AFPI Karnataka Newsletter

Issue: Volume 4, Issue 1
Practice Experience

A Tale of Continued Diagnosis

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Mrs. Pudina, aged around 30 yrs, is a working professional, from a middle class family. She is moderately obese, hypothyroid on treatment, with occasional episodes of allergic bronchitis, on inhalers sos. She has a child studying in primary school, while husband is an Entrepreneur. One fine day she develops moderate grade fever, headache, body pain, Throat irritation, and left side lower abdomen pain. She consults *Dr. Gabbar Singh*, a renowned Family Physician in her locality.

Mrs. Pudina's Temperature was 100°F, Heart rate was elevated, BP was normal. No significant Respiratory, cardiovascular or abdominal Signs could be elicited. Not finding her to improve with Paracetamol and anti-histaminics, Dr. Gabbar asks her to take a course of *Azithromycin*, for 5 days, and perform salt water gargles.

He assured her the lower abdomen pain could be due to impending dysmenorrhoea, as she was expecting her periods, which were recorded as Irregular.

She also informed Dr. Gabbar, that she was having homogenous, mucoid, white discharge through her vagina. Suspecting Bacterial vaginosis, she was advised for treatment with oral Metronidazole for 5 days and appropriate intimate hygiene with V-Wash solution or wipes.

Two days into treatment, vaginal discharge has reduced, but Mrs. Pudina developed urgency, burning while passing urine, and intense pain and burning sensation while passing motions. Unable to bear the pain, she had applied for Leave from work. She revealed that she was straining while passing motions. Her fever increased from moderate to high grade. Dr. Gabbar now advised her to consider a blood test – complete blood count, which showed an elevated Total counts (16,000) with Neutrophilic predominance, Dengue NS1 was negative, Peripheral smear

for Malaria Parasite was Negative, and Urine routine was normal.

Her antibiotics were now upgraded to Inj *Ceftriaxone* 1 gm IV BD, along with Oral Paracetamol, and IM Diclofenac sos. She was also started on Duphalac (laxative) suspension 20 ml BD, and advised to use "Smuth" Cream per-rectally.

Two days into her treatment, her per-rectal symptoms reduced, but left flank pain persisted, and fever spikes continued to be there more than 100°F, atleast twice a day. Dr. Gabbar advised to repeat CBC, along with a CRP (C-reactive protein), and plan for doing an Ultrasound of the abdomen. Total counts were increased to 20,000, hemoglobin had dropped from initial 12.4 to 11.6, platelets were normal, and CRP was more than 200 (high). At this juncture, Dr. Gabbar decided to consult a Specialist, *Dr. Mogambo*, a renowned Physician in their city.

Dr. Mogambo examined Mrs. Pudina, and advised for Blood Culture, Urine culture, and to go ahead with USG abdomen, and to continue medical care under the supervision of Dr. Gabbar. USG abdomen revealed *left side Ovarian cyst*, and mild hydronehprosis of left kidney. Dr. Mogambo opined, this could be a case of *Pyelonephritis*, and advised to upgrade antibiotics to *IV Meropenem* thrice daily, and to meet a Gynaecologist, and Urologist, and plan for DJ stenting of ureter, if not improved.

For the first time since a week, Mrs. Pudina did not spike any fever, and was happy to be back on her feet, carrying on her daily chores. Another day later, her fever spikes returned, and was treated with IV Paracetamol BD and sos. She now consulted a Gynaecologist at a Corporate Hospital, who advised a battery of investigations, and CT scan-abdomen. Her Biochemical parameters such as Creatinine, Electrolytes, and Liver function tests which were now worked out were within normal limits.

CT abdomen revealed *"Complex Ovarian cyst"* and to pleasant surprise, the Hydronephrosis (?Pyelonephritis) had now resolved. No evidence of abdominal lymph nodes or any other change in morphology. There was one blood test, which depressed her mood again, *"Ca-125"* which was elevated. Coming from a literate, working background, she and her doctor had worked out various possibilities of diagnosis.

Enter *Dr. Lal Pari*, the Gynaecologist/ Specialist Laparoscopic Surgeon. She patiently listened to the whole story, went through all the reports, and immediately took Mrs. Pudina for a Trans-vaginal Sonography, to understand the consistency and nature of the Ovarian swelling. The test revealed an *"Ovarian abscess"* and patient was advised Laparoscopic drainage under General anaesthesia. She also rightly assured Mrs. Pudina, that Ca-125 could be elevated due to ongoing Infection and inflammation, and told her not to worry about it now.

The procedure revealed frank pus, which was sent for Culture and sensitivity, post-operative period was uneventful. By then

Blood culture and Urine culture reports had come, both showed No growth. But the Pus culture revealed Growth of *"ESBL producing Escherichia coli"* an organism commonly causing urinary tract infection, probably implying an 'ascending' pelvic infection.

This bacterial isolate was reported susceptible to the action of Meropenem, and surprisingly to Co-trimoxazole. Patient was discharged with oral *Bactrim-DS*, and continued her follow up with Dr. Gabbar.

In the following week, Dr. Lal Pari treated Mrs. Pudina with IM Depot preparations of Progesterone, to take care of her Dysmenorrhea, with an advisory that she needs to get back to her atleast three months before her next conception.

After taking a few weeks off, Mrs. Pudina is now back to her work, hale and hearty, actively working on reducing weight, and trying to bring positive changes into the life of others.

This is the story of Dr. Gabbar and Mrs. Pudina. What would you do if you had been in place of Dr. Gabbar? Could your approach and management be any different from the one mentioned here.