DON'T FORGET TO TAKE THE SOCKS OFF!
Falls in a patient with pancreatic cancer

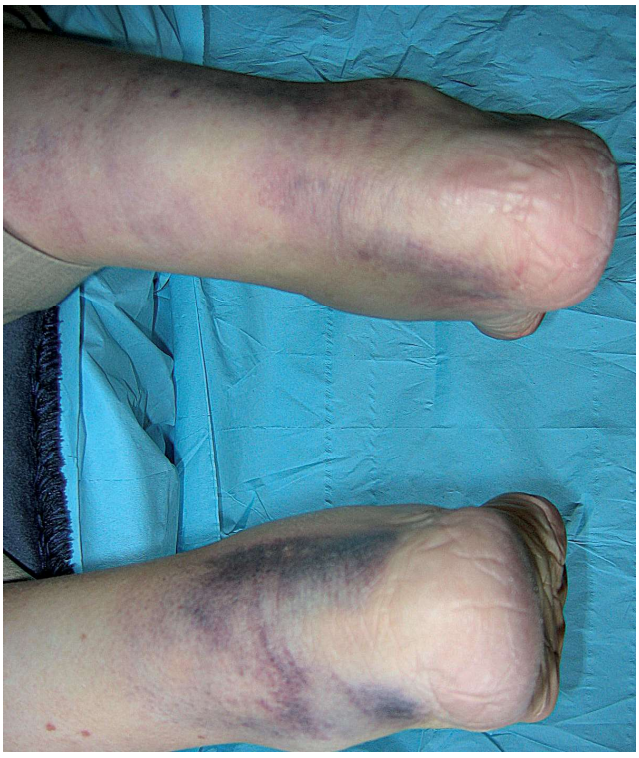
H Thomas, MBChB; M Denver, MRCGP

Falls are a common cause of morbidity in older people. Surveys have indicated that up to 25% of 65-69 year olds fall at least once a year, and this figure increases significantly with advancing years[1]. Dr Helen Thomas and Dr Mark Denver, doctors at the Meadowside Medical Practice, Lancaster, describe the case of a 77-year-old man with pancreatic carcinoma who presented at the surgery with multiple falls.

CASE REPORT

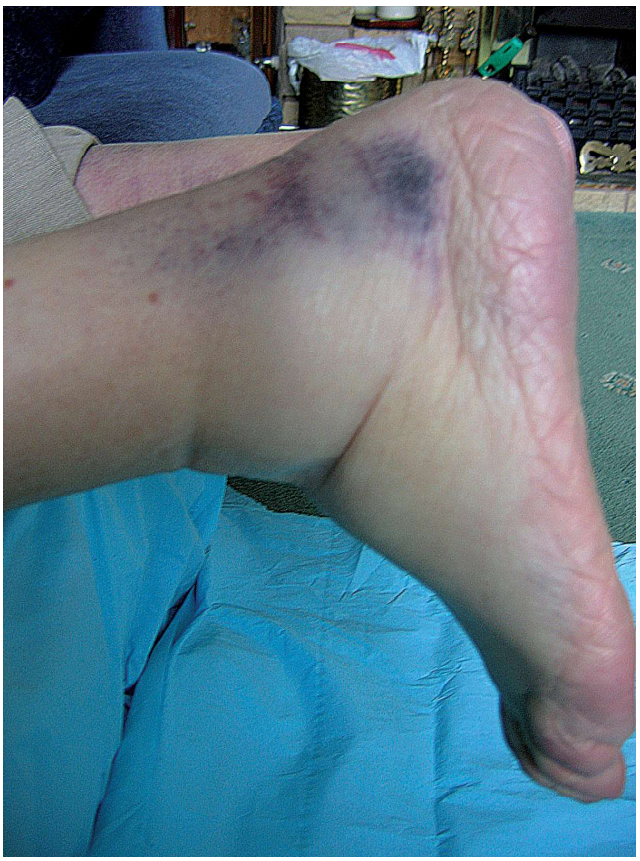
The patient was asked to attend the surgery by his Macmillan nurse, having a history of recurrent falls over the preceding two weeks. She had noted an irregular pulse at this time and was concerned he was falling because of a medical cause unrelated to the reason she was visiting him – her concerns were a heart or neurological problem. He had been diagnosed with inoperable pancreatic carcinoma several months earlier, and was prescribed dexamethasone as palliative treatment. He also had a history of hypertension and angina. He was feeling relatively well, living with his partner, and enjoying a reasonably active life.

The patient had never lost consciousness when he had fallen. He didn't remember tripping over anything, but described the feeling that his feet didn't seem to be able to keep up with the rest of his body. He denied any palpitations or dizziness, and always fell forwards. In addition to the dexamethasone he was taking loperamide, Creon, nicorandil, ranitidine, clopidogrel, atenolol and furosemide.



Extensive bruising both achilles.

On examination his pulse was 95 bpm irregularly irregular and blood pressure 122/84 mmHg. An electrocardiograph confirmed atrial fibrillation. Evidence of falls was found in the form of extensive bruising to the chest wall and abrasions to the knees. Both legs were well perfused with good pulses, and sensation was intact. Examination of the ankles revealed extensive bruising to the posterior aspect of the ankle and heel to both sides. There was an obvious step noted and the Thompson test was positive bilaterally, indicating bilateral ruptured Achilles tendons. On further questioning he said he had noticed the painless bruising when getting out of bed one morning two weeks earlier.



Painless bruise with step deformity achilles tendon.

DISCUSSION

This case highlights the need for a good history and thorough clinical examination when assessing any patient with falls. Before the patient arrived at the surgery after the call from the Macmillan nurse the most likely cause of his falls was

thought to be either a cardiovascular or neurological problem. If we had not removed his socks during the assessment we would not have been able to reveal painless spontaneous rupture of the Achilles tendons bilaterally.

Achilles Tendon Rupture

Sporting injury
Recurrent tendonitis
Gout
Parathyroiditis
Steroid therapy

Achilles tendon rupture is a relatively common problem that can affect any age, but particularly those aged 30-50 years[2]. In our patient's case we believe the rupture was probably caused by the oral steroids he was taking. Although the link between steroid use and tendonopathies is not well known it was first documented over 40 years ago. Both oral and parental steroids have been shown to lead to tendonopathies, particularly Achilles tendon rupture[3].

Treatment options for Achilles tendon rupture include surgical repair or conservative management in a plaster cast or orthosis[4]. Surgical repair is the treatment of choice for professional athletes or other patients with a high level of physical activity. Considering his co-morbidities, and since he was very keen to go on a cruise, a conservative management was chosen in this case. He was able to walk with a Zimmer frame, with some degree of foot drop.

REFERENCES

1. Evans JG. Medicine in old age. IN Warrell DA, Cox TM, Firth JD, Benz EJ Jr, editors. Oxford Textbook of Medicine. 4th Ed. Oxford: Oxford University Press; 2003. Section 30 pp1375-91

2. Bhandari M, Guyatt GH, Siddiqui F, *et al*. Treatment of acute Achilles tendon ruptures: a systematic overview and metaanalysis. Clin Orthop Relat Res 2002;400:190-200

3. Blanco I, Krahenbuhl S, Schleinger RG. Corticosteroid-associated tendinopathies: an analysis of the published literature and spontaneous pharmacovigilance data. Drug Saf 2005;28(7):633-43

4. Kingsnorth AN. Tendon injuries. IN Majid AA, Kingsnorth AN, editors. Fundamentals of Surgical Practice. 1st Ed. London: Greenwich Medical Media; 1998. Section 20 p13