Clinical Reminders

A case of recurrent rapidly progressive lower limb weakness

A 73-year-old man was admitted with progressive lower limb weakness of over 2 days. Cola-like urine was noted (see Appendix 1 in the supplementary data on the journal’s website http://www.ageing.oxfordjournals.org) and his CK was 16,788 U/L. He had a similar presentation with weak legs and renal failure, requiring temporary dialysis a year earlier. On both occasions fucidin had been commenced for a discharging sternal sinus. Other medications were simvastatin, omeprazole and aspirin. His symptoms promptly resolved after stopping simvastatin and fucidin. A diagnosis of rhabdomyolysis with myoglobinuria induced by the combination of fucidin and simvastatin was made.

Risk factors for statin-induced myopathy are higher doses, frail elderly, renal impairment, diabetes or multiple medications [1]. There are only three reports of fucidin and statin precipitating rhabdomyolysis [2–4].

Clinicians should consider rhabdomyolysis in any patient with weakness or reduced mobility while on statin. Visual examination of the urine is crucial. Pain or muscle tenderness is not always present. Timely recognition and intervention should help prevent the potentially serious complication of acute renal failure.

Conflict of interest

None

Supplementary data

Supplementary data for this article are available online at http://ageing.oxfordjournals.org.

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Could the 90s be a second childhood period? The case of Henoch-Schonlein purpura

Henoch-Schonlein purpura (HSP) is a common systemic vasculitis, which usually affects children and is quite rare in adults [1]. Herein we report the oldest patient with HSP, a 90-year-old woman with purpuric lesions on her lower extremities and buttocks (see Appendix 1 in the supplementary data on the journal’s website http://www.ageing.oxfordjournals.org). Other systemic complaints were absent although laboratory evaluation was normal. The diagnosis was based on the presence of palpable purpura and histological findings of cutaneous leucocytoclastic vasculitis with IgA-immunoglobulins and C3-deposits on the vessel walls. Other causes of leucocytoclastic vasculitis were excluded. Contrary to what has been reported in adults, HSP in this patient was almost ‘silent’ while similar to what is reported in most HSP cases during childhood, the disease was self-limited [2, 3]. This case study may suggest that HSP should be considered as a diagnosis irrespective of the severity of symptoms even at the extremes of age if at least a non-thrombocytopenic palpable purpura on the lower limbs and buttocks is present and an investigation for other causes of leucocytoclastic vasculitis is unrevealing.

Conflicts of interest

None

Supplementary data

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