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VAN DIE REDAKSIE

DIE PYN VAN DIABETIESE SENUWEESIEKTE

'n Opvallende siekteteken by baie suikersiektepasiënte is pyn, wat dikwels aan senuweesiekte toegeskryf kan word alhoewel bewyse van neurologiese aantasting meer dikwels met die ondersoek gevind word (die enkel ruk nie, die voet is nie vir trilling gevoelig nie) as wat van die pasiënt se klagtes vermoed sou word. Die uitstaande simptoom is pyn in die bene. Die pyn is kenmerkend kwaai en aanhoudend, dikwels onafgebroke, alhoewel elke nou en dan deurskiet met krampe, swak gelokaliseer en weerskantig, erger saans en versag deur beweging, nie deur houding of hitte geaffekteer nie, en dit gaan gepaard met abnormale gevoeligheid van die ‚pins and needles' tipe. Die vel en die spiere mag uitermate gevoelig wees, selfs die gewig van lakens en komberse kan ondraaglik wees.

Pyn, ischemies vaskulêr in oorsprong, mag ook met rustye voorkom, maar op tipiese wyse word dit erger met verandering van die weer of liggaamshouding in hierdie gevalle is 'n verswakte bloedsomloop, met geen kloppings nie, byna altyd vanselfsprekend—dikwels met dreigende gangreen.

Dit mag oor senuweepyne wees wat die onbehandelde suikersiektelyer kla. In so 'n geval kan spoedige verligting (soos bv. in die geval van pruritis vulvae) nie belowe word nie, maar die waarskynlikheid van verligting kan verduidelik word en uiteindelike verlossing kan byna verseker word. Hierdie vroeë gevalle toon miskien geen abnormale fisiese tekens dat die senuwees betrokke is nie.

Dit gebeur af en toe dat hierdie tipiese pyn begin sodra die hiperglisemie (in 'n matige of ernstige geval van suikersiekte) deur die insulien beheer is. Een jong man moes onlangs 'n week of wat na sy eerste ontslag weer in die saal toegelaat word omdat die pyn so kwaai was dat hy nie kon slaap nie; hy was maer en bleek en het vinnig gewig verloor. Sy bloedsuiker was nie abnormaal laag nie, tog het sy pyn alleen bedaar wanneer die insulien verminder was en die urientoetse groen en geel getoon het. Hy is nou heeltemal sonder pyn en goed beheer.

Ander pasiënte ondervind pyn eers na jare. Roetinemaatreëls en bevredigende beheer van die suikersiekte

EDITORIAL

PAIN ASSOCIATED WITH DIABETIC NEUROPATHY

Pain is a prominent symptom in many cases of diabetes. It may often be ascribed to neuropathy, though evidence for neurological involvement is more commonly found on examination (absence of ankle jerks, loss of vibration sense in the feet, etc) than suspected by reason of the patient's complaints. The outstanding symptom is pain in the legs. This pain is characteristically of severe aching type, often continous though punctuated by shooting spasms, poorly localized and bilateral, worse at night and eased by action, unrelated to posture or warmth, and accompanied by paraesthesiae of 'pins and needles' type. Both skin and muscles may be extremely tender; even the pressure of bedclothes may be unbearable.

Pain of ischaemic vascular origin may also occur at rest, but is typically related to change of posture and of temperature; in these cases impaired circulation, with absence of pulsations, is almost always obvious, often with threatened gangrene.

Neural pain may be the presenting complaint in any untreated diabetic. In such a case one cannot promise rapid relief (as for instance one can from pruritus vulvae), but one can explain the likelihood of such relief and can certainly almost promise eventual remission. In these early cases there may be no abnormal physical signs of neurological involvement.

Occasionally this typical pain starts just as the hyperglycaemia (in a moderate or severe diabetic) is brought under control by insulin. One young man recently required readmission to the ward a week or so after his initial discharge, because of pain so severe that sleep was impossible; his appearance was haggard and his weight had fallen rapidly. His blood sugar was not abnormally low, yet his pain subsided only when insulin was reduced and the urine tests showed green and yellow. He is now quite free from pain and again well-controlled.

In other patients the pain occurs only after years. In one middle-aged man it was unrelieved by good control

het aan een middeljarige man geen verligting gebring nie, en was die pyn so kwaai dat chordotomie nodig was.

Kramppyne in die kuit (of minder algemeen in die dy of die boud) wat na inspanning voorkom en wat spoedig deur rus verlig word, is die kenmerkende vroeë simptoom van aarbeskadiging (die sogenoemde *‚intermittent claudication'*). Somtyds egter toon sorgvuldige toetse, self met gespesialiseerde metodes, geen beskadiging in die bloedsomloop nie maar definitiewe tekens van periferale senuweeontsteking. Vermoedelik is bloedvatvernouingskreupelheid soms neuropaties van oorsprong.

Maagpyn wat by suikersiekte voorkom mag te wyte wees aan alvleesklierontsteking, ketose, 'n onlangs vergrootte lewer met verrekte kapsuul, of, baie selde, aan hipoglisemie. As hierdie kondisies uitgeskakel kan word bly daar nog 'n paar pasiënte oor van 'n ernstige, vroeë tipe wat insulien nodig het by wie maagpyn 'n voreë klagte of selfs 'n terugkerende episode is, dikwels met vomering gepaard. Hierdie aanvalle mag plaasvind wanneer die suikersiekte goed onder beheer is en wanneer daar geen tekens van hipoglisemie is nie. Dit kan vir beide geneesheer en pasiënt hoofbrekens besorg. Miskien is dit te wyte aan senuweesiekte van die abdominale outonomiese stelsel. Staan hul enigsins in verband met die ‚maagkrisisse' van uittering? Hul patroon is baie eenders. Die gereelde terugkeer van die pyn suggereer selfs ‚abdominale epilepsie' en behandeling met epanutin is al op die proef gestel.

Pyn in die vingertoppe gepaard met parestese en gewoonlik sonder fisiese tekens mag tergelyktydig met die hewiger pyne in die bene ondervind word. Andersins is dit twyfelagtig of pyn in die arms 'n teken van diabetiese senuweesiekte is. Weliswaar dat klagtes daaroor dikwels in die suikersiektekliniek aangehoor word; om dit as senuweeontsteking te bestempel is te gemaklik. Afgesien van kortstondige ‚fibrositis', of wat ook al, is die pyn meesal aan subakromiale slymbeursontsteking toe te skryf en X-straalbehandeling bring gewoonlik verligting.

Ander pyne ook, selfs in die bene, moet nie te geredelik aan senuweesiekte toegeskryf word nie. So is eensydige heupjig nie diabeties nie; inderdaad behoort baie sorgvuldige aandag geskenk te word aan enige mononeuritis of gelokaliseerde senuwee-aandoening van anatomiese beperking alvorens dít as ‚diabetiese neuritis' te bestempel.

Ortopediese voetmoeilikhede van verskeie tipes en selfs ingroeiende toonnaels word somtyds senuweesiektes genoem. Nagkrampe en ‚voete wat spring' kom dikwels by bejaardes voor wat nie aan suikersiekte ly nie, en behandeling met kina en soms klein dosisse barbituraat is meer geslaagd as met Vitamien-B.

Daar is geen bewys nie dat Vitamien-B al ooit 'n pasiënt met diabetiese senuweesiekte gehelp het nie. Die suikersiektelyer se dieet moet natuurlik nooit so abnormaal wees om in hierdie vitamien kort te skiet nie. Dit is twyfelagtig of enig iets behalwe tyd en goeie beheer van die suikersiekte die senuweesiekte raak. Vitamiene, lewer, B.A.L. en die res laat die meeste suikersiekte-navorsers onoortuig. In elk geval as aktiewe maatreëls nodig geag word, kan miskien aan die hand gedoen word dat die goedkoopste eerste probeer word.

of the diabetes and routine measures and was so severe that cordotomy was performed.

Cramping pain in the calf (or less commonly in the thigh, or buttock) on exertion, with rapid easement on rest, is the characteristic early symptom of arterial impairment (so-called 'intermittent claudication'). Sometimes, however, careful tests, even with specialized methods, indicate no circulatory abnormalities, but definite signs of peripheral neuritis. Presumably 'intermittent claudication' on occasion is neuropathic in origin.

Abdominal pain related to diabetes may be due to pancreatitis, ketosis, a recently enlarged liver with stretched capsule or, rarely, hypoglycaemia. When these conditions can be ruled out there remain some patients of the severe, 'young', insulin-requiring type in whom abdominal pain is an early complaint or even a recurrent episode, often accompanied by vomiting. These attacks may occur when the diabetes is under good control and when hypoglycaemia is not present. They can be very trying for both the patient and the doctor. Perhaps they are caused by neuropathy of the abdominal autonomic system. Could they be related to the 'gastric crises' of tabes? Their pattern is very similar. Their periodicity even suggests 'abdominal epilepsy' and treatment with Epanutin has been tried.

Finger-tip pain, with paraesthesiae and usually without physical signs may occur in conjunction with the more severe leg pain. Otherwise it may be doubted whether pain in the arms is a manifestation of diabetic neuropathy. Certainly the complaint is common in the diabetic clinic; it is too easy to call it 'neuritis'! Apart from transitory 'fibrositis' or what-you-will, the commonest cause for the complaint in general is probably a subacromial bursitis, usually amenable to X-ray therapy.

Other pains, too, even in the legs, must not readily be ascribed to neuropathy. Thus unilateral 'sciatica' is not diabetic; in fact any mononeuritis or localized neural involvement of anatomical delineation must be very carefully considered before being dubbed 'diabetic neuritis'.

Orthopaedic foot-strain of various types and even ingrowing toenail, are sometimes called neuropathy. Nocturnal cramps and 'jumping feet' of the elderly are common in non-diabetics and respond better to quinine and sometimes a little barbiturate than to vitamin B1!

There is no evidence that vitamin B1 ever helped a patient with diabetic neuropathy. A diabetic patient's diet should never be so abnormal as to be deficient in this vitamin. It is doubtful whether anything other than good diabetic control and time affects the neuropathy itself. Vitamins, liver, B.A.L. and the rest have left most workers in diabetes unconvinced. Anyway, if some active measure is considered essential it might be advised that the least expensive should be tried first.