



A case of abdominal pain

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A 46 y old woman was admitted with abdominal pains

Actual history

- 5 h increasing abdominal pains
- Watery, yellow stools
- Antibiotic treatment due to suspected diverticulitis

Previous history

- No family history of inflammatory bowel diseases
- 6 mo weight loss,
- non-bloody diarrhea
- unspecific abdominal pains

Medications

- Metronidazol
- Pivampicillin

Clinical appearance and laboratory findings

- Alert, reddish face color
- BP 120/55 mmHg
HR 104/min
Tp. 36.5° C
RR 16/min
W 46 kg
H 159 cm
- Heart and resp.: i.a.
- Diffuse abdominal pains, no peritoneal reaction

○ Haemoglobin	7.6 mmol/l
○ Thrombocytes	662 10E9/l
○ WBC	11.4 10E9/l
○ P-K	3.4 mmol/l
○ P-Na	127 mmol/l
○ P-creatinin	67 µmol/l
○ p-bilirubin	7 µmol/l
○ s-ALAT	59 U/l
○ p-alkaline phosphatase	196 U/l
○ p-amylase	53
○ CRP	45 mg/l
○ Orosomuroid	2.39 g/l

Arterial blood gases: respiratory alkalosis



Radiologic examination

Abdominal CT:

- No free intra-abdominal air or liquids
- Liver, kidneys, adrenal glands, and spleen: i.a
- Increased wall thickness of terminal ileum

Conclusion: Ileitis terminalis, obs.



Two days after admission

- Antibiotics: cefuroxime and metronidazole i.v.
- After two days increasingly confused, nausea and abdominal pains
- Became lethargic, kept eyes closed, answering with "yes" and "no"
- The situation worsened and pt. reacted only to pain stimulation



Laboratory findings after 2 days

Blood sample analysis

P-Na	113 mmol/l	(the previous day 128 mmol/l)
P-K	3.4 mmol/l	
P-Ca-ion	0.99 mmol/l	
B-glucose	4.8 mmol/l	
WBC	15.5 10E9/l	
CRP	61 mg/l	(the next day 165 mg/l)

Urine electrolytes

U-kalium-ion	24 mmol/l
U-natrium-ion	97 mmol/l



Status

- The patient was transferred to the ICU
- Electrolyte correction was initiated
- Developed severe hypoglycemia

- *What was the cause of this acute hyponatraemia?!*



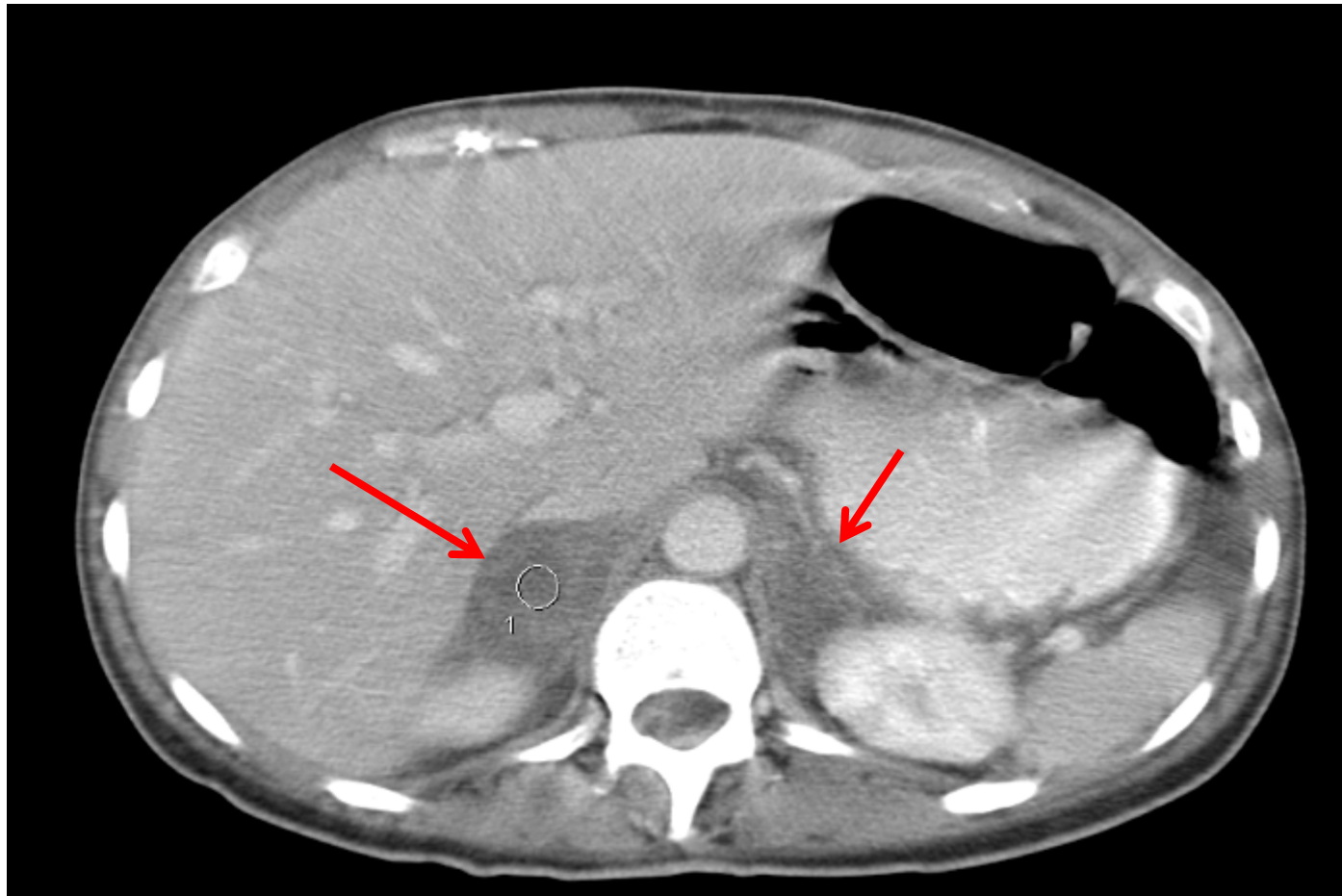
Short ACTH stimulation test

Minute 0	s- Cortisol 126 mmol/l	(240-730 mmol/l)
Minute 30	s- Cortisol 124 mmol/l	

Instant treatment: Hydrocortisone 100 mg * 4 i.v.

Response to treatment: The patient woke up and again was fully orientated

A new CT indicated hemorrhage i
both adrenal glands!!!





Acute hemorrhage of both adrenal glands - a rare cause of acute adrenal crisis.

1. In children: associated with septicemia (Waterhouse-Friderichsen's syndrome)
2. In adults: *anticoagulant therapy* or a *coagulation disorder*
3. In adults: *sepsis, pregnancy, idiopathic vein thrombosis, as complication of venography*
4. In the new born: *birth trauma*



Acute adrenal insufficiency is an elusive diagnosis

- Asthenia, nausea, vomiting, abdominal pains, fever
- Lethargy
- Hypovolemic vascular collapse

- Characteristic lab. abnormalities
low s-Na, high s-K, low b-glucose

- Diagnosed by demonstrating failure of exogenous ACTH ability to increase p-cortisol.

- ***Left untreated, the condition has a dismal prognosis***

- ***Therefore, treatment upon clinical suspicion is mandatory***



... back to the patient

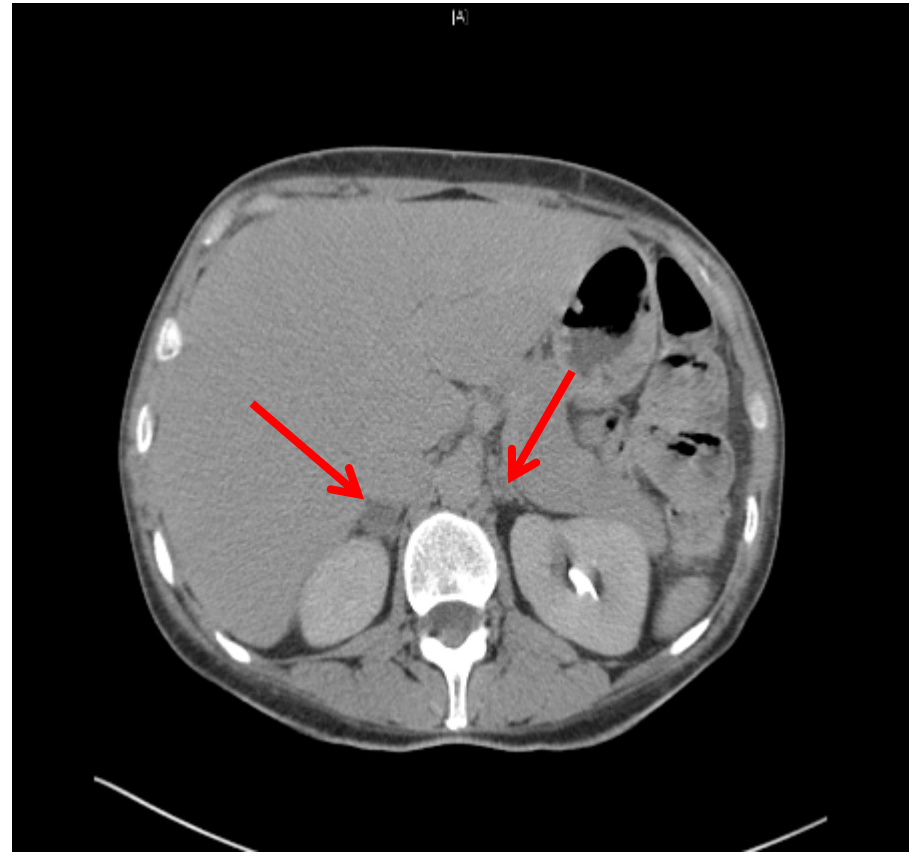
- The pt. improved clinically during the following days
- Changed to oral hydrocortisone treatment
- The suspected **inflammatory bowel disease** **was not confirmed** by small bowel series and colon biopsy.

Follow up

**CT abdomen after
3 mo:**

Regress in size of the
adrenal glands

Fibrotic changes of the
right adrenal gland





THANK YOU!