Unreviewed Reports

Facial numbness as presentation of parotid tumour

A 68 year old man presented with numbness in the distribution of his right mandibular nerve (3rd division of the trigeminal nerve). Taste and facial movements were normal. On examination there was a firm mass behind the angle of his jaw and a preauricular swelling; a biopsy specimen showed a squamous carcinoma. Tumours of the deep lobe of the parotid gland usually present with local pain or a mass inside the mouth.[1] They may infiltrate posteriorly across the base of the skull, but spread to the mandibular nerve has not been reported. A neurilemma of the mandibular nerve is the main differential diagnosis.—R MCR HIGGINS, The Brook Hospital, London SE18 4LW. *(Accepted 17 April 1984)*

[1] Baker DC, Congley J. Treatment of massive deep lobe parotid tumors. *Am J Surg* 1979;**138**:576-8.

Periorbital oedema caused by nifedipine

A 54 year old woman was started on a slow release formulation of nifedipine (Adalat Retard) as her blood pressure was uncontrolled by atenolol 100 mg and bendrofluazide 5 mg daily. After the first dose of nifedipine she developed severe periorbital oedema accompanied by facial flushing, paraesthesiae, headache, and dizziness which lasted six hours, recurring after her next dose. The patient was then given a single dose of 5 mg nifedipine, which caused identical symptoms. Clearly these were due to nifedipine itself and not to the slow release formulation. This side effect has not been reported.[1]—P H SILVERSTONE, Gravesend and North Kent Hospital, Kent DA11 0DG. *(Accepted 17 April 1984)*

[1] Terry RW. Nifedipine therapy in angina pectoris: evaluation of safety and side effects. *Am Heart J* 1982;**104**:681-9.

Magnesium induced neuropathy in patient undergoing haemodialysis

A 42 year old woman undergoing regular dialysis developed crippling peripheral neuropathy, unresponsive to extended dialysis time. Her plasma magnesium concentration was 1·85 mmol/l (4·5 mg/100 ml) (normal 0·7-1·1 mmol/l (1·7-2·7 mg/100 ml)). She was therefore dialysed on magnesium free dialysis fluid, and within a month her symptoms cleared. The neuropathic features reappeared after she was inadvertently dialysed against her usual dialysis fluid (magnesium 0·85 mmol/l (2·1 mg/100 ml)). They cleared again, however, with magnesium free dialysis fluid and she remains well. Hypermagnesaemia may have a role in neuropathy in patients undergoing dialysis.[1]—RASHEED AHMAD, Sefton General Hospital, Liverpool L15 2HE. *(Accepted 30 April 1984)*

[1] Steward WK, Flemming LW, Anderson DC, *et al. Proc Eur Dial Transplant Assoc* 1967;**4**:285-92.

Tuberculosis in a functioning gall bladder

Of the 49 reported cases of tuberculous cholecystitis, gall stones were present in 46 and cystic duct obstruction in the rest. The resistance of the intact gall bladder to tuberculous infection has been attributed to bile acid concentration sufficient to inhibit growth of tubercle bacilli.[1] A 48 year old Asian woman resident in the UK for nine years was investigated for chronic cholecystitis. Oral cholecystogram and ultrasonogram were normal, but because of persistent symptoms laparotomy was performed and a thick walled gall bladder removed. Histology confirmed tuberculosis with acid fast bacilli. Tuberculosis may thus occur in a functioning gall bladder.—T I DAVIDSON, R GARNHAM, Mount Vernon Hospital, Northwood, Middx HA6 2RN. *(Accepted 30 April 1984)*

[1] Miggar MS, Kariholu PL, Bhat DN, Fazili F, Yousuf M, Muhajid S. Tuberculosis of gallbladder. *J Indian Med Assoc* 1980;**74**:196-7.

Mesothelioma due to domestic exposure to asbestos

Two sisters, who lived in adjacent mobile homes, developed pleural mesotheliomas. One recovered after undergoing pleurectomy, but in the other the diagnosis was made post mortem. The only history of exposure to asbestos was that both had some years previously cleaned an outhouse roof made of corrugated white asbestos cement to remove moss growth. This was done as a dry process (with a wire brush and paint scraper) and without wearing masks, and the roof was described afterwards as "lovely and white." Exposure to asbestos on domestic premises may constitute an unrecognised hazard.—G C FERGUSON, H WATSON, Northampton General Hospital, Northampton NN1 5BD. *(Accepted 9 May 1984)*

Inaccurate home blood sugar monitoring in Raynaud's syndrome

A 43 year old man with chronic pancreatitis had poorly controlled insulin dependent diabetes despite good motivation and finger prick monitoring at home with a Hypocount meter. On three occasions metered finger prick samples indicated hypoglycaemia (1·9, 0·2, 0·6 mmol/l (34, 3·6, 11 mg/100 ml)), but his only symptoms were of mild Raynaud's syndrome. Glucose concentrations in earlobe and venous blood were in the normal range (4·1, 3·6, 4·9 mmol/l (74, 65, 88 mg/100 ml)), and no subsequent earlobe blood showed any disparity with simultaneous venous samples. Raynaud's syndrome may cause intermittently falsely low finger prick sugar concentrations; this should be considered if therapeutic decisions are safely to be based on the results of metered non-venous samples.—J E MACSWEENEY, A FORBES, Middlesex Hospital, London W1N 8AA. *(Accepted 10 May 1984)*

No link between acute pericarditis and HLA factors

Acute pericarditis is usually idiopathic or viral. It may also be secondary to various other diseases.[1] HLA factors help in modulating immune responses and may be important in determining susceptibility to viral infections. We studied 29 men and nine women with viral or idiopathic acute pericarditis. They were typed for 12 HLA-A, 20 HLA-B, and 5 HLA-C antigens. The distribution of antigens was compared with that found in normal healthy individuals. No significant differences were found; this excludes any strong association between known HLA-ABC factors and non-specific viral or idiopathic acute pericarditis.—REINHOLD BARTRAM, County Central Hospital of Frederiksborg, Denmark, ARNE SVEJGAARD, State University Hospital, Copenhagen Denmark, *et al.* *(Accepted 14 May 1984)*

[1] Shabetai R. *The pericardium.* New York: Grune and Stratton Inc, 1981: 108-53 and 348-65.

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