PICTORIAL

HYPOTHYROIDISM PRESENTING AS HOFFMAN SYNDROME

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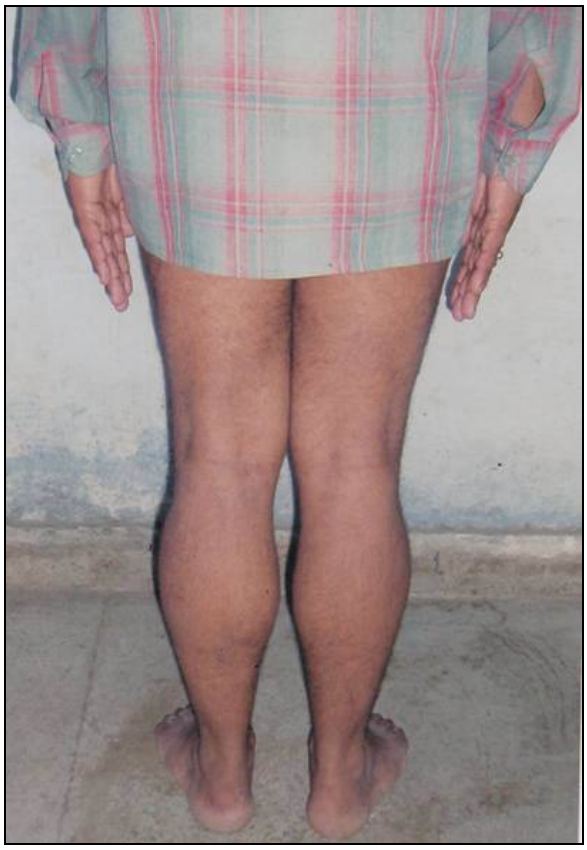

A 40 year old male presented with features suggestive of myxedema in the form of hoarseness of voice, fatigability, constipation, cold intolerance, non-pitting bilateral ankle edema and proximal muscle weakness from last 1.5 years. He was not a known diabetic and hypertensive. On examination, he had bilateral calf muscle hypertrophy with normal tone (photograph) along with percussion myoedema and delayed tendon jerk relaxation. His thyroid profile showed T3 0.2 ng/ml, T4 10 ng/ml and TSH 135 mU/ml. Anti-microbial antibody, anti-thyroglobulin titers were 210 AU/ml and 425 U/ml respectively. Ultrasound thyroid showed atrophy. CPK was 450 U/l. Electromyogram revealed polyphasic action potential consistent with hypothyroid myopathy. Nerve conduction velocity was normal. Muscle biopsy revealed atrophy of muscle fibers with increased inter-fiber ground substance. In this patient having features of myxedema and bilateral calf muscle pseudohypertrophy, a diagnosis of Hoffman syndrome was made and the patient responded to L-thyroxin therapy.

In hypothyroidism skeletal muscle atrophy usually occurs in the form of diffuse myalgia, weakness, stiffness with slowness of both contraction and relaxation phases of deep tendon reflexes. However calf muscle pseudohypertrophy, myoedema and wasting are rarely encountered. Prominent muscle pseudohypertrophy in adults is known as Hoffman syndrome. Definitive diagnosis is made on muscle biopsy. Therapy with thyroxin corrects these muscle abnormalities.

http://www.ayubmed.edu.pk/JAMC/26-2/Pictorial.pdf

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