Figure 4. Left ventriculography showing extensive anterior and inferio-apical areas of dyskinesia.

tion to prevent mural thrombus has been suggested by some (Chen et al, 2006).

Figure 5. Left ventriculography showing extensive anterior and inferio-apical areas of dyskinesia.

Short-term outcomes are excellent, with complete resolution in all reported cases. However, there are no data in the literature regarding long-term outcome in patients who have experienced Tako–Tsubo cardiomyopathy (Tarkin et al, 2008). BJHM

Abdulla I, Ward MR (2007) Tako-Tsubo cardiomyopathy: how stress can mimic acute coronary occlusion. *Med J Aust* **187**(6): 357–60

Chen YL, Yu TH, Fu M (2006) Takotsubo cardiomyopathy--transient left ventricular apical ballooning mimicking acute myocardial infarction. *J Formos Med Assoc* **105**(10): 839–43

Movahed MR, Donohue D (2007) Transient left ventricular apical ballooning, broken heart syndrome, ampulla cardiomyopathy, atypical apical ballooning, or Tako-Tsubo cardiomyopathy. *Cardiovasc Revasc Med* **8**(4): 289–92

Pezzo SP, Hartlage G, Edwards CM (2009) Takotsubo cardiomyopathy presenting with dyspnea. *J Hosp Med* **4**(3): 200–2

Tarkin JM, Khetyar M, Kaski JC (2008) Management of Tako-tsubo syndrome. *Cardiovasc Drugs Ther* **22**(1): 71–7

Medical mystery: an unusual cause of anaemia

An 82-year-old Indian man presented with a month's history of increasing lethargy, shortness of breath and 2 kg weight loss. No significant past illness was elicited, specifically no history of change in bowel habit, malaena, haematemesis, fever, abdominal or chest pain. At admission, he was on oral iron therapy only and was a non-smoker who rarely drank alcohol. On examination he was pale, haemodynamically stable, with normal cardiorespiratory, abdominal and digital rectal examinations.

Haematology demonstrated haemoglobin 6.7 g/litre, white cell count $3.7x10^9$/litre, neutrophils $3.4x10^9$/litre, platelets $85x10^9$/litre, reticulocytes 2.4% and erythrocyte sedimentation rate 20 mm/hour. Iron results were iron 4 mg/litre, total iron binding capacity 75 mg/litre, transferrin saturations 5% and ferritin 18 mg/litre. Renal and liver function and serum tumour markers alpha-fetoprotein, CEA and CA19-9 were also normal.

Serum electrophoresis was negative for sickle and thalassaemia. His blood film is shown in *Figure 1*. Gastroscopy revealed three large columns of varices, marked portal hypertensive gastropathy without evidence of recent bleeding. Colonoscopy was normal, so computed tomography of his abdomen was arranged (*Figure 2*).

Discussion

The blood film is consistent with iron deficiency anaemia with microcytosis, hypochromia and pencil cells. There is no evidence of leukaemia and the reticulocyte count indicates good bone marrow synthetic function.

Computed tomography demonstrates an inflamed gall bladder containing a 12 mm calcified stone and smaller stones. There is intra-hepatic biliary dilatation without common bile duct dilatation and there are no masses. Splenic and portal varices are seen, with cavernous transformation at the porta-hepatis, indicating proximal venous thrombosis.

Silent cholecystitis was the most likely cause of the proximal venous thrombosis and consequently varices and cavernous transformation. As the only positive findings in the upper and lower gastrointestinal tracts were oesophageal varices with portal hypertensive gastropathy, it is highly likely this caused the patient's iron deficiency anaemia. Cavernous transformation at the porta-hepatis is likely to be responsible for the mild intra-hepatic biliary dilatation. BJHM

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Figure 1. Blood film.

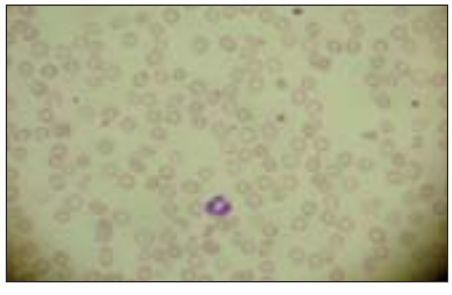

Figure 2. Computed tomogram of the abdomen.