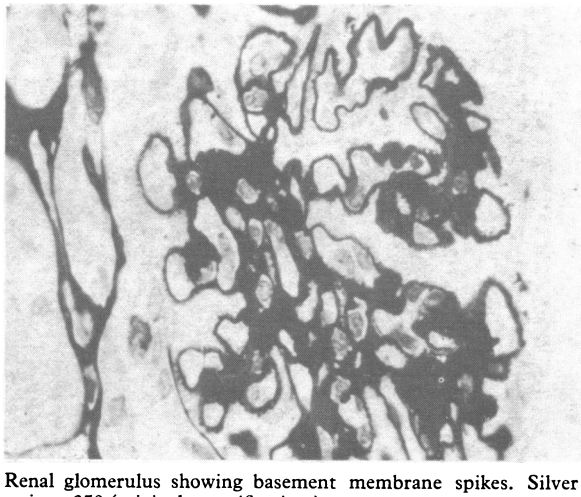
SHORT REPORTS

Membranous glomerulonephritis, dermatomyositis, and bronchial carcinoma

Membranous glomerulonephritis is associated with malignant disease in about 10% of cases.[1] The prevalence of neoplasia in patients with dermatomyositis is estimated at 15-20% in those aged over 45.[2] The occurrence of membranous glomerulonephritis with dermatomyositis is extremely unusual and in the one documented case malignancy was not implicated.[3]

Case report

A woman aged 58 years presented with ankle swelling and proteinuria. She smoked 20-30 cigarettes a day, was taking no medication, and was normotensive. Urine microscopy showed red cells with granular and cellular casts. The proteinuria was selective and amounted to 5·2 g/24 h. Serum concentrations were as follows: albumin 25 g/l, urea 6·8 mmol/l (41 mg/100 ml), and creatinine 129 μmol/l (1·46 mg/100 ml), ESR 50 mm in 1 h, and C3 1·28 U (0·8-1·4). A renal biopsy specimen showed diffuse capillary loop thickening and basement membrane spikes (figure). Immunofluorescence showed granular IgG deposition along capillary loops. The features were typical of membranous glomerulonephritis. Treatment with frusemide was started.



Renal glomerulus showing basement membrane spikes. Silver stain ×350 (original magnification).

Three years later she developed dermatomyositis with periorbital oedema; dusky erythema of the face, trunk, and hands; proximal muscle weakness; and dysphagia. The serum concentration of creatinine phosphokinase was 290 U/l (10-60), aldolase 3·6 U/l (0·5-3·0), and lactate dehydrogenase 760 U/l (50-220). The proteinuria had diminished to 0·7 g/24 h, and serum concentration of albumin was 29 g/l, urea 9 mmol/l (54 mg/100 ml), creatinine 105 μmol/l (1·1 mg/100 ml), and ESR 60 mm in 1 h. Antinuclear antibody was not detected. A chest radiograph was normal but lung tomography showed a 1-cm opacity in the right mid-zone. An oat cell tumour was later resected with the upper lobe. Preoperative treatment with prednisone and azathioprine dramatically improved the dermatomyositis and this improvement was sustained when the drugs were stopped postoperatively.

Comment

The presence of both membranous glomerulonephritis and dermatomyositis in a cigarette smoker strongly suggested an underlying malignancy. Membranous nephropathy is thought to be an immune complex disease. The renal lesion in this patient may have resulted from the deposition of immune complexes induced by the tumour.[1] Circulating immune complexes tend to be found early in the course of malignant disease and an associated nephropathy may precede the discovery of a tumour by over one year.[4] Although the pathogenesis of dermatomyositis is not clear, the link with cancer may provide a clue. This association perhaps results from an immune response to tumour antigen which cross-reacts with muscle. Both humoral and cell-mediated mechanisms may participate.[5] In our patient the nephropathy had already improved when the dermatomyositis first appeared. If both conditions were precipitated by tumour antigen this disparity in time course suggests that their pathogenic mechanisms differ.

I would like to thank Dr J S Comaish for permission to publish this case, Dr M G C Dahl and Dr M Ward for helpful criticism, and Dr A Morley for the photomicrograph.

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Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP
JOHN D G ROSE, MB, MRCP, senior house officer in dermatology

Current trends in contraception

Recent evidence[1 2] of mortality and morbidity among women taking oral contraceptives has been widely and often sensationally reported in the press. Fortunately this was countered by the clear, balanced recommendations of the presidents of the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists.[3] To assess the impact of these developments we analysed the contraceptive trends over the last four years in a large family planning clinic in our area.

Methods and results

The Palatine Centre is the largest family planning clinic in the Manchester area, with 11 000 first-visit patients and a total of 26 000 consultations each year. The contraceptive trends during the years 1975-8 inclusive, which covered the relevant period, were analysed. The age grouping of first-visit patients each year (table) shows a fairly constant distribution with only 8% aged over 35. There was a small decrease, from 21% to 17%, in patients aged under 20 seeking contraceptive advice. The figures for the contraceptive method being used by patients at their first visit in each year clearly show a trend away from the pill (from 83% to 73%) over the four years, with a corresponding move towards the IUCD (6% to 9%), cap (5% to 8%), and condom (3% to 5%), which is statistically significant with such large figures. During 1977 this trend appears to have accelerated. The IUCD and cap seem to have substantially taken up the ex-pill users. Additionally there has been a steady increase each year in condom users.

Ages of first-visit patients and their contraceptive methods

Year	No aged under 20	No aged 20-35	No aged over 35	Total patients	Contraceptive method			
					Oral	IUCD	Cap	Condom
1975	2407	7980	875	11 338	9374	697	561	320
1976	2454	8420	953	11 827	9481	817	702	381
1977	2235	8637	909	11 781	9368	895	764	439
1978	1951	8514	923	11 388	8363	1050	942	548

Discussion

This trend away from the pill corresponds to that found in a similar study in the United States,[4] although that reported figures only up to 1976. The major move away from the pill occurred in the subsequent two years in our study. Furthermore, the American report showed a small decrease in the use of the IUCD, which did not occur in Manchester. The significant movement away from the use of hormonal contraceptives in this group of women, most of whom were below the age of

35, suggests that the press reports have had considerable bearing in these decisions. A more detailed study of age distribution and contraceptive usage as well as smoking habits would be of interest. This is under way.

The effect of adverse publicity on the pattern of contraceptive usage is considerable. In this instance the balanced and responsible statement by the presidents of the Royal Colleges probably played a major part in preventing the panic that ensued in 1969 in relation to oestrogen dosage and thromboembolic risk.[5] Other factors that may have been operating, such as the increasing provision of contraceptives by general practitioners, are probably of minor consequence in this clinic since the age distribution of attenders remained substantially the same. In women aged under 30 the risk:benefit ratio of oral contraception compared with unplanned pregnancy is such that the pill probably remains the optimal contraceptive. The decrease in the number of women aged under 20 attending for contraceptive advice is worrying. More use of the media for health education and more readily available and acceptable contraceptive advice for younger women should be urgently considered.

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University Hospital of South Manchester, Manchester M20 8LR
I D NUTTALL, MB, MRCOG, registrar in obstetrics and gynaecology
R W BURSLEM, MD, FRCOG, consultant obstetrician and gynaecologist
MAX ELSTEIN, MD, MRCOG, professor of obstetrics and gynaecology

Palatine Family Planning Clinic, Withington, Manchester M20 8LR
E FOX, BSC, senior administrator
D ROWLEY, MB, DOBSTRCOG, medical officer
B EVANS, MB, medical officer

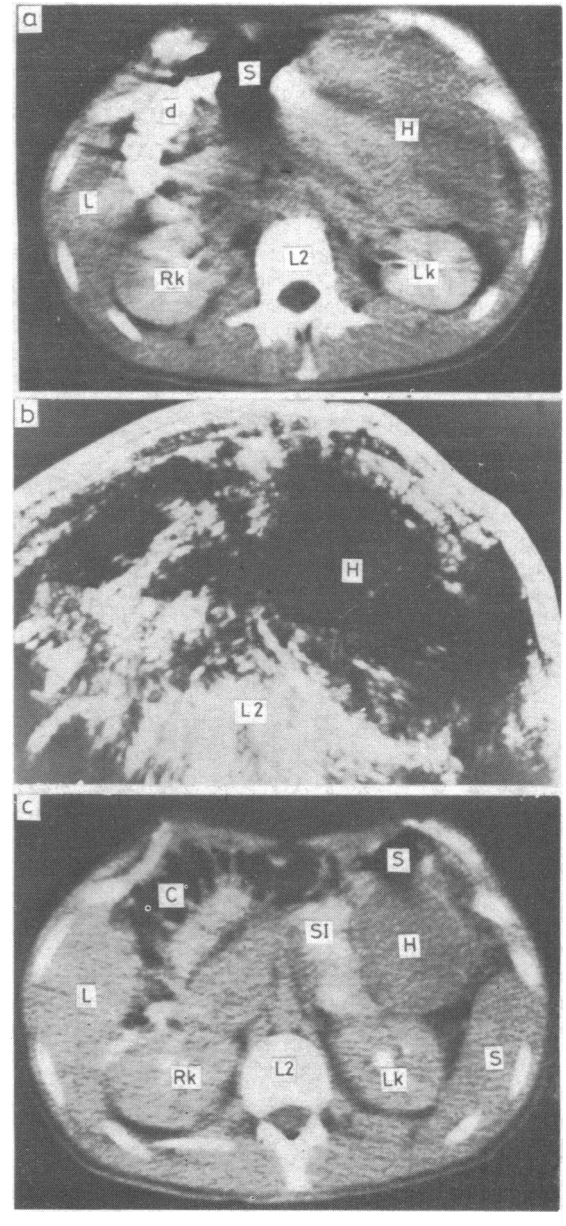
Localised intramesenteric haemorrhage—a recognisable syndrome in haemophilia?

Acute occult intra-abdominal haemorrhage in the absence of direct trauma is relatively rare, even in severe haemophilia. Cases of intramural haematoma causing intestinal obstruction and occasionally intussusception have been described. The clinical features are well recognised,[1 2] but routine radiology often fails to show other sites of bleeding where surgery is inappropriate.[3] The features of this case of intramesenteric haemorrhage are sufficiently distinctive to constitute a recognisable syndrome in haemophilia which may be diagnosed clinically and confirmed by non-invasive investigations.

Case report

A 31-year-old haemophiliac man (plasma factor VIII <1%) was admitted as an emergency to King's College Hospital on 26 August 1978. After a gluttonously eaten gargantuan meal two days previously he had had immediate epigastric discomfort. The next day left hypochondrial and bilateral shoulder pain developed. He was unable to eat or drink. His stools were loose but normal in colour and frequency. On arrival in the casualty department he was clinically shocked. Pulse rate was 160/min, blood pressure 65/40 mm Hg. The abdomen was distended (girth 75 cm) with generalised abdominal tenderness and guarding. The rectum was empty. A plain abdominal *x*-ray picture showed an ill-defined opacity occupying the left side of the abdomen, displacing the stomach to the right. A provisional clinical diagnosis was made of acute intra-abdominal haemorrhage. He responded to resuscitation with 1·5 l normal saline, dried human plasma, and 1500 IU factor VIII concentrate.

In the first 12 hours his haemoglobin fell to 11 g/dl despite 10 units of whole blood. His girth now measured 78 cm, blood pressure and pulse rate were normal, and the abdominal tenderness was localised to a firm mass extending down from the epigastrium and left hypochondrium to the umbilicus. A fluid thrill was elicited but no shifting dullness. Ultrasonography showed a large mass with an echo pattern consistent with a localised haematoma (figure b). His condition remained stable for the next 24 hours, during which time he was given about 1500 IU factor VIII concentrate every 12 hours. After two days this was reduced to 500 IU daily. After a week the abdominal pain had gone but tenderness remained. The patient was unable to stand erect and could eat only small quantities of well-chewed food. Computerised axial tomography (CAT) of the abdomen, to identify the site of bleeding and to anticipate future complications, showed a large mass (12 × 12 × 20 cm) displacing the stomach, containing gastrografin, anteriorly and to the left (figure a). The patient was discharged 10 days after admission. He returned on 15 September and on 29 October complaining of recurrent epigastric and left hypochondrial pain. This was treated with bed rest and factor VIII concentrate, and was assumed to be due to recurring mesenteric haemorrhage. Follow-up CAT on the 13 November (figure c) confirmed that the haematoma was still present but much reduced in size to 6 × 6 × 14 cm. There was no new site of haemorrhage.



Case of localised intramesenteric haemorrhage. (a) CAT scan of abdomen showing mass (H) displacing stomach to left. (b) Ultrasonogram showing large mass (H). (c) Follow-up CAT scan of abdomen after three months.
H = Intramesenteric haematoma. RK = Right kidney. LK = Left kidney. SI = Small intestine. d = duodenum. L = Right lobe of liver. S = Spleen.

Comment

The diagnostic features of intramesenteric haemorrhage are (1) a history of a large meal or vomiting resulting in acute epigastric pain; (2) spread of pain to the left hypochondrium (with pain referred to the shoulder); (3) a palpable "pseudotumour" extending down from the left hypochondrium; (4) dysphagia and feeling of fullness after