CPC case on 7th Sept 2014 for Regional Symposium on IBD

Patient: K, 39yrs Female, DOA:12/6/05; DOD: 14/6/05

PRESENTING COMPLAINTS

Bloody diarrhea	6 weeks
Pedal edema	3 days
Abdominal distension	3 days
Reduced urine output	3 days

Apparently well 6 weeks back, when she developed loose stools which were bloody, predominantly watery, large volume, 10-12 times/ day with associated mucus. There was associated mild abdominal pain which was predominantly non-colicky (occasionally colicky). 3 days prior to hospitalization she developed increased pain, abdominal distension, bilateral pedal edema and decreased urine output. She took 3 tablets of NSAIDS for headache prior to the onset of this illness. There is associated anorexia and weight loss. There is no h/o joint pains/ fever/ rashes.

She was seen at a private clinic where she underwent a colonoscopy and a CT scan. Colonoscopy showed multiple colonic ulcers and she was diagnosed as ulcerative colitis and given some treatment the nature of which is not known. Subsequently she was seen at GMCH and Dxed to have toxic megacolon and referred to PGI.

Past History: 6 years back had fresh bleeding per-rectum with passage of stools, diagnosed to have hemorrhoids and treated with ayurvedic medication with good response.

Personal History: No addictions, Married and having two children. She was a housewife.

Examination:

Conscious, oriented, afebrile, dehydrated, looking sick with a puffy face. PR 130/ min, BP 80/60 mm of Hg, RR 45/ min. Peripheral pulses were feeble.

Pallor^{+} , B/L pitting pedal edema +.

No cyanosis, JVP elevation, clubbing, lymphadenopathy or icterus.

P/A: Distended tense. No tenderness, rebound tenderness, rigidity or guarding. There were palpable bowel loops, sluggish bowel sounds and minimal free fluid.

PR: Rectum was empty and there was no bloody stool.

Chest/ CVS/ CNS: WNL.

Date	12/6/05	13/6/05	13/6/05	13/6/05
pH	7.46	7.34	7.33	7.34
PO_2	59	47	60	50
PCO_2	28	30	40	29
SaO_2	92%	81%	89%	85%
HCO_3	19	16	21	15
BE	-3	-9	-5	-8.5

Date	12/6/05	13/6/05
Hb	15.4	9.5
TLC	13,000	48,000
DLC	P73L20M3E4	P94L4M1E1
P/S	N/N Plat ↓ ed	N/N Plat ↓ ed
Na	130	137
K	2.5	3.6
Urea	32	35
Creat	1.0	1.0
S Bil (T/C)	0.7	
RBS	68	
PTI	67%	50%
APTT	47(C30-40)	58(C30-40)
PT	15 (C-10)	20 (C-10)

Investigations:

CXR: Normal ⇒ Bilateral pleural effusion⇒ atelectasis⇒ ARDS

AXR: Transverse colon 7cm. Dilated small bowel loops.

CPK MB: 96.5 IU/ lit (N<25 IU/lit)

Ascitic fluid: Serous, Pro 850mg%, Sugar 76, WBC 400 (P95 L5)

Blood C/S: sterile

EKG: HR 100/ min, Junctional rhythm. Low voltage. ST ↓ T↓. Reversal on K^+ R_X
Terminally Ventricular tachycardia

USG abdomen: Liver 17.5 cm, Increased echotexture, Hepatic veins normal. Portal vein 15.5mm. Intrahepatic biliary radicals not dilated. Gallbladder sludge+. Gallbladder wall normal. Pancreas and retroperitoneum obscured by bowel gas. Kidneys/ spleen normal. Significant dilatation of bowel loops. Ascites+ and bilateral pleural effusion.
CECT Abd: Dilated ileal & large bowel loops. Thickened walls. No Lymphadenopathy. B/L Pleural effusion. Minimal ascites

Course and management:

The patient was initially managed with IV fluids, IV Cefipime, IV Ciprofloxacin, IV metronidazole, IV Hydrocortisone, blood transfusion and FFP with no significant response. Hypokalemia was corrected with IV K^+ infusion. Consultation under GE-I services was sought, a diagnosis of ulcerative colitis with toxic megacolon was offered and advised surgical consultation, intensive supportive care and addition of cyclosporine. Surgical consultation under GS-III was sought and advised conservative management as she was unfit for surgery and there was no evidence of perforation. IV cyclosporine was added. She was intubated and on ambu ventilation. She was started on dopamine, noradrenaline and vasopressin infusions despite which she remained hypotensive. She subsequently developed repeated ventricular arrhythmias followed by cardiac arrest from which she could not be revived.

Unit Final Diagnosis
Ulcerative colitis with toxic megacolon
Refractory septic shock
ARDS
Liver parenchymal disease
Bilateral pleural effusion and ascites