MEET THE EXPERT SESSION – CASE PRESENTATION

PRESENTED BY

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A 36 YEARS OLD LADY WITH RECURRENT UPPER ABDOMINAL PAIN, FEVER & FATIGUE

PARTICULARS OF THE PATIENT

- NAME : Mrs. SHARMIN AKTAR
- AGE : 36 YEARS
- SEX : FEMALE
- RELIGION : ISLAM
- OCCUPATION : HOUSE WIFE
- MARITAL STATUS : MARRIED
- ADDRESS : KUSHTIA (PRESENT AND PERMANENT)
- DATE OF ADMISSION: 01.04.2013

CHIEF COMPLAINTS

- RECURRENT UPPER ABDOMINAL PAIN FOR 2 YEARS
- RECURRENT FEVER FOR 2 YEARS
- PROGRESSIVE FATIGUE AND LOSS OF APPETITE FOR SAME DURATION

HISTORY OF PRESENT ILLNESS

According to the statement of the patient, she was reasonably well about 2 years back . Then she developed moderate to severe pain in the middle of upper abdomen which was continuous, dull aching in nature with radiation to the back. Pain was aggravated on daily activities and relieved on taking rest . The pain was not associated with food.

HISTORY OF PRESENT ILLNESS (CONTINUED)....

She also complained about fever which was initially high grade for few days , then followed by low grade with 2/3 peaks a day . It was associated with chills but no rigor and relieved with sweating . Her maximum recorded temparature was 103° F.

Her other complaints were progressive fatigue and joint pain involving both ankles ,elbows and hand joints .

HISTORY OF PRESENT ILLNESS (CONTINUED)….

She also noticed loss of appetite and disturbance in her sleep pattern . Her bowel and bladder habits were normal.

She had no history of vomiting, constipation, cough, weight loss or yellow discoloration of skin and urine. She is normotensive and diagnosed as a case of diabetis mellitus in 2011.

PAST ILLNESS AND PREVIOUS TREATMENT

The patient had occasional abdominal pain since she was a high school girl, which intensified in 1990 and laparotomy was done in Rajshahi but sufficient data is not available. Then 3 weeks later of this laparotomy, She became dyspnoic, transferred to BSMMU . She diagnosed as a case of tubercular pleural effusion and given anti-TB therapy for 9 months .

PAST ILLNESS AND PREVIOUS TREATMENT (CONTINUED)....

Then her next 20 years were uneventful except her diagnosis of diabetes in 2011 and she recieved insulin therapy and again she started having recurrent abdominal pain and irregular fever and one of the General physician prescribed her Anti-TB in the month of February, 2013.since she did not show any improvement ,she got herself admitted in DMCH in April ,2013.

- **FAMILY HISTORY**

Her brother also received anti-TB therapy.

- **PERSONAL HISTORY**

She is non-alcoholic and non-smoker.

- **IMMUNIZATION HISTORY**

Completed as per EPI schedule

- **TRAVELLING HISTORY**

Nothing significant

- MENSTRUAL HISTORY

MC: 32-36 days

MP: 4-5 days, average flow

- OBSTETRIC HISTORY

Para: 3 (2 alive,1 died)+ 1 (spontaneous abortion)

She used to take OCP, but since 2000 on barrier method.

PHYSICAL EXAMINATION

- **GENERAL EXAMINATION**
  - ANAEMIA-SEVERE
  - LYMPHNODE-ENLARGED PARA-AORTIC GROUP
  - JAUNDICE- ABSENT
  - CYANOSIS -ABSENT
  - OEDEMA-ABSENT
  - CLUBBING-ABSENT
  - KOILONYCHIA- ABSENT
  - LEUCONYCHIA-ABSENT

•GENERAL EXAMINATION (continued).....

- Pulse-90/min ,regular
- Blood pressure-100/70 mmHg
- Temparature-98 F
- Respiratory Rate-16/min
- Thyroid Gland-not enlarged
- Jvp-not raised

SYSTEMIC EXAMINATION

(ABDOMEN)

Inspection:

- Shape –Normal,
- Umbilicus was Central & Vertical,
- Flanks were Normal,
- Scar Mark Of Upper Midline Incision.

SYSTEMIC EXAMINATION (CONTINUED)….

- Palpation:
- Abdomen was Non Tender,
- Hepatomegaly (16cm in size from the right costal margin along the mid clavicular line , Non tender, Firm in consistency, Smooth surface)
- Splenomegaly (6cm from left costal margin, Firm in consistency , smooth surface),
- Palpable Firm Para-aortic Lymph Nodes.
- Percussion:

  Percussion note -Tympanic
- Auscultation:

  Bowel Sound - Present,

  Hepatic Bruit - Absent

  Renal Bruit - Absent

SYSTEMIC EXAMINATION (CONTINUED)….

Examination of other systems reveal no abnormality

WHAT IS YOUR CLINICAL DIAGNOSIS???

DIFFERENTIAL DIAGNOSIS:

1. LYMPHOMA???
2. DISSEMINATED TUBERCULOSIS???

INVESTIGATION PROFILE (Complete blood count)

Hemoglobin (g/dl)	08.50 07.70 10.70 11.40	04.02.2013 30.03.2013 18.01.2012 13.05.2011
WBC (/mm^3)	7,200 5,000	04.02.2013 30.03.2013
Platelet (/mm^3)	3,80,000 3,40,000	04.02.2013 30.03.2013

INVESTIGATION PROFILE

PBF	RBC-normocytic, normochromic WBC-mature Platelet-adequate	09.02.2013
ESR (mm in 1st hr)	125 84 56 26	04.02.2013 30.03.2013 18.01.2013 13.05.2011

INVESTIGATIONS PROFILE

URINE R/M/E	Normal study
Urine Micro-albumin (mg/L)	46.6 (normal range<300)

INVESTIGATION PROFILE

Investigations	Report	Normal Range	Date
S. Creatinine (mg/dL)	0.6	0.6-1.5	03.04.2013
SGPT (IU/L)	16	10-45	30.03.2013
S. Bilirubin (mg/dL)	0.6	<1.00	30.03.2013
ALP (U/L)	152	40-125	21.01.2012
S. Albumin (g/dL)	4.1	3.5-5.00	21.01.2012
HBA1C (%)	6.9%	4.0-6.0%	04.02.2013

INVESTIGATION PROFILE

Investigations	Report	Normal range	Date
S. Calcium (mg/dL)	8.5 9.2	8.5-10.5	01.04.2013 21.01.2012
S. Phosphate (mg/dL)	3.9	2.4-4.3	21.01.2012
Free T4 (pmol/L)	19.44	9-21	10.02.2013
TSH (μIU/L)	6.64 5.69	0.2-5.0	10.02.2013 21.01.2012

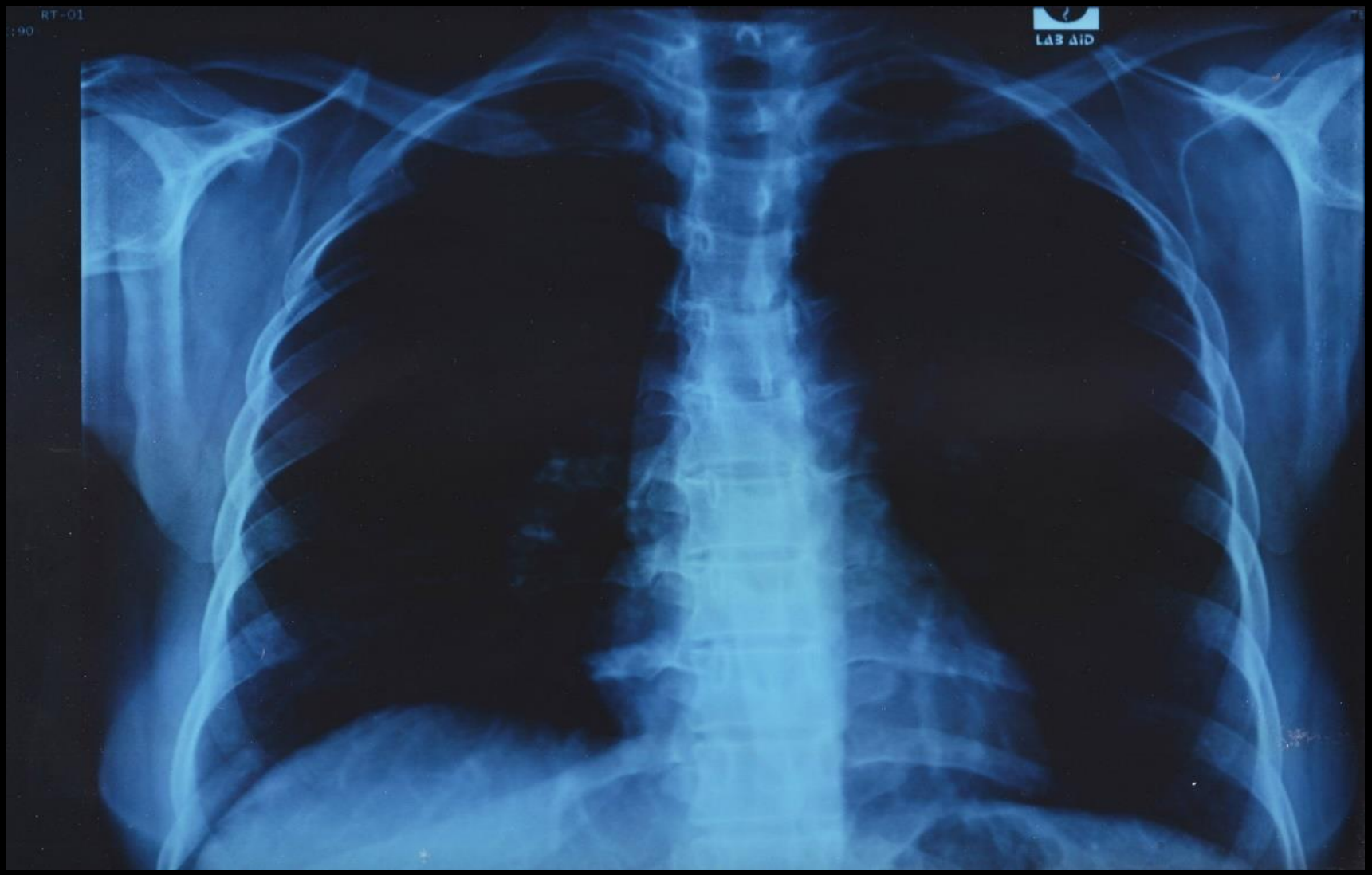
INVESTIGATION PROFILE		
ICT for Malaria	Negative	09.02.2013
ICT for Kala-Azar	Negative	10.02.2013
Hemoglobin Electrophoresis	Normal	10.02.2013
CRP (mg/L)	6.0	13.05.2011
RA test	Negative	13.05.2011

INVESTIGATION PROFILE

Investigation	Report	Date
ECG	Sinus Tachycardia	04.04.2013
Upper GI Endoscopy	Normal	15.05.2011
MT	Negative	30.03.2013

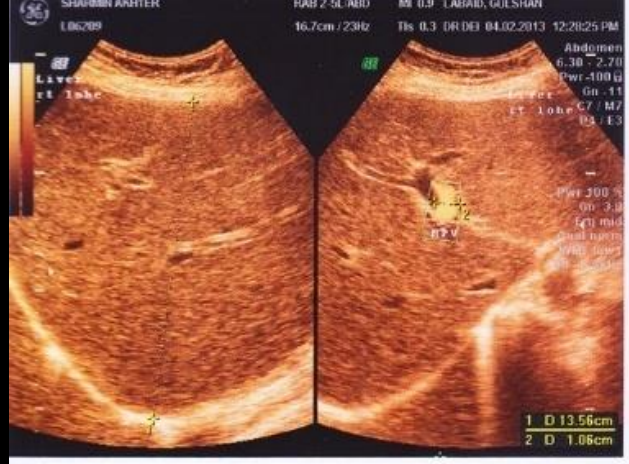
INVESTIGATION PROFILE

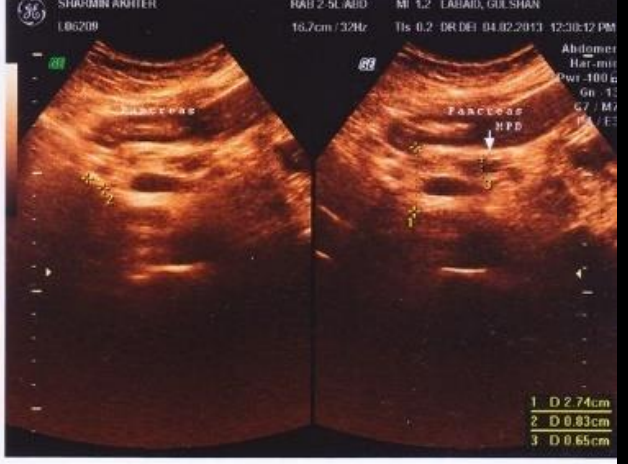
X-ray of Chest (P/A view)	Right sided Pneumonitis with small pleural thickening	30.03.2013

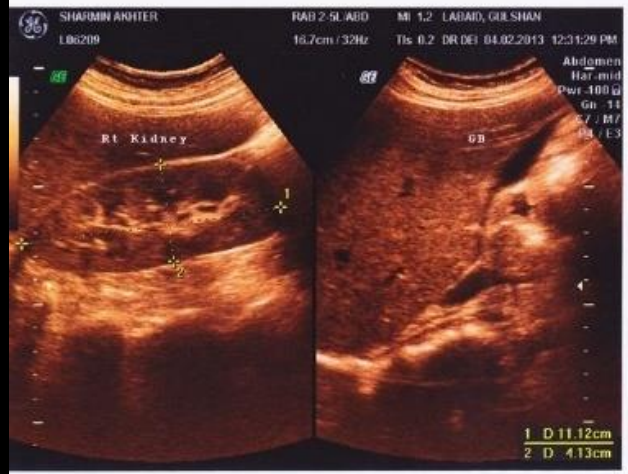

RT-01
LAB AID

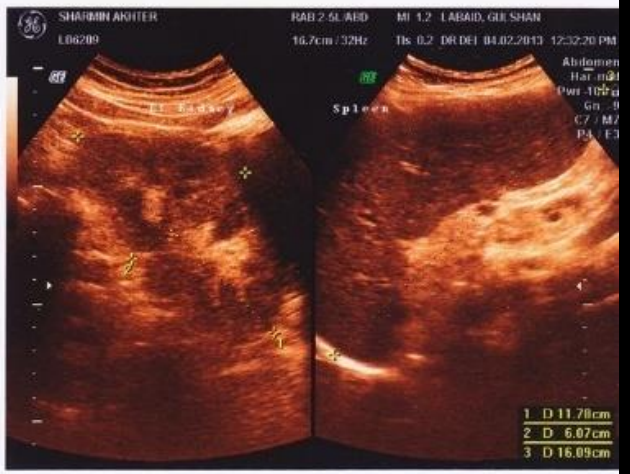
INVESTIGATION PROFILE

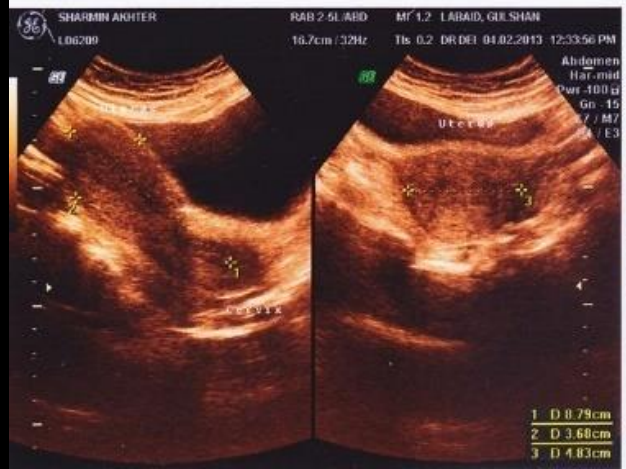
USG of Whole Abdomen	Hepato-splenomegaly, irregular pancreas, abdominal lymphadenopathy	28.03.2013

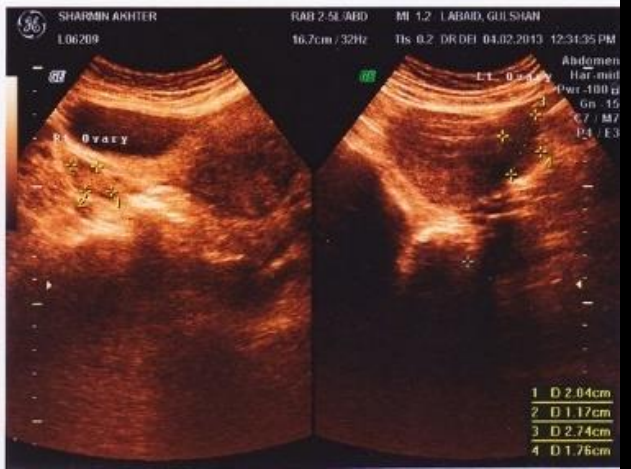

SHARMIN AKHTER
L06209
Abdomen
1 D 13.56cm
2 D 1.06cm


SHARMIN AKHTER
L06209
Pancreas
MPD
1 D 2.74cm
2 D 0.83cm
3 D 0.65cm


SHARMIN AKHTER
L06209
Rt Kidney
GB
1 D 11.12cm
2 D 4.13cm


SHARMIN AKHTER
L06209
Spleen
1 D 11.78cm
2 D 6.07cm
3 D 16.09cm


SHARMIN AKHTER
L06209
Uterus
1 D 8.79cm
2 D 3.68cm
3 D 4.83cm


SHARMIN AKHTER
L06209
Ovary
1 D 2.04cm
2 D 1.17cm
3 D 2.74cm
4 D 1.76cm

DIAGNOSIS

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INVESTIGATION PROFILE

Investigation	Report	Date
X-ray of Abdomen (A/P view)	Pancreatic Calcification	02.04.2013
USG of Whole Abdomen	Hepato-splenomegaly, Chronic Pancreatitis with Calcification, Abdominal Lymphadenopathy.	03.04.2013

INVESTIGATION PROFILE

CT Scan of Abdomen and Pelvis	Chronic Pancreatitis with pancreatic calcific foci, chronic distal splenic vein thrombosis and collaterals, Spleen shows hypodense lesions with extensive abdominal lymphadenopathy (Suggestive of koch's ?)	05.04.2013

Chronic Pancreatitis With Diabetes Mellitus was confirmed.

DIAGNOSTIC DILEMMA

How can we explain

HEPATO-SPLENOMEGALY with ABDOMINAL LYMPHADENOPATHY ??

INVESTIGATION PROFILE

FNAC from Abdominal Lymph node	Granulomatous Inflammation marked by clusters of Epithelioid cells, Giant cells and Lymphocytes, but no caseation ,no malignant cell is seen.(Suggestive of Sarcoidosis??)	08.04.2013

INVESTIGATION PROFILE

Investigation	Report	Date
Serum ACE (U/L)	144 (Normal range-8-65 U/l)	10.04.2013

CONFIRMATORY DIAGNOSIS

Chronic Pancreatitis with Diabetes Mellitus with Abdominal Sarcoidosis.

Treatment in our unit

- Her Anti-Tb therapy was stopped.

- For Chronic Pancreatitis:

The patient was treated with Omeprazole and Pancreatic Enzymes .

- For Abdominal Sarcoidosis:

She received Prednisolone 1mg/kg/day for 2 weeks, then gradual tapering was done.

Follow up of the patient

- Patient has neither fever, nor abdominal pain on follow up.
- On 26,April 2013, the USG of whole abdomen showed a reduction in size of spleen, liver and abdominal lymph nodes.
- On 7, July 2013, the USG of whole abdomen showed mild hepatomegaly (suggestive of fatty change) with normal sized spleen and no enlarged abdominal lymph nodes.

THANK YOU