Original Research Paper

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Medicine

PATIENT WITH FULMINANT HEPATITIS A RARE CASE OF EXPANDED DENGUE

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ABSTRACT PATIENT WHO PRESENTED AS FEVER FOR 3 DAYS, HEMATURIA FOR 3 DAYS, LOWER ABDOMEN PAIN FOR 3 DAYS HAD BEEN DIAGNOSED WITH DENGUE AND LFT WHICH PROGRESSED RAPIDLY TO FULMINANT HEPATITIS AND DEATH, WHICH IS A RARE CASE OF EXPANDED DENGUE WITH FULMINANT HEPATITIS .

KEYWORDS :

HISTORY-

A 18 year old male came with.

- Complaints of fever for 3 days - high grade, intermittent in nature, associated with chills.
- History of cough with expectoration for 3 days, sputum yellow, not associated with hemoptysis
- History of abdomen pain, 3 days, upper abdomen, dull intermittent, no aggrevating /relieving factors .
- History of hematuria for 1 day, no associated dyusria /polyuria/ burning micturation

No history of chest pain /palpitations/breathlessness -No history of vomiting /loose stools/other bleeding manifestations

PAST HISTORY..

- Not a known case of DM/HTN/CAD/Bronchial Asthma

PERSONAL HISTORY..

- Not a Smoker /Alcoholic , Mixed Diet
- Conscious, oriented.
- Afebrile.
- Bp – Initally not recordable , Repeat BP 120/100mmhg after 1.5 litre bolus, Inj. noradrenaline 0.2 mcg/kg/min, Spo2 - 100%, Pulse – 102/min, Respiratory rate – 18 min, Temperature – Normal
- No pallor /Cyanosis / clubbing / Pedal odema /GL
  Local Examination had Patient Dehydrated, Petechiae present in bilateral lower limbs .
- CVS – S1 S2 +, regular rhythm
  RS- bilateral air entry present, clear
  P/A – Diffuse tenderness present
  CNS – GCS -15/15 , Obeying commands , Moving all four limbs .
- CBC showed Hb-19.1, PCV -56.3, Tc- 6500 with P-72% , L-19.2 , Mcv – 83, Mch -27.8, Platelet – 10000 . Pt-15.1 , Ptt -99.4 , INR – 1.24 . Rft showed Bun – 20, Creatinine- 1.3 Electrolytes showed Sodium – 136, Potassium – 5.1 , Chloride – 108 , Bicarbonate – 13
- Lft showed T.Bil – 3.50, D.Bil – 2.61, SGOT – 264 , SGPT -94, T.Protein – 5.8, Albumin – 3.6, Globulin -2.2, Alkaline Phosphatase -234. Urine routine showed ph -6.5 , specific gravity - 1.025, Protein -3+, Bilirubin -2+, Urobilinogen -2.0 ,Pus cells 10-12 , Rbc -2-3 , with Granular casts seen.
- Initial Abg showed ph-7.20 , pco2 – 53.6 , po2- 25.3 , lac- 4.3 , cHco3 – 20.4. ECG showed Sinus Tachycardia, Chest Xray showed bilateral minimal plaural effusion in lower zone. USG Abdomen showed cholecystitis, borderline splenomegaly, bilateral pleural effuson right > left , moderate ascitis .
- Patient was initially started on NS at 150 cc/hr, Inj.Lactogard 1.5gm iv bd, T.Azithro 500 mg od, C.Doxy 100mg od, Inj artesunate 180 mg od, 2 Units RDP,1unit SDP given, Inj Trapic 500mg iv stat, Inj Vitamin K 1 amp od.

ON DAY 2

Patient became disoriented, restless. BP was 90/60 on noradrenaline 0.3 mcg/kg/min, SpO2 – 98% room air, NS 200ml/hr, Pulse -128, Spo2- 97%. Input was 5280 ml output 2150 m . Patient was kept on ryles tube

	HB/ PCV	TC	PLT	T.BIL/D .BIL	SGOT/S GPT	PT	PTT	INR	BUN/ CR
DAY 1	19.1/ 56.3	6500	10000	3.50/ 2.61	264/ 94	15	99.4	1.24	20/ 1.3
DAY 2	18.9/ 56.1	18200	36000	5.66/ 3.83	11138/ 3173	37	55.4	3.21	28/ 1.3

- Other Lft showed T.protein -4.7, Albumin-2.8 , Globulin – 1.9, Alkphosphatase – 265 . Electrolytes had Hco3- 13, other normal . Serum ammonia 225. Peripheral smear showed Thrombocytopenia. Patient had urine culture no growth. Patient had Dengue antigen assay 86.35. Dengue Serology was positive with IgM – 64, IgG- 19.9. Scrub Typhus, Malarial Antigen, Leptospirosis was negative.CT Brain showed mild cerebral odema. 1 unit SDP, 4 unit FFP transfused . T.Rifagut 550 mg bd , T.Metrogyl 400mg tds, Syrup Duphulac 30 ml tds , Duphulac Enema was started .
- MGE opinion obtained advised HbsAg , Anti Hcv , Hav IgM , suggested Liver Transplant , NAC Infusion . Patient was started on NAC infusion as advised . At around 3.30pm on 9/10/16 , patient was intubated in view of worsening GCS and Tacycardia . ABG showed a ph -7.26, pco2 – 30.5 , po2 – 88 , lactates-8.6 , cHco3 - 13

ON DAY 3

- Patient was intubated with pressure control mode. Patient wasnt arousable. Hematuria was persistent. Oral and Nasal bleed was present. BP was 130/70 on noradrenaline support with NS 200cc/ hour, Pulse – 124/min, Spo2 -98% at pc mode. Patient had no fever spikes.
- ABG showed ph- 7.31, with pco2 – 33, po2- 105, lac-5.1, cHco3 – 16.

	HB/ PCV	TC	PLT	T.BIL/D. BIL	SGOT/ SGPT	PT	PTT	INR	BUN/ CR
DAY1	19.1/ 56.3	6500	10000	3.50/ 2.61	264/ 94	15	99.4	1.24	20/ 1.3
DAY2	18.9/ 56.1	18200	36000	5.66/ 3.83	11138 /3173	37	55.4	3.21	28/ 1.3
DAY3	10.1	10400	48000	7.18/ 4.93	22580 /5200	23.9	47.3	2.02	50/ 3.5

Other Lft showed had T.Protein -4.6 with albumin – 2.6, globulin -2.0, alk phosphate -319. Blood cultures showed no growth. Viral markers showed HEV IgG- Negative, HEV IgM – Negative, AB to HAV – 0.24, HIV – non reactive, HbsAg/Hcv – non reactive. MGE review advised S.Fibrinogen, LDH, D dimer levels, Dextrose infusions in view of low sugars, 4 unit FFP transfusions, Liver Transplant team opinion .

- At around 1.30 pm, patient developed bradycardia. Despite Cardiopulmonary resuscication, Adrenalines cycles, Patient couldnt be revived . Patient was declared dead at 2.48 pm .

CONCLUSION -

Thus the patient who presented as fever with hematuria had Lft which rapidly progressed to Fulminant hepatitis and death due to fulminant hepatitis, a rare case with Expanded Dengue syndrome.