occur in some cases. Most cases have been reported with ulcerative colitis, although Crohn's disease has also been reported in inflammatory bowel disease-related pericarditis (Manomohan et al, 1984). Cooper et al's (1997) study of 86 patients with idiopathic giant cell myocarditis revealed inflammatory bowel disease as the most common associated disorder. In all cases, the diagnosis of inflammatory bowel disease preceded myocarditis by several years.

Occult inflammatory bowel disease should be excluded in patients who present with pericarditis of unknown origin. Pericarditis may occur independently of other extraintestinal manifestations, and may recur despite quiescence of the inflammatory bowel disease (Sarrouj et al, 1994). Bragagni and colleagues (2007) demonstrated that cardiac involvement in Crohn's disease is frequent, but the mechanisms that cause these phenomena are unable to be identified. Pericarditis caused by inflammatory bowel disease or other autoimmune diseases such as systemic lupus erythematosus, Sjögren's syndrome, scleroderma or polymyositis usually responds well to corticosteroids while pericarditis caused by rheumatoid arthritis has a poor response to medical therapy and requires surgery.

Conclusions

Serositis is an uncommon extraintestinal manifestation of inflammatory bowel disease. It should be considered in the differential diagnosis of inflammatory bowel disease patients presenting with chest pain and breathlessness. A high index of suspicion is crucial as the outcome is usually good with steroids. **BJHM**

Bragagni G, Brogna R, Franceschetti P, Zoli G (2007) Cardiac involvement in Crohn's disease: echocardiographic study. *Gastroenterol Hepatol* **22**(1): 18–22

Camus P, Piard F, Ashcroft T, Gal AA, Colby TV (1993) The lung in inflammatory bowel disease. *Medicine (Baltimore)* **72**: 151–83

Cooper LT Jr, Berry GJ, Shabetai R (1997) Idiopathic giant-cell myocarditis--natural history and treatment. Multicenter Giant Cell Myocarditis Study Group Investigators. *N Engl J Med* **336**: 1860–6

Ho GT, Innes JA, Shand AG, Satsangi J (2006) Bronchopulmonary manifestations of inflammatory bowel disease: a case report and literature review. *J R Coll Physicians Edinb* **36**: 299–303

Mahadeva R, Walsh G, Flower CD, Shneerson JM (2000) Clinical and radiological characteristics of lung disease in inflammatory bowel disease. *Eur Respir J* **15**: 41–8

Manomohan V, Subbuswamy SG, Willoughby CP (1984) Crohn's disease and pericarditis. *Postgrad Med J* **60**: 682–4

Oxentenko AS, Loftus EV, Oh JK et al (2002) Constrictive pericarditis in ulcerative colitis. *J Clin Gastroenterol* **34**: 247–51

Sarrouj BJ, Zampino DJ, Cilursu AM (1994) Pericarditis as the initial manifestation of inflammatory bowel disease. *Chest* **106**: 1911–12

Storch I, Sachar D, Katz S (2003) Pulmonary manifestations of inflammatory bowel disease. *Inflamm Bowel Dis* **9**: 104–15

IMAGES IN MEDICINE

Aquagenic pruritus

A 24-year-old man presented to his GP with a 3-week history of pruritus confined to the palms of his hands within minutes of bathing or showering. He stated that his symptoms generally regressed within 45 minutes. The pruritus occurred regardless of water temperature and he denied any allergy to soaps or shampoos.

Upon immediate exposure to water the patient's fingertips and thenar eminence became markedly wrinkled (*Figure 1* – A). In addition he developed a small rash on his left palm comprised of red non-blanching macules (*Figure 1* – B). A routine full blood count, liver and renal function as well as haematinics were unremarkable.

The GP initially prescribed the antihistamine hydroxyzine which provided only mild relief. The medication was stopped and cimetidine was later instigated. After 1-month follow up the patient remained asymptomatic. He was instructed to continue with the medication only as needed. **BJHM**

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Figure 1. The patient's hands following immediate exposure to water.