A RARE CASE OF FEVER WITH THROMBOCYTOPENIA

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Abstract: 26 YEARS OLD MALE PATIENT PRESENTED WITH 10 DAYS OF FEVER. ON PRESENTATION PATIENT HAD DARK COLOURED URINE, THROAT PAIN WITH GENERALIZED BODY PAIN. ON EXAMINATION PATIENT HAD PURPURIC SPOTS, CONGESTED UVULA, PHARYNGEAL WALL AND PALATE. PATIENT STRIKINGLY HAD GROSS EDEMA OF THE NECK REGION. INITIAL LAB INVESTIGATIONS REVEALED GROSSLY ELEVATED SGOT 1938 AND THROMBOCYTOPENIA WITH NORMAL SGPT AND LFT VALUES. FEVER PROFILE WAS NEGATIVE. USG NECK REVEALED EDEMA OF THE SUBCUTANEOUS TISSUE AND MUSCLES. NEXT DAY PATIENT DEVELOPED GENERALIZED EDEMA WITH WEAKNESS OF ALL FOUR LIMBS AND SEVERE MUSCLE PAIN. FURTHER INVESTIGATIONS REVEALED GROSSLY ELEVATED CPK LEVEL AND EMG FINDING SUGGESTIVE OF MYOSITIS. ANA BY ELISA AND WESTERN BLOT WAS ALL NEGATIVE. PATIENT WAS STARTED ON INJ. METHYL PREDNISOLONE. AS THE PATIENTS SPO2 DECREASED, PATIENT WAS INTUBATED AND WAS PUT ON VENTILATOR. SWELLING AND TENDERNESS DECREASED ON DAY 10 OF ADMISSION. PATIENT WAS TREATED WITH PLATELETS AND OTHER SUPPORTIVE MEASURES. OTHER CO-MORBID CONDITIONS THAT DEVELOPED DURING THE HOSPITAL STAY WAS TAKEN CARE OF. PATIENT RECOVERED.

Lessons Learnt: All fever with thrombocytopenia should not be thought as infectious alone. Connective tissue disorder though a rare entity should be kept in mind and timely intervention can prevent life threatening complications of this disorder.

Keyword: POLYMYOSITIS, FEVER WITH THROMBOCYTOPENIA, GENERALISED BODY SWELLING

Not a known case diabetes mellitus/ hypertension/ bronchial asthma/tuberculosis.
No h/o any drug intake.
No h/o recent travel.
On examination at the time of admission patient was Conscious, febrile, purpuric spots present over the chest, abdomen. Throat, uvula, palate were congested.
Vitals and system examination were normal.

Investigations:
Complete blood count: total count: 5000 cells /mm^3
Differential count: polymorphs-63%, lymphocytes- 24%, eosinophils-2%, basophils-1%
Haemoglobin- 9.8 gms/dl
Rbc- 3.5 million/mm^3
Platelets- 40,000

LIVER FUNCTION TEST:
Total bilirubin- 0.8mg%, direct bilirubin-0.3mg%, indirect bilirubin-0.5mg%, SGOT- 1938u/l, SGPT- 408u/l, alkaline phosphatase-275u/l
total proein-4.2gms%, alb-2.2, glo2.0
GGT- 90u/l
ESR 1 HR- 57 MM

PERIPHERAL SMEAR FOR MALARIAL PARASITE- NEGATIVE
IgM, IgG FOR dengue, MAT FOR LEPTOSPIRA- NEGATIVE

CXR-PA VIEW- NORMAL
HIV 1&2 – NON REACTIVE

The next day patient developed b/l swelling of neck, ultrasounds neck was done- it showed subcutaneous tissue and muscle edema, b/l few nonspecific lymphnodes seen, thyroid normal.

26 year male, an agricultural labourer admitted in the emergency department with high grade fever, throat pain, generalised body pain of 10 days duration.
no h/o rashes present,
no h/o vomiting, loose stools, cough with sputum.
weakness of all 4 limbs

swelling of upper limb

purpuric rash with swelling of upper limb

swelling of neck region

Subsequently the next day patient developed generalised swelling of body and weakness of all four limbs, particularly proximal muscles. So proceeded with creatine kinase level and it was highly elevated 1,01,500 IU Urine for myoglobinuria- negative ANA BY ELISA done (dsDNA, SS-A, SS-B, cl-70, u1SnRNP, jo-1, ml-2 , ku)- negative

Nerve conduction velocity – normal EMG- bizarre fibrillar waves seen Provisional diagnosis of polymyositis was arrived and patient was given inj methyl prednisolone 1g iv od for 5 days. Pt developed respiratory muscle weakness & desaturation, managed with ventilator support Pt weaned from ventilator after eight days, started on oral prednisolone on day 10 of admission swelling and tenderness of muscle started to reduce On discharge pt was put on tapering dose of tab. prednisolone tab azathioprine 50mg od, tab methotrexate 7.5 mg once a week.

DISCUSSION
Typically, adult-onset PM begins insidiously over 3 to 6 months with no identifiable precipitating event. Only rarely is the onset abrupt and associated with clinically evident rhabdomyolysis and myoglobinuria
Symptoms include pain, with marked weakness and/or loss of muscle mass in the proximal musculature, particularly in the shoulder and pelvic girdle
The etiology of polymyositis is unknown and may be multifactorial, perhaps related to autoimmune factors,[1] genetics, and viruses. In rare cases, the cause is known to be infectious, associated with the pathogens that cause Lyme disease, toxoplasmosis, and other infectious agents
Diagnosis is symmetric proximal muscle weakness, increase in serum muscle enzymes, such as creatine kinase, AST, ALT, LDH. Abnormal EMG findings, abnormal muscle biopsy
Increased frequency of cancers like non hodgkin lymphoma reported
If polymyositis is associated with interstitial lung disease the prognosis is worse
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If polymyositis is associated with interstitial lung disease the prognosis is worse

LESSONS LEARNT:
ALL FEVER WITH THROMBOCYTOPENIA SHOULD NOT BE THOUGHT AS INFECTIOUS ALONE. CONNECTIVE TISSUE DISORDER THOUGH A RARE ENTITY SHOULD BE KEPT IN MIND AND TIMELY INTERVENTION CAN PREVENT LIFE THREATENING COMPLICATIONS OF THIS DISORDER

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