immense value in diagnosing this rare condition in living individuals. Most patients of adrenal metastases may be asymptomatic and are generally diagnosed at autopsy.

PP Roy*, Nandita Basu**
*Assistant Professor and Head, Chest Medicine; **Associate Professor, Department of Pathology; Medical College, Calcutta. Received : 7.9.2002; Revised : 7.6.2003; Re-Revised : 1.8.2003; Accepted : 26.4.2006

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Idiopathic Clubbing

Sir,

Although finger clubbing is relatively innocuous, yet it is important because of its frequent association with significant underlying disease. The major conditions associated with clubbing and hypertrophic osteoarthropathy are: pulmonary diseases (75-80%), cardiovascular abnormalities (10-15%), diseases of the liver and gastrointestinal tract (5-15%) and miscellaneous disorders (5-15%).1 Finger clubbing may also occur rarely without evidence of underlying disease, in an idiopathic or primary form.

A 25 years male nursing assistant in the Indian Army presented with the chief complaint of bulbous swelling of all fingers and toes since one and a half years. This swelling was painless, except for some discomfort during the winter months, and gradually progressive. There was no history of palpitations, chest pain, syncope, ankle swelling, cyanosis, or any gastrointestinal complaints. He was a non-smoker and did not consume alcohol. There was no past history of any major illness. There was no family history of clubbing.

On examination, his pulse was 72/min, respiratory rate 16/min, and blood pressure 120/70 mm Hg. There was no pallor, cyanosis, icterus, or lymphadenopathy. Clubbing was present in all the fingers and toes with a drumstick appearance (Fig. 1). There was no swelling or tenderness of the wrists, elbows, ankles or knees. There was no thickening of the skin over the arms or legs. The systemic examination was normal. On investigation, his blood counts and biochemical parameters were within normal limits. Chest radiograph, electrocardiogram and spirometry were normal. Two-dimensional echocardiography did not reveal any intracardiac shunt. High resolution computerized tomography of thorax showed no evidence of any diffuse or localized parenchymal disease. A radiograph of the wrists and hands showed no evidence of periostitis or new bone formation. His thyroid and liver function tests were normal. The serum tests for RA factor and anti-dsDNA were negative. As no cause of the clubbing could be found, a diagnosis of idiopathic clubbing was made.

Primary or idiopathic clubbing, though rare, has been reported in literature.2,3 Primary or idiopathic clubbing can be of two types: a) Hereditary or familial form, b) Associated with pachydermoperiostosis. Both are distinct clinical entities. In the hereditary or familial form, the clubbing develops during childhood in the absence of any associated disorder and it persists throughout the life of the individual. Family studies have suggested an autosomal dominant pattern of inheritance.2

Clubbing associated with hypertrophic osteoarthropathy, is also referred to as pachydermoperiostitis or Touraine-Solente-Gole syndrome. This condition is characterized by clubbing, periostitis, and skin changes.

In our patient it was initially thought that this could be congenital clubbing, which the patient may not have noticed earlier. However, he had undergone a thorough medical check-up at the time of recruitment into the army at the age of 18 and also subsequently, during periodic routine medical examination conducted by medical specialists. It is, therefore, extremely unlikely that such gross clubbing would have been missed. The patient has been under follow-up for the last two years, and there are no fresh complaints or clinical findings to point towards a cause for the clubbing.

MS Peerbhoy*, KE Rajan**, RB Deoskar**, MS Barthwal**
*Resident; **Professor (Retd.); ***Associate Professor; Department of Respiratory Medicine, Military Hospital (Cardio Thoracic Centre), Pune - 40.
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