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Corresponding Author
Nayan Paul,
Department of General Medicine, KPCMCH, India

Author Designation
[1,2,6]Post Graduate trainee
[3]Associate Professor
[4,5]Assistant Professor
[7,8]Senior Resident

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A Case of Non Dilated Cardiomyopathy and Recurrent Hypoglycemia: A Rare Manifestation of Sheehan's Syndrome

[1]Nayan Paul, [2]Nabanita Mondal, [3]Kausik Munsi, [4]Nasim Akhter, [5]Sudipto Roy, [6]Amit Karmakar, [7]Puja Mahato and [8]Sourav Kundu

[1-8]Department of General Medicine, KPCMCH, India

Abstract
Sheehan's Syndrome is a rare clinical condition characterized by post-partal panhypopituitarism due to necrosis of pituitary gland . Due to PPH, the blood supply to the pituitary gland is jeopardized resulting in necrosis of the gland. There can be a wide range of symptoms, a patient with Sheehan's syndrome can present with. These symptoms can be often misleading if proper history is not taken. Here, we present a case of 50 years old female who was previously admitted with complaints of fever and pain abdomen, developed anasarca, dyspnea and recurrent hypoglycemia with due course of time and was ultimately diagnosed as a rare manifestation of 'Sheehan's Syndrome'.

CASE PRESENTATION

A 50 years old female, house-wife, resident of survey park , kolkata admitted with fever for last 3 days and epigastric pain and multiple episodes of vomiting for same duration for which she was admitted in surgery ward and was relieved temporarily with the treatment. She was waiting for investigations to rule out the cause of her Symptoms .Surprisingly Later during hospital stay, she developed shortness of breath with anasarca, yellowish discoloration of eye and urine and was transferred under medicine ward.

There was no significant similar history in past. She is a known case of hypothyroidism (on tab. Eltroxin 25 mcg), h/o intake of tab. Omnacortil 10 mg (no document available) but stopped few years back. Past h/o LUCS 30 years ago. She was amenorrheic, 1 LCB(girl).

There was no other significant family , allergy and addiction and personal history . There was No h/o Hypertension or Type 2 Diabetes Mellitus,CAD or any type of heart disease, any lung pathology , chronic liver disease, chronic kidney disease.

Her physical examination revealed: alert, conscious, cooperative (GCS-E4V5M6), Built and nutrition normal (BMI-22.2 kg/m2), Pulse-118/min, Temperature-98.4 degree F, BP-110/70 mm hg,RR-26/min, rapid and shallow breathing , Spo2- 91% with 2Lt/min Oxygen via nasal cannula, CBG-103 mg/dl with glucometer, Pallor+, generalized oedema+neck veins engorged, icterus+but no clubbing ,cyanosis or lymph nodes.

Systemic examination showed **CARDIOVASCULAR SYSTEM**-S1 and S2 normal, S3 gallop audible. No murmurs, **RESPIRATORY SYSTEM**-Bibasal fine crackles +,tachypnea+. Decreased breath Sound bilaterally, **PER ABDOMEN**-soft, tender epigastric region, distended, shifting dullness+, **CENTRAL NERVOUS SYSTEM**-Within normal limit, Rest other systems are within normal limit.

So the possibilities of Heart failure-volume overload/Hepatic failure/Renal failure/Sepsis/ Endocrine abnormalities/Drug induced were thought initially and investigations were done and showed-CBC: HB-9.8mg/dl , TLC- 4800/ cumm, MCV-83.2 fl, PLC-1.60 lac/cumm, LFT: T. Bil-5.5 C. Bil-3.5 T. Protein-6.4 albumin-3.5, globulin-2.9 SGOT-2620, SGPT-1568, ALP-566., ABG-respiratory alkalosis, Urea/creatinine-39/ 1.1, Na/K-129/3.1, Calcium/ phosphate/ magnesium-9.6/3.2/1.9,TSH/ FT4-0.96/ 1.20, urine R/E-01 pus cell, Serology-non reactive, IGM Hep A and Hep E-negative, CRP-48, Serum amylase/lipase-23/25,NT-pro BNP-21252 pg/ml, ECG 12 leads-sinus tachycardia, CXR(AP)-enlarged cardiac silhouette, ECHO 2D- Normal LV cavity size, moderate global.

LV wall hypokinesia, Moderately reduced LV systolic function EF-43%, LVDD, moderate MR/TR, Reduced RV systolic function, evidence of severe PAH Tissue Doppler ECHO- E/A: 2.5/1, E/ E' : 26. Coronary angiography-planned but not done due to financial issues.

Hence, the patient was provisionally diagnosed with **Heart failure With moderately reduced ejection fraction(HFmrEF) with non Dilated cardiomyopathy with drug induced hepatitis/ congestive Hepatopathy** for which resuscitating treatment was initiated with Appropriate measures and medications. But then, another problem arises. The patient was having recurrent h/o hypoglycemia with persistent Shortness of breath during the hospital stay and was managed with Oral glucose and diuretics and other supportive measures. Hypoglycemia recurred even after resolution of drug induced Hepatitis. She was further investigated in detail for the cause of recurrent Hypoglycemia and persistent SOB.To find out the possible reason of her symptoms, the history was reviewed in detail. Surprisingly, it was found that she is amenorrheic for last 30 years (after her child birth) and also had lactational failure.

Fig.1: She had a dramatic response with complete resolution of symptoms and was discharged with oral steroids

Fig.2: MRI Pituitary with Contrast: Thin homogeneously enhanced Pituitary gland (1.5-1.7 mm) is pushed to the sellar floor with CSF located on it-'Partial Empty Sella'. Pituitary hormonal assay

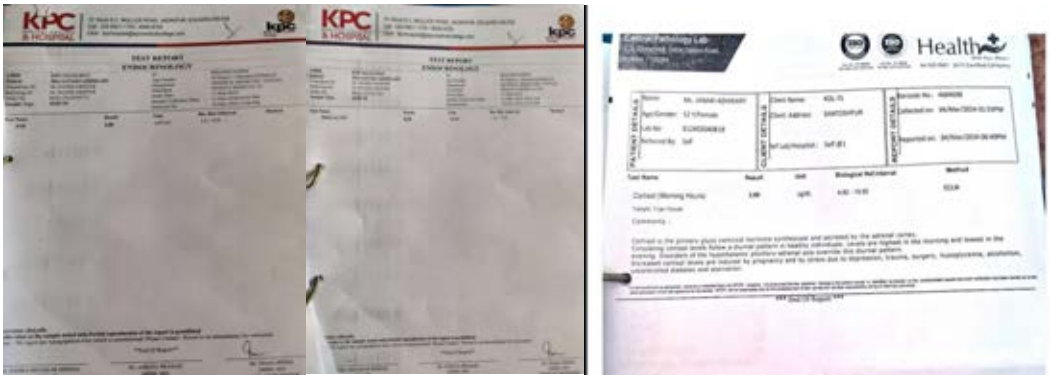

Fig 3: FSH(low-1.68), Prolactin(low-0.73) and cortisol Levels(low-3.89)

A clinical diagnosis of **Sheehan's syndrome presenting with Non Dilated cardiomyopathy and recurrent hypoglycemia** was made. To Confirm the diagnosis, further anterior pituitary hormonal assay, MRI Pituitary fossa and other related tests were done. She was started with tablet Wysolone 5mg ABF and 2.5mg AND along With LT4 supplementation and diuretic therapy. She had a dramatic response with complete resolution of symptoms and was discharged with oral steroids.

CONCLUSIONS

Sheehan's syndrome occurs as a result of ischaemia-induced pituitary necrosis in pregnant women usually due to severe postpartum haemorrhage[1]. Recognition and appropriate treatment of this reversible cause may allow reversal of the disease process. Hence it is very relevant to ask for the history of postpartum events, including postpartum haemorrhage and lactational failure, from women of not only fertile age but of all ages[1]. This case highlights the importance of diligent history taking in the diagnosis of panhypopituitarism in a middle aged female patient[2]. Although Non dilated cardiomyopathy and recurrent hypoglycemia is rare in sheehan's syndrome but can be a rare manifestation of it and thus initially can mislead us from the actual diagnosis. So every physician must be alert and look for these presentations. Timely intervention can be life saving and can provide full recovery of the patient[3].

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