levels were higher still, and greater than those in patients with acute myocardial infarction. In a small group of patients with myocardial infarction from whom samples were obtained shortly before (<30 min) cardiac arrest, still higher levels were seen. The highest levels were found in patients in cardiac arrest. Plasma dopamine (DA) concentrations generally followed those of NA and A.

Within each group there tended to be a relationship between catecholamine concentrations and severity of the stress/trauma measured by independent means, e.g. with Injury Severity Score (Baker et al., 1974) after injury, or with sepsis score (Elebute & Stoner, 1983) in the surgical patients. There were some differences between the conditions in the extent to which the different amines responded, e.g. the elevated A response to severe injury compared with that after accidental hypothermia, perhaps reflecting different afferent stimuli.

We conclude that the elevation of plasma catecholamine concentrations seen in various acute states of stress and trauma broadly reflects the expected sympathoadrenal activity, and might even be useful in ‘grading’ different states on a common severity scale.

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R. A LITTLE, K. N. FRAYN, P. E. RANDALL, H. B. STONER & PAULA F. MAYCOCK
MRC Trauma Unit, University of Manchester, Manchester, England

AIDS and the accident and emergency department

Sir

A 35-year-old man presented to the Accident and Emergency Department of Edinburgh Royal Infirmary in April 1984, complaining of cough, productive of purulent sputum, and intermittent haemoptysis for the previous week. On further questioning, he admitted to a 3-month history of night sweats, intermittent ‘fevers’ and weight loss of 6.5 kg. His past history included repair of an inguinal hernia, an avulsion of an ingrowing toe-nail, together with attendance at a sexually transmitted diseases clinic in another city.

For 10 years, he had been a practising homosexual, averaging two new partners each week. He had used nitrite drugs and had practised oral and anal intercourse. At the time of presentation he was itinerant, but had been working as a cook.
Examination revealed him to be thin, apyrexial with bilateral inguinal, axillary and left cervical lymphadenopathy. Two non-pigmented, firm subcutaneous nodules, approximately 1 cm in diameter, were detected; these were non-tender and unattached to skin or underlying tissues. The patient left the hospital before the lesions could be identified. Chest and abdominal examination was unremarkable and in particular there was no hepatosplenomegaly.

He was admitted to a local infectious diseases unit, where further investigations showed a normal haemoglobin, total white count, ESR and bone marrow aspirate; however, the absolute lymphocyte count was low at $1.5 \times 10^9$/litre. Routine biochemical blood tests, including urea, electrolytes, liver function tests, calcium, phosphate and creatinine were normal. There was anergy to tuberculin at 1:10000 and 1:1000, but produced induration of 1-cm diameter at 1:100. In addition there was anergy to trichophyton skin testing, but not to mumps. The total IgG assay was elevated at 13.2 g/l (normal 5–13 g/l). Virology titres showed evidence of past infection with Epstein–Barr virus, hepatitis B and cytomegalovirus.

No pathogens were isolated from sputum (including Ziehl–Neelsen staining) or stools, and culture of sputum and lymph node for acid- and alcohol-fast bacilli was negative. Lymph node biopsy showed a reactive hyperplastic change.

Although the patient took his own discharge prior to the completion of full investigations, his clinical and laboratory findings are compatible with the syndrome of progressive generalized lymphadenopathy (PGL) which is thought to represent a prodromal stage of the Acquired Immunodeficiency Syndrome (AIDS) and may lead on to the full-blown AIDS picture in approximately 8% of cases per year (Anon., 1983; Harris et al., 1983).

AIDS is a relatively ‘new’ disease, first brought to light in the USA in 1981, and it appears to be communicable (Curran et al., 1984). By June 1984 there were more than 5000 cases recognized in the USA, and 51 reported cases in the UK (Communicable Disease Report, 1984). With a mortality approaching 100%, the syndrome has undergone a rapid increase among homosexual males in the USA, although it is by no means confined to this group.

The most common modes of presentation to AIDS are Kaposi’s sarcoma and atypical opportunistic infections, but as far as we are aware, no such case has been reported following presentation to an accident and emergency department in Great Britain.

With the known increase in AIDS worldwide it may be anticipated that further cases will be seen with increasing frequency in the UK. Because of the likely long incubation period of 2–5 years, and until HLTV type 3 antibody tests are available, it would seem appropriate when dealing with patients suffering symptoms or signs compatible with PGL who are in a high risk group to take those precautions at present advised for full-blown cases of AIDS (Anon., 1983). These include avoidance of contact of mucous membranes and skin with blood or blood products, secretions or tissues of suspected cases.

W. G. TENNANT & R. P. BRETTLE
*Department of Accident and Emergency Medicine,
Royal Infirmary, Edinburgh and †Infectious Diseases Unit,
City Hospital, Edinburgh, Scotland
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Dislocation of the distal radio-ulnar joint

Sir

The common association of dislocation of the distal radio-ulnar joint with fractures of the radius is well documented. The incidence of this dislocation with radial head fractures is quoted as 1% (Essex-Lopresti, 1950, 1951; McDougall & White, 1957), and is even more common in Colle’s and Galeazzi fractures (Mikic, 1975). Simple acute anterior dislocation of the distal ulnar at the inferior radio-ulnar joint without a fracture is rare, but a few cases have been reported (Cox, 1942; Curr & Coe, 1946; Rose-Innes, 1960).

A 24-year-old left-handed man was brought to the accident and emergency department following a fall on to his outstretched right hand during a game of football. He was in severe pain and there was a depression (furrow) along the distal posterior half of the ulna, with prominence of the radius at the wrist. Elbow movements were normal, but he could not perform supination, pronation or rotation of the forearm. Although he complained of numbness in the ring and little fingers, circulation was normal and there was no objective evidence of sensory loss. Radiographs were interpreted as showing rotation of the ulnar styloid and widening of the wrist joint (Fig. 1). The views were not good but could exclude fracture. The diagnosis of dislocation of the distal radio-ulnar joint was made. Unsuccessful attempts were made to reduce this dislocation using local anaesthesia and diazepam. Under general anaesthesia the clinical deformity was corrected and a check x-ray was satisfactory (Fig. 2). He was immobilized in a plaster of Paris for 4 weeks and later regained full rotation of the forearm.

O. ONUBA
University of Calabar Medical School,
Calabar, Nigeria