



Figure 1 Spontaneous vitreous haemorrhage in Fanconi's anaemia

haemoglobin was 3.5 g/dL and platelet count $6 \times 10^9/L$; therefore he was referred promptly back to his paediatrician.

On transfusion his haemoglobin rose to 7.3 g/dL but the platelet count remained very low ($7 \times 10^9/L$). The preretinal haemorrhage resolved within three months and had not recurred after one year of follow-up.

Short gastric artery perforation after use of 'ecstasy'

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J R Soc Med 1998;91:541-542

Potentially fatal reactions to 3,4-methylenedioxymethamphetamine (MDMA) or 'ecstasy' include cardiac arrhythmias, fulminant hyperthermia, convulsions, disseminated intravascular coagulation, rhabdomyolysis, acute renal failure and hepatotoxicity^{1,2}. Non-fatal reactions have included psychosis and depression³. Vascular complications are rare. We report an unusual case.

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COMMENT

Possible causes of a preretinal haemorrhage in a child such as this include trauma, Valsalva manoeuvre, hypertension and deteriorating blood indices. A history of trauma or raised intra-abdominal pressure was carefully sought and denied. His left kidney was non-functioning, but blood pressure was 116/64 mm Hg. Worsening blood indices were deemed the most likely reason for his haemorrhage.

Preretinal and retinal haemorrhages may complicate severe anaemia², but we can find no previous report of exclusively anaemic retinopathy before the age of 14. Thrombocytopenia is a recognized cause of retinal haemorrhage³ and probably contributed to the pathophysiology of this bleed. However, the haemorrhage has not recurred despite continuing thrombocytopenia; we postulate that it was the combination of severe anaemia and thrombocytopenia that caused the preretinal haemorrhage.

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CASE HISTORY

A 23-year-old man reported sudden onset of severe epigastric pain radiating to the back. He had vomited. The night before he had taken 'ecstasy' for the first time. There was no medical history of note and he was on no regular medications. He admitted to smoking cannabis regularly but denied other drug abuse and drank alcohol only occasionally.

On examination he was in pain and shocked, with heart rate 140 beats per minute (normal rhythm) and blood pressure 78/62 mmHg. The abdomen was rigid and bowel sounds were absent; rectal examination was normal. He was afebrile but had a leucocytosis of $27.7 \times 10^9/L$. Electrolytes were normal apart from a raised creatinine at $160 \mu\text{mol/L}$. The serum amylase was within normal limits as were liver function tests and arterial blood gases. An erect chest X-ray showed no free gas under either hemidiaphragm.

At laparotomy after resuscitation, the abdomen was found to contain approximately 500 mL blood. One of the short gastric arteries had ruptured. This was ligated and a section was taken for histological examination. Post-operatively he made a complete recovery. The resected

material showed interstitial haemorrhage into omental fat from rupture of a normal medium-sized artery. There was no evidence of an aneurysm or of vasculitis. A subsequent autoantibody screen was normal.

COMMENT

Spontaneous gastric artery perforation is extremely rare. It has been reported as an unusual presentation of atypical polyarteritis nodosa or Wegener's granulomatosis⁴. Subarachnoid haemorrhage has been reported in association with cocaine or amphetamine abuse, but only one case has been reported with MDMA use⁵, and that in the presence of a berry aneurysm. MDMA can cause a sympathetically mediated surge in blood pressure. In this case, no

underlying aneurysm was found. If the drug was responsible in part or whole for the arterial rupture in this case, the risk extends to apparently normal vessels.

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Pulmonary embolism in Klippel-Trénaunay syndrome of the upper limb

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J R Soc Med 1998;**91**:542-543

Klippel-Trénaunay syndrome is one of the commoner congenital vascular abnormalities, characterized by cutaneous naevi, severe venous varicosities, and hypertrophy of one or more limbs. In most cases the condition affects one leg only, and though thrombophlebitis is a common complication pulmonary embolism is infrequent. We report a case of upper limb Klippel-Trénaunay syndrome complicated by life-threatening pulmonary thromboembolism.

CASE HISTORY

A woman aged 63 was admitted with breathlessness that had begun suddenly two weeks earlier. Before this she had noticed discomfort in her left arm which had also become more swollen than usual. Her medical history included multiple minor operations to remove tender lumps that had appeared in her left arm, which over the years had become increasingly swollen and misshapen.

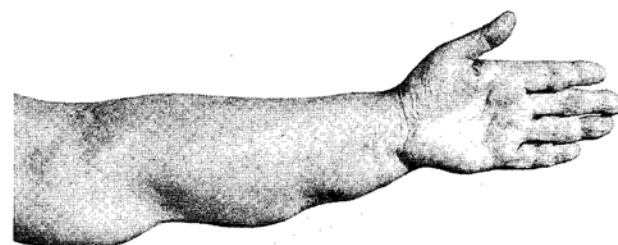


Figure 1 Photograph of left arm

On examination she was slightly breathless but her lungs were clear on auscultation. The left arm was cyanosed and swollen with multiple dilated vessels and no palpable thrills. The fingers were swollen and there was isolated gross clubbing of the index finger. Superomedial to the elbow was a tender subcutaneous lump (Figure 1). A chest radiograph was normal as were routine haematology and serum biochemistry tests. A ventilation/perfusion scan (V/Q) was arranged, but the patient was claustrophobic and only able to complete the perfusion scan. This showed multiple perfusion defects throughout both lungs (Figure 2). A doppler ultrasound examination of the left arm showed multiple dilated abnormal veins throughout the arm, many of which were disorganized and involved in a fibrotic mass. A massively dilated vein filled with clot extended from the medial aspect of the mid-upper arm distally. A plain film of the arm showed pronounced soft-tissue swelling and multiple phleboliths (Figure 3).

The diagnosis was Klippel-Trénaunay syndrome, with extensive thrombosis of the abnormal vessels and subsequent pulmonary embolism. The patient was started on warfarin anticoagulation and there have been no further episodes of breathlessness in follow-up of 9 months.

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