Unreviewed Reports

Pain in the ear—a presenting symptom of aortic dissection

Two previously well men developed sudden severe pain in the ear. One subsequently had anterior chest pain, the other episodes of confusion, and both died soon after. Ruptured dissecting thoracic aortic aneurysms were found on postmortem examination. The acute onset of pain in the ear as a presenting symptom of aortic dissection is extremely uncommon and recorded in only one of 349 cases.[1] The neurological basis is probably the auricular branch of the vagus, but it is of no apparent value in localising the dissection. Dissecting thoracic aneurysms should be considered in the differential diagnosis of acute ear pain.—B I HOFFBRAND, A HOLLMAN, Whittington and University College Hospitals, London. *(Accepted 29 February 1985)*

1 Hurst AE, Johns VJ, Kime SW. Dissecting aneurysm of the aorta. A review of 505 cases. *Medicine* 1958;37:217-79.

CA 125: a new tumour marker for ovarian germ cell tumours

CA 125 is an antigenic determinant defined by the monoclonal antibody OC125, which is present in most epithelial tumours.[1] Recently we have found appreciably raised concentrations of CA 125 in three new cases of germ cell tumours before cytoreductive surgery and in one case on treatment (190, 154, 390, 56 U/ml). The level of CA 125 paralleled that of the other tumour markers after surgery and chemotherapy. In one case CA 125 was the only marker present, and we suggest that it may be a useful new tumour marker in germ cell tumours of the ovary.—MARKO ALTARAS, GARY L GOLDBERG, *et al*, Division of Gynaecological Oncology, Department of Obstetrics and Gynaecology, Groote Schuur Hospital and University of Cape Town. *(Accepted 5 March 1985)*

1 Kabawat SE, Best RC Jr, Welch WR, *et al*. Immunopathologic characterization of a monoclonal antibody that recognizes common surface antigens in human ovarian tumours of serous endometroid and clear cell type. *Am J Clin Pathol* 1983;79:98-104.

Aplastic crisis and erythema infectiosum due to human parvovirus infection

Human parvovirus causes aplastic crisis in patients with haemolytic anaemias.[1] It also causes erythema infectiosum (fifth disease). No patient presenting simultaneously with both disorders has yet been described, which could suggest that two different strains of the virus are concerned. We report on a father and his son who presented simultaneously with an aplastic crisis during documented infection with human parvovirus. Examination of a blood smear showed hereditary spherocytosis (previously unsuspected) in both patients. The son also had clinical symptoms of erythema infectiosum. These data show that one strain of human parvovirus may be responsible for two different pathological conditions in the same person.—JEAN-JACQUES LEFRERE, ANNE-MARIE COUROUCE, *et al*, Centre National de Transfusion Sanguine, 6 rue Alexandre-Cabanel, 75015 Paris. *(Accepted 18 March 1985)*

1 Serjeant GR, Topley JM, Mason K, *et al*. Outbreak of aplastic crisis in sickle cell anaemia associated with parvovirus like agent. *Lancet* 1981;ii:595-7.

Trancopal (chlormezanone) and thrombocytopenia

A previously well 38 year old woman developed widespread spontaneous bruising 10 days after starting Trancopal (300 mg daily). There was no history of ingestion of other drugs. Platelet count was 3×10^9/l, and a specimen of bone marrow showed changes typical of immune thrombocytopenia. Platelet associated IgG was increased. Other routine screening tests were within normal limits. The treatment was stopped, and over the next eight days the platelet count rose steadily to normal levels, and three weeks later platelet associated IgG was normal. The manufacturers (but not the Committee on Safety of Medicines) is aware of one other case linking immune thrombocytopenia with Trancopal.—R D FINNEY, APPS, Department of Haematology and Medicine, North Tees General Hospital, Stockton-on-Tees TS19 8PE. *(Accepted 18 March 1985)*

Pseudomembranous colitis and trimethoprim

A man of 82 developed urinary retention after a hip replacement and underwent retropubic prostatectomy. This was covered with six doses of cefuroxime followed by oral trimethoprim. He was well until 12 days postoperatively, when he complained of mild diarrhoea. Twenty four hours later he was toxic, with a tense, distended, silent abdomen. Radiographs showed a very dilated colon. *Clostridium difficile* was isolated from his stool. Despite intensive resuscitation he died; pseudomembranous pancolitis was found at postmortem examination. Pseudomembranous colitis is closely associated with current antibiotic treatment,[1] and accordingly we believe that trimethoprim is implicated in this case.—JAMES DE COURCY, JOHN MACKINNON, Department of Surgery, Gloucester Royal Hospital, Gloucester. *(Accepted 20 March 1985)*

1 Tures J, Townsend W. Cephalosporin associated pseudomembranous colitis. *JAMA* 1976;236:948-9.

Treatment with nifedipine for malignant hypertension inducing acute reversible renal impairment

A 54 year old woman, previously well, presented with malignant hypertension, biventricular cardiac failure, and polyuria. Plasma creatinine concentration was 452 mmol/l (5113 mg/100 ml) on admission. After a single oral dose of nifedipine 20 mg her blood pressure fell from 268/132 mm Hg sitting to 152/76 mm Hg supine after 30 minutes. Oliguria and noticeable deterioration of renal function followed. After six days plasma creatinine concentration was 724 mmol/l (8190 mg/100 ml) but with continued control of blood pressure dropped to 323 mmol/l (3654 mg/100 ml). Nifedipine 20 mg has been advocated as a safe and effective oral treatment in hypertensive emergencies.[1] We would suggest using a lower initial dose.—J A SPENCER, M J BROWN, *et al*, Department of Clinical Pharmacology, Royal Postgraduate Medical School, Hammersmith Hospital, London W12 0HS. *(Accepted 26 March 1985)*

1 Bertel O, Donen D, Radii EW, Muller J, Lang C, Duback VC. Nifedipine in hypertensive emergencies. *Br Med J* 1983;286:19-21.

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