tone, arterial wall normal; blood pressure 150/100; apex beat displaced slightly downwards and outwards; a soft systolic murmur audible over the apex. Fundi: early silver wiring and tortuosity of the vessels.

Investigations.—Hb, 110%; white cells, 9,000; E.S.R., 19 mm./hour. W.R. and Kahn test negative. Urine normal. Chest x-ray examination showed no active disease in the lung fields; slight tenting of the right diaphragm was due to a minimal adhesion; the heart shadow was normal. Electrocardiograms were taken (1) before exercise (Fig. 1); (2) after exercise which caused a typical attack of retrosternal pain with sweating and coldness; the symptoms were relieved by inhalations of amyl nitrite (Fig. 2); and (3) 3½ hours after exercise (Fig. 3).

Trinitrin tablets for individual attacks, and quinidine sulphate, 6 gr. (0.4 g.) three times daily, have been given since. Up to the time of writing the patient managed fairly well, although he still had occasional tightness of the chest.

COMMENT

Schwartz (1942) describes three phases in the production of ventricular fibrillation—ventricular tachycardia proceeding to multifocal ectopic beats and eventual establishment of ventricular fibrillation. The ectopic beat prior to the run of tachycardia (initial premature beat) bears a constant relationship to the preceding ventricular complex, and all such beats appear to be identical in form and direction.

Runs of ventricular tachycardia are thought to originate from an irritable ventricular focus, and are the precursor of fibrillation.

Wetherbee *et al.* (1952) published tracings showing ventricular tachycardia following quinidine therapy in six cases of auricular fibrillation. Schwartz *et al.* (1953) showed tracings of transient ventricular fibrillation following quinidine therapy in cases of atrioventricular dissociation. A case of complete heart block described by Gresham (1952) gave rise to a series of electrocardiograms showing, at first, runs of ventricular tachycardia but, terminally, evidence of ventricular flutter and fibrillation.

The case described would appear to be in the first phase described by Schwartz in the production of ventricular fibrillation, and it is interesting to postulate an irritable ventricular focus arising from recurring relative ischaemia of a patch of ventricular musculature.

I wish to express my sincere thanks to Dr. Robert Mowbray for his constant help and permission to publish this case. I would also like to thank both the secretarial staff and members of the E.E.G. department, Dryburn Hospital, for their valuable assistance.

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Grafting of Finger-nails

The restoration by grafting of lost or congenitally absent finger-nails is a subject upon which very little has been written. After carrying out a series of experiments it may be of interest to record that in suitable cases either the whole or part of the toe-nail can be transferred to the finger or thumb.

Apart from the disfigurement associated with absence of a nail, there is often a considerable reduction in function in the finger-tip. The normal nail acts as a support to the highly sensitive pulp, and without this counter-pressure the finer qualities of tactile appreciation are blurred. In the index finger or thumb this may be a very real disability in fine work.

The example shown here is the hand of a girl aged 8 in whom the middle finger showed congenital absence of a nail associated with brachydactyly (fusion of the distal and middle phalanges). Part of the great toe-nail with its

Restoration of middle finger-nail by free grafting of part of a toe-nail. One year after operation.

germinal matrix was implanted on the finger, and one year after the operation is seen growing normally. The donor toe-nail has also regenerated and causes her no discomfort.

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