Chikungunya virus. Further investigations are required, because this situation is likely to occur more frequently in nature and may cause problems in diagnosing true illnesses.

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CATECHOLAMINE SECRETING ADRENAL MYELOLIPOMA

Sir,

We report a patient with biochemically proven pheochromocytoma, whose histology of a resected adrenal mass revealed adrenal myelolipoma, raising queries about this association.

A 48 year female presented with right upper quadrant abdominal discomfort, regurgitation and occasional anxiety attacks associated with sweating and diabetes mellitus, for 45 days. She was known to be hypertensive for 12 years, controlled on beta-blockers.

Her BP was 140/80 mm of Hg, with no postural drop. Abdominal examination revealed a vague, ill-defined, retroperitoneal lump in the right hypochondrium. CT abdomen revealed a 11 x 10.5 x 7 cm, well-encapsulated, non-homogenous, low density (-100 to -200 HF units), right adrenal mass with normal left adrenal gland. Serum potassium (4.2 meq/l), basal cortisol and low dose and high dose dexamethasone suppression tests were normal (22.5, 0.5 and 0.5 micro gm/dl, respectively). The 24 hour urinary metanephrine was 2.86 mg/day (normal-less than 0.8). DHEAS and testosterone estimation was not done, as there was no suspicion of malignancy. Thus, a diagnosis of pheochromocytoma was made and the patient was prepared with an alpha blocker (Prazosin 10 mg/day for 13 days). A beta blocker (Propanolol 80 mg/day) was added on the 10th day. She was explored via the anterior transperitoneal subcostal approach. A 13 x 11.7 cm well-encapsulated right adrenal tumor (weight: 575 gm) was excised. Hemodynamically, the patient was stable intra-operatively. The cut surface showed fatty content which was bright yellow in colour [Figure 1]. Histopathology [Figure 2] revealed myelolipoma with no evidence of pheochromocytoma or medullary hyperplasia. Our pathologist looked for medullary hyperplasia with specific immunohistochemical staining by chromogranin A, but there was no evidence of it.

The patient became normotensive immediately following surgery and the 24-hour urinary metanephrine collected on the 10th post-operative day was 0.63 mg/day (normal). In the follow-up of 14 months, the patient was normotensive and her blood sugar was normal.

Myelolipoma is an uncommon benign tumor of the adrenals, occurring in 0.08 to 0.2% of autopsy series. Adrenocortical dysfunction occurs in 10% and may present as Addison’s disease, Cushing’s disease, hermaphroditism, virilism, extreme obesity or multiple endocrinopathy. Associated hypertension is either incidental or due to mechanical compression on the renal vessels by the tumor. Rocher et al have reported pheochromocytoma with a myelolipoma on the contra-lateral side, while Ukimura et al reported a case with coexistence of the two lesions as histologically separate areas within same gland. Ishay et al have reported combined adrenal myelolipoma and medullary hyperplasia. In our patient, we suspected myelolipoma on the established CT criteria of a well-circumscribed, non-homogenous mass containing fat localized to the adrenal gland with low attenuation values (-100 to -200) and pheochromocytoma on biochemical evidence, but no evidence on histopathology, has no explanation. The cure of hypertension and diabetes in follow-up are the only clinical parameters which suggest that the mass was functioning.

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Pregnancy in most cases, is associated with remission of rheumatoid arthritis (RA), but a quarter of patients continue to have active disease or even worsening of the disease and most patients who improve, relapse in the postpartum period. The pathophysiology of this improvement in disease activity during pregnancy remains unknown, but hormonal, cell-mediated immunological and humoral immunological changes during pregnancy have been proposed responsible for this. Most of the pregnant women with RA have an uneventful course, with no significant complications. In general, no significant increase in maternal or fetal morbidity seems to be attributable to RA. Patients with RA do not have decreased fertility. A majority of patients with RA may go in remission and anti-rheumatic treatment may not be required as soon as women become pregnant. But other patients who continue with the disease activity require treatment. The preferred disease-modifying agents during pregnancy are sulfasalazine and hydroxychloroquine. Azathioprine and cyclosporine can be used if the benefits outweigh the risks. Paracetamol and low dose prednisone are preferred and considered safe, both for mother and fetus. Methotrexate and lefunomide are contraindicated and must be prophylactically withdrawn before a planned pregnancy. Biologics generally should be stopped when pregnancy is discovered. An overall rational approach is highly warranted to treat RA during pregnancy.

**Key words:** humans, pregnancy, rheumatoid arthritis, (physiopathology or physiology)

**ABSTRACT**

PREGNANCY AND RHEUMATOID ARTHRITIS  
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Pregnancy has an important impact on rheumatoid arthritis (RA) and on many other rheumatic diseases like systemic lupus erythematous, Sjogren’s syndrome, juvenile idiopathic arthritis, Reiter’s syndrome, scleroderma, dermatomyositis / polymyositis and psoriatic arthritis. [1-3] It is well known that females suffer more of musculo-skeletal and rheumatic complaints, including RA. [4] RA is three times more common in females. [5] Because of female predominance of this disease, it is likely that pregnancy will be a question encountered by patients and their practitioners. Hence, it becomes important for practitioners to know the course of RA in pregnancy.

**PRACTITIONERS’ SECTION**

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