the platelet counts weekly and the knowledge that a cyclical variation may occur was important in assessing the severity of the thryotoxicosis and the response to treatment, and the timing of surgical procedures.

The documented case in which a patient with clinical thryotoxicosis and cyclic thryotoxicosis was found to have platelet, thryoid, and mitochondrial antibodies—the latter thought to be suggestive of primary biliary cirrhosis (Doniach et al., 1966)—and a positive antinuclear test (speckled variety) with clinical response to steroids, lends support to the concept that thryotoxicosis may be attributed to disorders of the immunological system.

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Doniach at the Middlesex Hospital and Dr. K. L. G. Goldsmith at the Lister Institute.

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Fatal Intestinal Atony in Myxoeedema

British Medical Journal, 1969, 3, 398

Constipation and abdominal distension are well-recognized features of hypothyroidism, but serious atony of the gastrointestinal tract and urinary bladder may result in retention or incontinence of faeces or urine and even in death from intestinal obstruction without external features of hypothyroidism being obvious.

CASE REPORT

In 1958 a man aged 59 complained of sore tongue, tiredness, dyspnoea on exertion, paraesthesiae, and intermittent constipation and diarrhoea. He had a normoblastic macrocytic anaemia (haemoglobin 13 g./100 ml.) with histamine-fast achlorhydria. X-ray examination showed normal stomach, small intestine, and colon. The vitamin-B12 therapy that he was already receiving was continued. In 1960 the macrocytic anaemia was still present. In 1964 he again complained of intermittent constipation and diarrhoea. A barium enema showed a voluminous colon requiring three times the normal quantity of barium. In January 1967 he was readmitted with persistent bouts of constipation and diarrhoea with distension. For the first time there were external features of hypothyroidism. His skin was coarse and dry, his speech was slow and hoarse, and his movements were lethargic. Psychomotor retardation and delayed tendon jerks were present. The thyroid was not enlarged. Pubic and axillary hair were present. The abdomen was distended and tympanitic. Ascites could not be detected. The pulse was 80 and the heart slightly enlarged. The electrocardiogram showed no features of hypothyroidism. There was anaemia (HB 9 g./100 ml., P.C.V. 27%, M.C.H.C. 33.3%). X-ray examination of the abdomen showed distension of stomach, small intestines, and colon with fluid levels. Barium enema showed gross megacolon; five times the normal quantity of barium was required. The right side of the colon could not be filled, being distended by faeces, but the left half emptied well. The serum cholesterol was 280 mg./100 ml. and serum carotene 60 µg./100 ml. Thyroid function tests showed F.B.I. 2.6 µg./100 ml. (normal 3–8 µg./100 ml.); 24-hour iodine uptake was only 2% of a 5-µCi tracer dose.

Although the possibility of mechanical obstruction was entertained it had become evident that the megacolon was part of the gastro-intestinal atony of "internal myxoedema." He was treated by gastric aspiration, intravenous fluids, and triiodothyronine 10 µg. b.d., but he died on 23 February 1967. Bladder retention was present for 24 hours before death.

At necropsy there was slight left ventricular enlargement. The peritoneal cavity contained 750 ml. of fluid (protein 3.7 g./100 ml., cholesterol 25 mg./100 ml.). The stomach showed a smooth congested mucosa. Both small and large intestines were dilated, oedematous, and necrotic, but there was no mechanical obstruction of the bladder was not distended. The pituitary and adrenal glands were normal macroscopically and histologically. The thyroid gland weighed only 8 g. Histologically it consisted mainly of fibrous tissue with a few distorted acini. There was only moderate lymphocytic infiltration without follicle formation.

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COMMENT

In 1935 Escamilla, Lister, and Shepardson described under the term "internal myxoeedema" a case showing cardiac, intestinal, and bladder atony, ascites, secondary anaemia, and carotenaemia due to hypothyroidism, although the external features of this were only scanty. Our patient showed atony of the small and large bowel, ascites, macrocytic anaemia, and bladder retention. He was observed intermittently over nine years; there were at first no external features of myxoeedema, and barium studies of small intestine and colon were initially normal. During the subsequent years there was progressive enlargement of the colon and ultimately generalized intestinal atony. Only in this latter phase did the external signs of myxoeedema appear. Thus internal myxoeedema can present insidiously as unexplained atony of the gastrointestinal tract or bladder, cardiomegaly, ascites, or macrocytic anaemia. Intestinal atony may affect the stomach, small intestine, and colon. It is rare for it to cause intestinal obstruction as in the case of Escamilla et al. (1935) or our own, and has not to our knowledge been previously described as a cause of death.

Combination of gradually developing constipation with bladder retention or incontinence and slowness of ambulation may simulate a neurological disorder.

The term "internal myxoeedema" (Escamilla–Lister syndrome) embraces anaemia of various types. It is usually normocytic; but macrocytic anaemia, unresponsive to vitamin B12, and in the present instance, may be found. Steady progressing atony of the megacolon should raise the suspicion of internal myxoeedema even with paucity of external signs. Early treatment by thyroid replacement will result in resumption of normal bowel habit and abdominal girth, whereas parenteral thyroid replacement at the time of generalized dilatation and atony of the bowel may not be sufficient to save the patient. The dangers are atomic intestinal obstruction and perforation.

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