INTERESTING CASE OF BICYTOPENIA

2 MEDICAL UNIT

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CHIEF COMPLAINTS

16 years old adolescent girl was admitted with complaints of

- Fever & Giddiness 5 days
- Headache 2 days
- Oral ulcers 2 days

PRESENTING ILLNESS

- She was apparently normal before 5 days then she developed fever and giddiness for which she was admitted in a private hospital . Her lab investigations showed decreasing trend of Hb from 7gm to 4gm in 4 days. She was treated with iron injections despite which she had drop in Hb level hence she was referred to GRH for further management.

PRESENTING ILLNESS

- H/O Fever for 5 days
- Intermittent in nature
- Low grade
- Not associated with vomiting

- H/O headache for 2 days

-right temporal region

Not associated with vomiting or blurring of vision

No H/O aura

- H/O oral ulcers + 2 days
- No H/O bleeding from the ulcers
- H/O nausea +
- No H/O drug intake other than paracetamol
- No H/O syncope
- No H/O jaundice
- No H/O cough
- No H/O dyspnoea
- No H/O chest pain
- No H/O photosensitivity

- No H/O Abdominal pain
- No H/O loose stools
- No H/O bleeding manifestations
- No H/O seizures
- No H/O arthralgia
- No H/O hair loss
- No H/O myalgia
- No H/O oliguria
- No H/O hematuria

PAST HISTORY

- Got admitted at GRH 2 months back with complaints of fever for 1 wk
- She had Bicytopenia predominantly of THROMBOCYTOPENIA
- Hb 8 gm
- Platelet dropped from 1.5 lakhs to 18000
- ESR 89mm/hr
- PS - microcytic hypochromic anemia
- IgM IgG for Dengue was POSITIVE

PAST HISTORY

- Since she had microcytic hypochromic picture in PS, iron studies were done and it was normal.

- She was treated conservatively with fluids and discharged when her platelet count raised above 1 lakh in 5 days

PAST HISTORY

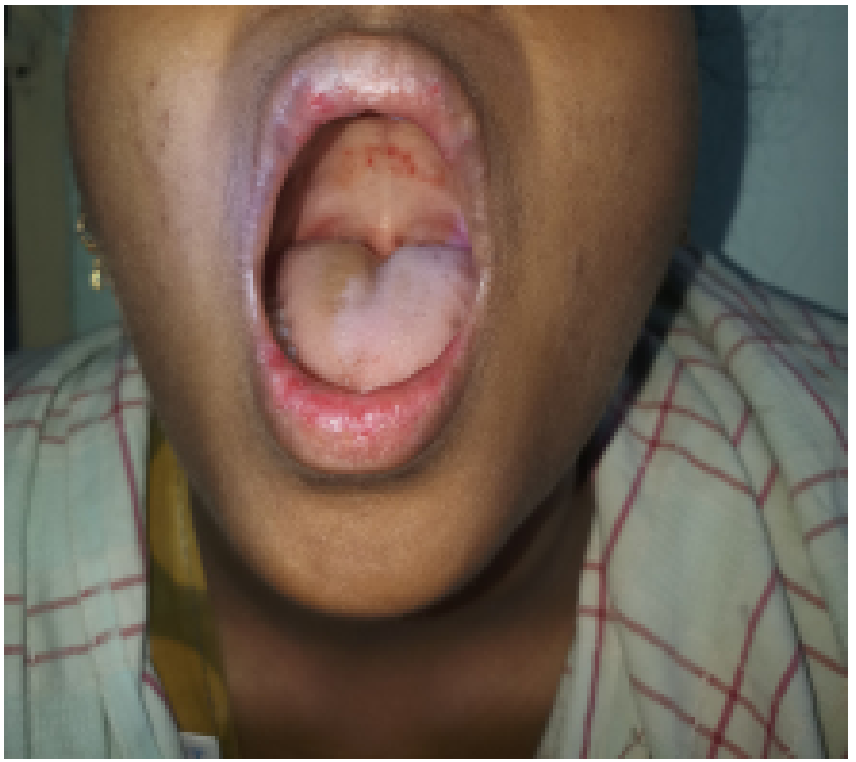
- H/O appendicectomy done 2 years back
- No H/O blood transfusion
- No H/O jaundice
- No H/O type I DM/ TB/BA

PERSONAL HISTORY

- Consumes mixed diet
- Bladder and bowel habits are normal
- She attained menarche at 14 years of age
- Regular 4/28 days cycle with normal flow
- LMP 10.3.18

GENERAL EXAMINATION

- Conscious
- Oriented
- Febrile
- Oral petechiae+ over soft palate
- Oral ulcers over her inner aspect of cheeks
- Pallor +
- No icterus/ cyanosis
- No clubbing
- No pedal edema
- No generalized lymphadenopathy



VITAL SIGNS

- Pulse 98/min regular in rhythm , large volume

No specific character, no RR/RF delay

- BP 120/70 mm/hg
- Spo2 98% @ RA
- RR 16 / min
- FUNDUS EXAMINATION:

Preretinal haemorrhage seen in both eyes

SYSTEMIC EXAMINATION

- CUS : S1 S2 +
  ESM in pulmonary area
- RS : BAE+
  NUBS
  no added sound
- PA : Soft
  Tenderness at left hypochondrium +
  Mild splenomegaly + 3cm below Lt hypochondrium
- CNS : NFND

INVESTIGATIONS

TOTAL COUNT	8400
RBC	1.3 MILLION
HB	5.7gm/dl
HCT	16%
PLT	1.5 lakh
DC	56/34/16
ESR	140mm/hr
MCU	117

INVESTIGATION

RBS	97
UREA	23
CREATININE	0.8
TOTAL BILIRUBIN	1.2
DIRECT	0.3
INDIRECT	0.9
SGOT	33
SGPT	23

PROVISIONAL DIAGNOSIS

Fever + oral ulcer + Splenomegaly + Anemia

- To R/O Connective tissue disorder
- Infective endocarditis

TREATMENT

- Plenty of oral fluids
- IV Fluids
- Inj. Cefotaxime 1 gm IV TDS
- Inj. Ranitidine 50 mg IV bd
- T. Paracetamol 500 mg tds
- T. Fst 1 OD
- T. Bct 1 OD

INVESTIGATIONS

- PERIPHERAL SMEAR:

  Dimorphic anemia

  Spherocytes are seen
- RETICULOCYTE COUNT - 12.5%
- DIRECT COOMBS TEST - Positive
- LDH - 780 (140-300IU/L)
- CRP - NEGATIVE
- RF - NEGATIVE

INVESTIGATIONS

- Uctc - non reactive
- HbsAg and HCU Ab - negative
- USG abdomen - mild splenomegaly
- Blood C&S : NO growth
- Urine routine - Normal
- Chest X ray - Normal

INVESTIGATIONS

- TFT - normal
- Echo ; normal study with EF 62%
- Vitamin B12 770 pg/ml (211- 911)
- Folate 10 ng/5ml (>5.3)

INVESTIGATIONS

- Bone marrow : Hypercellular marrow with spherocytes
- ANA : POSITIVE Homogenous pattern
- Anti ds DNA : POSITIVE
- Anti histone +
- Anti sm/ulrnp +

DIAGNOSIS

- SYSTEMIC LUPUS ERYTHEMATOSUS with

AUTOIMMUNE HAEMOLYTIC ANEMIA

OPINION

- RHEUMATOLOGIST:

  SLE

  T. Prednisolone 5 mg 8OD

  T. Hydroxychloroquine 200 mg 1 HS

  T. Calcium 1-0-2

  PC 1 Unit to transfuse

OPINION

- Ophthalmologist:

  B/L Tortuous vessels with splinter haemorrhage

  Preretinal haemorrhage around the disc

Suggestion

continue FST and BCT

- Cardiologist:

Echo was fixed

On day of discharge

- Hb 6 gm
- PCU 18%
- TC 11100
- PLATELET 1.8 lakhs
- MCU 97fl
- MCH 33.1 pg
- MCHC 34.1g/dl

On follow up

- Hb 6.8 gm
- PCU 20%
- TC 1000
- PLATELET 86000
- MCU 90fl
- MCH 33.1 pg
- MCHC 34.1g/dl

AIM OF PRESENTATION

SLE presenting as secondary EVAN SYNDROME .

Co occurrence of SLE and dengue fever leading to diagnostic delay.

THANK YOU