Management Uncertainty in a Young Woman with Fever and Abdominal Pain

Shaifali Bansal, People’s College of Medical Sciences, Bhopal, India
Sushil Jindal, People’s College of Medical Sciences, Bhopal, India
Anil Kapoor, People’s College of Medical Sciences, Bhopal, India

ABSTRACT
Reversible quadriplegia is a relatively rare condition. Here, the authors describe an interesting case where a patient, three and a half months after her delivery, presented with fever and abdominal pain. She further developed hyponatremia, became delirious, and then developed quadriplegia.

Keywords: Acute Intermittent Porphyria, Hyponatremia, Medical, Quadriplegia, Reversible Quadriplegia

INTRODUCTION
A 24 year old / lady, a housewife and mother of two children presented to the Gynecology department of our hospital on March 15, 2007 with the complaints of severe, cramping, poorly localized pain in abdomen of acute onset, associated with nausea, vomiting, and constipation. She was a resident of a village located in the outskirts of Bhopal. Her younger child was only three and a half months old. The onset of pain coincided with the first day of menses and this was her first menstrual period since the delivery (3 ½ months ago). The lady had earlier been treated by local doctors for fever with drugs including chloroquin about seven days ago.

On examination, she was conscious and oriented. Her pulse was 110/min., blood pressure was 150/100 mmHg and she was perspiring. There was no pallor or icterus. The abdomen was soft, non tender, there was no guarding or rigidity and the bowel sounds were present, though sluggish. The hematological and biochemical parameters including leucocytes counts, blood sugar, kidney and liver function tests were normal at the time of admission. She was treated with antispasmodics and analgesics for possible spasmodic dysmenorrhoea and also enalapril 5 mg daily was added for hypertension. There was no response to treatment.

On the third day of admission, she developed low grade fever (99.6° F), without chills or rigors. The tachycardia and hypertension persisted. Patient had not moved her bowels for the past six days. She had not passed flatus for two days. Abdomen was distended and

DOI: 10.4018/ijudh.2012100105
pain persisted. Per rectal examination revealed a loaded rectum. The X-ray examination of the abdomen showed distended bowel loops with multiple fluid levels. She was reviewed by the Surgeons who felt that it was a sub acute intestinal obstruction and she was put on conservative management for the same. The routine investigations for fever ruled out malaria and other causes of fever, however the urine was brownish [Menstrual contamination] with 8-10 pus cells/hpf. Her constipation and abdominal obstruction were relieved over next two days but pain in abdomen persisted.

On March 21, patient developed numbness in both lower limbs associated with proximal muscle weakness of sudden onset. She went to the toilet walking but could not get up from squatting unsupported. She later became delirious and also passed urine in clothes once. She reported relief from pain but continued to have nausea and vomiting. She was now transferred to the ICU of Medicine department. By then the patient was afebrile but had tachycardia and hypertension. Examination of the abdomen, the cardiovascular and the respiratory system was unremarkable. The Neurological examination revealed that the patient was delirious, had no neck rigidity, had normal pupils, cranial nerves and sensory system. The motor system of upper limbs was normal but there was truncal muscle weakness and areflexic flaccid paraparesis with bilateral flexor planters. The serum Sodium was 118 meq/l and the Potassium was 3.6meq/l. Therefore, Sodium supplementation was started in the form of oral tablets and isotonic saline. For delirum, Inj. Haloperidol was given. Her fundus examination and CT scan head were normal. Her condition continued to be same for next two days.

On March 24, patient’s condition deteriorated and she became unconscious. She maintained her vitals and did not require ventilatory support. Her serum sodium further dropped to 103 meq/l but serum potassium remained normal at 3.6 meq/l. Infusion of hypertonic saline was given, in addition to isotonic saline according to the calculated deficit, over the next five days. The CSF examination was normal. The Serum Na+ level gradually improved from 103 meq/l on March 24, to 111 meq/l, on March 25, to 122 meq/l on March 26. Patient’s consciousness level gradually improved and she started responding first to painful stimuli and later to verbal commands. Pupils remained normal, neck soft, planters not elicitable. There was no paresis of horizontal \ vertical gaze, no internuclear ophthalmoplegia and no respiratory paralysis but she developed flaccid quadriplegia. Patient on treatment of hyponatremia developing, quadriplegia despite all odds generated the possibility of Central Pontine Myelosis. However MRI brain was normal and to our great relief excluded the remote possibility.

On March 27, the patient was shifted to another bed in the ICU that was exposed to direct sunlight. The same day, a note was made of dark urine in the urine collection bag which pushed us into rethinking the sequence of events – a lady three and a half months post delivery, in the third decade of life, having been exposed to a drug (Choroquine) and hormones (first ovulatory cycle after delivery) presented with severe abdominal pain, constipation, nausea, vomiting accompanied by tachycardia and high BP. She became delirious and developed paraparesis which progressed to quadriplegia. Severe hyponatremia was also noted and her urine turned brownish red on exposure to sunlight. When these jigsaw pieces were correctly assembled, a clear picture of Acute Intermittent Porphyria emerged. We immediately ordered the qualitative Watson Schwartz test which came strongly positive.

The patient denied any family history of similar complaints. She did not have any cutaneous manifestations and had been normotensive throughout pregnancy. She did not have discoloration of gums and basophilic stippling was absent in the RBC’s. Thus clinically the diagnosis of Acute Intermittent Porphyria was made.

Unfortunately, the patient could not afford Haematin. She was put on carbohydrate rich diet and given intravenous dextrose. Gradually the patient improved and so did the power in truncal and distal muscles. On April 1, the serum

Copyright © 2012, IGI Global. Copying or distributing in print or electronic forms without written permission of IGI Global is prohibited.
Related Content

A Community-Based Participatory Research Model and Web Application for Studying Health Professional Shortage Areas in the United States
www.igi-global.com/article/a-community-based-participatory-research-model-and-web-application-for-studying-health-professional-shortage-areas-in-the-united-states/93041?camid=4v1a

Patients on Weaning Trials Classified with Neural Networks and Features Selection
www.igi-global.com/chapter/patients-weaning-trials-classified-neural/13046?camid=4v1a

Dynamic Stress Management: Self-Help through Holistic System Design
www.igi-global.com/chapter/dynamic-stress-management/73899?camid=4v1a
Scrutinizing the Rule: Privacy Realization in HIPAA
www.igi-global.com/chapter/scrutinizing-rule-privacy-realization-hipaa/46673?camid=4v1a