

PICTORIAL CME**Pitting Edema in Hypothyroidism****N. S. Neki**

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A 21 year old female reported to us with complaints of generalized swelling, puffiness of face, constipation, weakness, hoarseness of voice for 4 months. She was normotensive & nondiabetic. On examination she had pitting pedal edema bilaterally (fig 1), normal JVP, delayed relaxation of ankle jerks, Pulse 58/min regular, BP 130/80 mmHg. Neck examination revealed thyromegaly. Rest of general physical examination & systemic examination was normal. Her laboratory profile revealed Hb 10.3 gm%, TLC & DLC, Total and differential S.proteins, SGOT & SGPT, B. urea, S. creatinine all within normal limits. S. cholesterol 310 mg/dl. X ray chest & 2D Echocardiography was normal. ECG showed sinus bradycardia with normal voltage. Thyroid profile revealed T₃ 0.36 µg/ml (0.58- 1.59µg/ml), T₄ 1.56 ng/ml (4.87- 11.72 ng/ml) & TSH 118mU/L (0.35- 4.94 mU/L). She was started with L-thyroxin 25 µg per day which was later increased to 100 µg per day over one month. She is on regular follow up with dose increased to 175 µg with subsidence of edema and disappearance of symptoms. Peripheral edema is noted in 55% patients of hypothyroidism & 22% patients of hypothyroidism show periorbital edema. Pitting edema in hypothyroidism is rare & may be due to increased capillary permeability, decreased (vasoconstrictor) tone & increased serotonin (vasodilator) metabolism¹.

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The Prayer Sign**N. S. Neki**

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A 58 years old female patient presented to us with complaints of difficulty in approximating palmar surface of the phalangeal joints & difficulty in bending their fingers backwards despite maximal effort. She was a known case of diabetes mellitus since 13 years & hypertension 9 years and was on regular antidiabetic & antihypertensive medications. Her laboratory profile revealed Hb 10.2%, TLC & DLC & B. urea, S. creatinine within normal limits, RBS 213%, HbA1c 8.9%, S. cholesterol 175mg/dl, S. Triglycerides 310mg/dl, S.HDL 35mg/dl, S.LDL 112mg/dl. X ray chest showed cardiomegaly. ECG revealed LVH & 2D Echocardiography showed diastolic dysfunction with ejection fraction 51%. RA factor negative. X ray hands was non contributory. Examination of the hands revealed limited joint mobility with evidence of abnormal waxiness, thickness & rough skin on dorsum of all fingers which was diagnostic of diabetic cheiroarthropathy. The Prayer sign is characterized by inability to completely close gaps between opposed palms & fingers when pressing their hands together in prayer's position (see figure 1). Diabetic cheiroarthropathy, also known as diabetic stiff hand syndrome or limited joint mobility syndrome is encountered in 8-50% of all patients with type 1 diabetes mellitus & is also seen in type 2 diabetes patients. The prevalence increases with duration of diabetes. This condition is associated with & predictive of diabetic complications like retinopathy, neuropathy & hypertension^{1,2}. It begins in the little finger with painless limitation of hand movement & proceeds radially to involve other fingers. The skin becomes pebbled & rough over interphalangeal joints, knuckles & periungual regions. It is probably due to increased glycosylation of collagen in the skin & periarticular tissue, decreased collagen degradation, diabetic microangiopathy & diabetic neuropathy³.

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