anaplastic large-cell carcinoma, one of the main differential diagnoses, was ruled out since the lymphoma was ALK negative and negative for the t(2;5) translocation in the TCR receptor, and no tumour cells were found in the vascular endothelium.

The importance of CD30 for prognosis has only lately been realized.⁶ It is a type 1 membrane glycoprotein and belongs to the tumour necrosis factor receptor family. CD30+ve CTCL is indolent whereas CD30-ve CTCL is aggressive. This is reflected in their 5-year survival rates of 90% and 15%, respectively.

REFERENCES

- 1 Gamelin E, Beldent V, Rousselet MC, *et al.* Non-Hodgkin's lymphoma presenting with primary adrenal insufficiency. A disease with an underestimated frequency? *Cancer* 1992;**69**:2333–6
- 2 Levy NT, Young WF, Haberman TM, Strickler JG, Carney JA, Stanson AW. Adrenal insufficiency as a manifestation of disseminated non-Hodgkin's lymphoma. *Mayo Clin Proc* 1997;**72**:818–22
- 3 Kung AW, Pun KK, Lam K, Wang C, Leung CY. Addisonian crisis as presenting feature in 'malignancies'. *Cancer* 1990;**65**:177–9
- 4 Willemze R, Kerl H, Sterry W, *et al.* EORTC Classification for primary cutaneous lymphomas: a proposal from the cutaneous lymphoma study group of the European Organization for Research and Treatment of Cancer. *Blood* 1997;**90**:354–71
- 5 Jaffe ES, Harris NL, Stein H, *et al.*, eds *World Health Organization Classification of Tumours*. Lyon: IARC Press, 2001
- 6 de Bruin PC, Gruss H-J, van de Valk P, Willemze R, Meijer CJ. CD30 expression in normal and neoplastic lymphoid tissue: biological aspects and clinical implications. *Leukemia* 1995;**9**:1620–7

Lifelong migraine aura without headache: change of pattern with upper respiratory infection

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Changes in the features of migraine during a lifetime may offer clues to the pathogenesis.

CASE HISTORY

A retired professor of psychiatry (SIC) experienced migraine aura without headache from the age of 20, about once in 2 years. Without prodromal symptoms he suddenly

became aware of not being able to see properly in the left visual field and had difficulty with reading. Within two minutes a bright light appeared, enlarged into three-quarters of a circle enclosed by zigzag scintillating lines coloured black with a golden edge surrounding a scotoma (Figure 1). The visual symptoms lasted about twenty minutes then gradually disappeared; he never experienced headache or gastrointestinal, visual or mental symptoms after his aura. He was unable to identify any precipitants for the visual disturbance, which could occur during reading or other activities.

At the age of 76 there was an episode with different features. A typical attack occurred but as the day progressed he experienced several more. On the next day an aura lasted 2 hours. The following day two more attacks occurred, each of ten minutes' duration. Throughout the subsequent day similar episodes recurred, about twelve in all. All auras were in the left visual field. Later that day he had a severe, steady pain behind the right eye and began to feel cold although the day was hot; his temperature was 37.6°C. He assumed that the pyrexia was due to sinusitis, as he had developed a yellow nasal discharge in the previous few days. With amoxicillin the temperature became normal within a day and the nasal discharge cleared. The last visual episode, still on the left, occurred on the subsequent day, lasting twenty minutes, but was joined by a right-sided headache starting ten minutes later; the aura and headache persisted together for another thirty minutes, when the aura disappeared, although the headache continued for a further hour. He then noticed a faint glow surrounding bright white objects—for example, around the edges of the kitchen dishwasher—which lasted over the next few hours. There were no further attacks in the subsequent nine months.

Figure 1 Scintillations surrounding scotoma drawn up to full development, at which they persisted for a further 10 minutes before gradually disappearing

The previous history is relevant. A year earlier, mild effort intolerance had been treated with a coronary artery stent. At that time a raised blood cholesterol was found and was restored to normal with atorvastatin. He noticed an increased nasal discharge and a hoarse voice—a rare side effect. A month before the above episode, his general practitioner therefore changed the statin to simvastatin, which both increased and thickened the discharge which

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became yellow a week before this episode. Chronic lymphatic leukaemia had been diagnosed 8 years previously and remained well controlled; because of this he took an antibiotic whenever he developed a cold but did not do so on this occasion. In the past he had had many febrile upper respiratory infections, but had never experienced an aura during these. Previously he had not had multiple attacks, headache or post-aura light sensitivity. In childhood he had had no travel sickness or recurrent abdominal pain. His sister had migraine with aura; no other family member was known to have migraine currently or in the past.

COMMENT

Alvarez¹ described similar personal experiences. His aura began in youth, occurred about once a month for no apparent reason, and was not followed by a headache until age 67: the headache was then mild but he did not state its site or duration. Aged 72, he had two attacks on one day and two more three days later associated with 'a trace of fever' due to a saphenous vein thrombosis. On one occasion after an aura in the morning, he noticed that afternoon at a musical recital that he felt 'distressed by a brilliant after-image of the piano which I got if I looked at it for more than a few seconds.' Perhaps the white piano keys were responsible. Alvarez also recorded one patient whose vision remained hypersensitive for five hours after an aura.

Migraine aura without headache is well recognized. The International Headache Society Classification² specifies the aura duration as usually less than sixty minutes, though sometimes longer. However, scant attention has been given to the mechanism(s) of increased number or changes in pattern of attacks as in this case. The additional headache here could have arisen from meningeal vasodilatation by extension of mucosal vasodilatation in the nasopharynx and paranasal sinuses secondary to the infection.³ Observations during migraine episodes indicate that the headache arises from nociceptive nerve endings of the meninges,⁴ the brain itself being insensitive to pain. More difficult to explain is the increased frequency of the visual aura and its increased duration. If the aura arises in the occipital cortex⁵ perhaps the pyrexia was contributory.

REFERENCES

- 1 Alvarez WC. The migrainous scotoma as studied in 618 cases. *Am J Ophthalmol* 1960;49:489–504
- 2 Classification and diagnostic criteria for headache disorders, cranial neuralgias and facial pain. *Cephalalgia* 1988;8(suppl 7):20–2
- 3 Gray RF, Hawthorne M. *Synopsis of Otolaryngology*, 5th edn. Oxford: Butterworth-Heinemann, 1992:546–50
- 4 Blau JN, Dexter SL. The site of pain origin during migraine attacks. *Cephalalgia* 1981;1:143–7
- 5 Gowers WR. *A Manual of Diseases of the Nervous System*, Vol II. London: Churchill, 1888:788–92

Combined surgical and endoscopic clearance of small-bowel polyps in Peutz–Jeghers syndrome

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In Peutz–Jeghers syndrome (PJS) a combined surgical and endoscopic procedure allows effective clearance of the multiple hamartomatous polyps from the entire length of the small bowel.

CASE HISTORIES

Case 1

A woman of 18 was referred with intestinal obstruction. 4 years previously PJS had been diagnosed after an episode of intussusception. She had the characteristic perioral pigmentation. At that time she had undergone near-total clearance of her small-bowel polyposis by combined laparotomy and small-bowel enteroscopy, with subsequent yearly surveillance and polypectomy by small-bowel enteroscopy. At the latest admission a small-bowel meal suggested further extensive polyposis. Repeat combined laparotomy and small-bowel enteroscopy allowed removal of over 40 polyps by snare loop diathermy. The entire length of the small bowel was visualized, as well as the ascending colon to the hepatic flexure. No enterotomies were required to remove the polyps.

Case 2

The second patient, now aged 17, was diagnosed at age 11 years. She had required an emergency ileo-caecal resection after intestinal intussusception. Since the diagnosis of PJS, surveillance endoscopies were conducted and several small gastric polyps were removed over the years. The present episode began with colicky abdominal pain and she proved to have iron-deficiency anaemia. A small-bowel meal revealed several small-intestinal polyps. At laparotomy with

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