Unreviewed Reports

Solitary, asymptomatic, functioning femoral bony metastasis of an adrenal phaeochromocytoma

A 30 year old woman developed a solitary osteolytic lesion of the femoral head, confirmed by bone scanning, 15 years after having an adrenal phaeochromocytoma removed. Blood pressure was consistently normal. Twenty four hour urine concentrations of vanillylmandelic acid, metadrenalines, total catecholamines, and noradrenaline/adrenaline were not diagnostically raised. During curettage and bone grafting under general anaesthesia three hypertensive peaks (systolic pressure 220, 170, 170 mm Hg) occurred. Recovery was unremarkable and urine concentrations at follow up normal. Curettage histology was the same as the primary tumour. One similar lesion has been reported.[1]—P COOK, Department of Anaesthesia, Oldham Royal Infirmary, Oldham. *(Accepted 4 January 1985)*

1 McCarthy EF, Bonfiglio M, Lewton W. A solitary functioning osseus metastasis from a malignant phaeochromocytoma of the organ of Zuckerkandl. *Cancer* 1977;**40**:3092-6.

Malignant metastatic ovarian melanoma: an unusual case report

A 42 year old woman was admitted with abdominal pain of two days' duration two years after undergoing wide excision of a malignant melanoma from the right calf. She had a rapid pulse rate, declining blood pressure, and free fluid in the peritoneal cavity. Laparotomy showed 2 l blood and an apparent ovarian pregnancy on the right. Histological investigation showed a malignant melanoma. Ovarian melanoma is rare, and this presentation has not been reported before.[1] Ovarian tissue is free from melanogenic cells, and ovaries are therefore excluded as a potential source of melanotic tumours with the exception of teratomas.—V KANDIYIL NANU, Department of Obstetrics and Gynaecology, Frimley Park Hospital, Frimley, Surrey. *(Accepted 14 January 1985)*

1 Silveira E, Palhares FA, De Oliveira Filho JA, Alberti O Jr, Alberti VN, Silveira MI. Peritonitis following rupture of metastatic malignant melanoma of the ovary. *Gynaecol Oncol* 1977;5:305-7.

Meningoencephalitis due to Listeria monocytogenes in a patient with AIDS

A homosexual man with diarrhoea and lymphadenopathy lost 7 kg in weight. Lymphocytopenia (250×10^6/l) and candida oesophagitis were present, while fever, stupor, sixth cranial nerve palsy, and vestibular syndrome developed. Investigations disclosed lymphocytic meningitis and a right candeus nucleatus abscess. *Listeria monocytogenes* was isolated from blood cultures. The neurological impairment resolved with ampicillin and gentamicin. This is the first reported case of listeriosis in a patient with AIDS. Its rarity in patients with AIDS is unexplained because the T lymphocyte has a crucial role in host defence and *L monocytogenes* is excreted in the faeces of one person in 100.[1]—S KERNBAUM, A FRANCILLON, Infectious and Tropical Diseases Clinic, Hospital Claude Bernard, 75019 Paris, France. *(Accepted 25 January 1985)*

1 Armstrong D. Listeria monocytogenes. In: Mandell G, Douglas G, Bennet J, eds. *Principles and practice of infectious diseases*. New York: Wiley, 1979:1626-33.

Acute alveolitis associated with dothiepin treatment

Six weeks after starting dothiepin for depression, an organic cause having been excluded, a 73 year old woman had dyspnoea and bilateral basal crackles with diffuse bilateral interstitial shadowing on chest radiography. She had a reduced vital capacity, severe hypoxaemia, and a high lymphocyte count. Steroids for two months produced no improvement, and six months later her condition was stable. Previously antidepressants have induced pulmonary interstitial changes with eosinophilia.[1] In two similar reactions reported to the Committee on Safety of Medicines, dothiepin was not the sole treatment. The manufacturer is aware of one previous report linking alveolitis with dothiepin.—D VEALE, J J GILMARTIN, Department of Chest Medicine, Freeman Hospital, Newcastle upon Tyne NE7 7DN. *(Accepted 5 February 1985)*

1 Mutnick A, Schneiweiss F. Desipramine induced pulmonary interstitial eosinophilia. *Drug Intell Clin Pharm* 1982;**16**:966-7.

Upper gastrointestinal bleeding and gastric rupture

A 74 year old woman presenting with vomiting was found to have a chronic duodenal ulcer without clinical or endoscopic stigmata of active bleeding. The day after admission she became hypotensive following a fresh haematemesis. During resuscitation painful abdominal distension developed. At laparotomy a massive haemoperitoneum was found, arising from a full thickness longitudinal tear along the lesser curve of a tense, blood filled stomach. Haemorrhage was arrested by under running a spurting vessel in the base of a posterior duodenal ulcer. The passage of a nasogastric tube may have averted this previously unreported complication of upper gastrointestinal haemorrhage.—S HOLT, S HAWKYARD, Professorial Surgical Unit, Broadgreen Hospital, Liverpool. *(Accepted 6 February 1985)*

Bacterial parotitis due to Haemophilus influenzae in an infant

A 10 month old boy presented with a six hour history of swelling of the left cheek, progressing rapidly. He had a temperature of 39·4°C and a hard tender swelling over the left parotid gland. Pus and blood were emerging from Steneen's duct. He was systemically unwell but responded rapidly to intravenous flucloxacillin and amoxycillin. Blood culture grew *Haemophilus influenzae* type B, sensitive to amoxycillin. We could find only one case in childhood reported since 1960.[1] The commoner organisms in the age range 3 months to 20 years are staphylococcus and streptococcus.—Q SPENDER, E DOUEK, Queen Elizabeth Hospital for Children, Hackney, London E2 8PS. *(Accepted 6 February 1985)*

1 Leaks DL, Krakowiak FJ, Leake RC. Suppurative parotitis in children. *Oral Surg* 1971;**31**:174-9.

Correction

Domperidone induced regrowth of a prolactinoma during dopaminergic tumour suppression

We regret that an error occurred in this unreviewed report (19 January, p 208). The first author's name should have read A P van Seters, not A P van Sters.

"Unreviewed Reports" aims at publishing very brief findings quickly, without the usual external peer review. Each item should be no more than 100 words long, with a title of up to 10 words, only one reference, and no more than two named authors (*et al* is allowed). Authors of papers about side effects must have reported them to the Committee on Safety of Medicines and the manufacturers. Correspondence asking for further details about these items should be sent directly to the authors, who should be willing to supply answers.