HEADACHE AS THE ONLY SIGN OF PHEOCHROMOCYTOMA: AN ANALYSIS

Sir,

Pheochromocytoma is an uncommon disease and headache is one of the most frequent symptoms, present in 80% of cases. Headache as the only presentation of pheochromocytoma in the absence of other symptoms is rare.

In this paper, we present the characteristics of patients in whom headache was the only presentation of pheochromocytoma in the absence of symptoms of sympathetic overactivity. The present study is based on a retrospective review of data collected (prospectively) over a 10-year period of 28 consecutive patients with pheochromocytoma admitted in the medical/surgical endocrinology department between December 1996 and June 2005. Diagnosis of pheochromocytoma was based on 24-hour urine metanephrines/ Vanillylmandelic acid with CT of the abdomen.

Patents were included in the present study if headache was the only presentation of pheochromocytoma in the absence of features of sympathetic overactivity, and also they had normal blood pressure.

We obtained a detailed description of the features of headache, including its mode of onset, location, severity, pattern and evolution; and these were classified according to the criteria of the International Headache Society (IHS). For all patients, we recorded the past history of the headache and residual headache.

History of use of beta blockers and no history of diabetes, which would have impaired the sympathetic nervous system manifestations. All the three patients had visual aura in the form of fortification spectra. All the four patients had complete resolution of headache after surgery, further relating the headache to pheochromocytoma. The demographic characteristics, the biochemistry and the radiological features of patients with headache were different from patients presenting with other classical features.

Of the 28 patients, 4 patients (14.3%) presented with headache as the only manifestation at the time of initial evaluation. There were 3 males and 1 female; with mean age 20 years, range 17-23 years. The mean delay between the onset and diagnosis was 54.3 days (range 36-48 days). All the patients had tumors in the adrenal region and had predominant secretion of norepinephrine.

The headache characteristics are given in Table 1.

<table>
<thead>
<tr>
<th>Patient</th>
<th>History of migraine</th>
<th>Onset</th>
<th>Evolution</th>
<th>Pattern</th>
<th>Associated signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>No</td>
<td>Progressive</td>
<td>Continuous</td>
<td>Constrictive</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Throbbing</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cranium</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>No</td>
<td>Progressive</td>
<td>Intermittent</td>
<td>Throbbing</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cranium</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>No</td>
<td>Progressive</td>
<td>Intermittent</td>
<td>Throbbing</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cranium</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>No</td>
<td>Progressive</td>
<td>Intermittent</td>
<td>Throbbing</td>
<td>10</td>
</tr>
</tbody>
</table>

The most frequent characteristics were migraine-like presentation in three patients (75%), unilateral location (75%) and throbbing quality (75%). There was no family history of migraine in all the three patients. There was no history of use of beta blockers and no history of diabetes, which would have impaired the sympathetic nervous system manifestations. All the three patients had visual aura in the form of fortification spectra. All the four patients had complete resolution of headache after surgery, further relating the headache to pheochromocytoma. The demographic characteristics, the biochemistry and the radiological features of patients with headache were different from patients presenting with other classical features.

REFERENCES

Acute acalculous cholecystitis is a rare complication of dengue fever.\(^1\)\(^-\)\(^4\) The pathogenesis is not entirely clear, though a likely mechanism may be the abnormal permeability of serous membranes causing capillary leak, as a result of direct viral invasion and hypoalbuminemia. Both patients had upper abdominal pain, gallbladder wall thickening and transient rebound tenderness, confirming the diagnosis of AAC. In a previous report of AAC, the histopathology of two gallbladders removed surgically showed chronic inflammatory cell infiltrate in the wall with erythrocytes in the lumen.\(^5\) However, a recent contrasting report revealed a normal gallbladder wall in a patient with AAC with DF complicating pyrexia of unknown origin.\(^6\) If a patient with dengue fever develops abdominal pain with localized tenderness in the right upper quadrant, AAC should be suspected and investigated. The course of AAC in DF is usually benign and management is conservative.

REFERENCES


OUTCOME OF CORONARY BYPASS GRAFTING

Sir,

We read the article ‘Outcome of coronary artery bypass grafting in patients……artery disease’ by Nozari et al., which was published in the October 2007 issue of the journal.\(^7\) It is an interesting article; and in the extant literature, one finds an endless list of articles focusing on the outcome of coronary artery bypass grafting (CABG) surgery. Under ‘Material and methods,’ the authors describe a stenosis of 50% or more in the left main coronary artery as significant. We would appreciate an exact anatomical location of the stenosis under such circumstances. As anatomists, we also wonder if 70% or greater than...