International Journal of Medical and All Body Health Research

Disrobing the onion peels-Unrevealing the mysteries within

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Article Info

ISSN (online): 2582-8940
Volume: 03
Issue: 03
July-September 2022
Received: 13-08-2022;
Accepted: 19-09-2021
Page No: 52-54

Keywords: angioplasty, erosive gastritis, pacemaker, foreign body in stomach, cholecystitis with cholelithiasis, musculo skeletal pain

Abstract
It is an old axiom that a good Internal Medicine specialist must be very cunning, resourceful and permanently incredulous. For, what appears, may be just a tip of the iceberg and there may be more devious disease lurking behind the obvious. We describe a case which presented suggesting a particular etiology and which went on progressively to assume not one but SIX different medical conditions. His underlying medical conditions made it even more challenging.

Introduction

Mr. CLK, M/ 78, was a known case of (1) HTN (2) Obstructive airway disease (3) IHD (Angioplasty done 5 months ago- on dual antiplatelet therapy. (4) Permanent cardiac pacemaker implanted a year ago.
He presented to us in emergency with severe retrosternal burning, water brash, acidity, vomiting and indigestion of 2-3 days duration.

On examination

Vitals were normal. He had bi-basal crackles. There was tenderness in epigastrium, right hypochondrium and right lower rib cage. However, it was the epigastrium which was the epicenter, with other areas being secondary.
Because of the classical history, dual antiplatelets and findings, we suspected severe gastritis/ Ulcer. He was kept NBM and scheduled for OGD'scopy. Meanwhile his USG abdomen revealed a solitary, mobile 23-24mm sized calculus in the gall bladder with mildly thickened gall bladder without signs of cholecystitis. The patient was categoric that this was an old finding. His old USG's were compared and confirmed that the calculus was indeed chronic, with no significant changes over last many years.

Course

The patient was started on intravenous fluids and given symptomatic treatment for vomiting and gastritis.
OGD scopy was S/O erosive gastritis. RUT was negative. Incidentally, the puzzled gastroenterologist reported a 10*5mm foreign body, which appeared to be a piece of plastic.
His Aspirin and Ticagrelor was stopped and substituted by Clopidogrel.

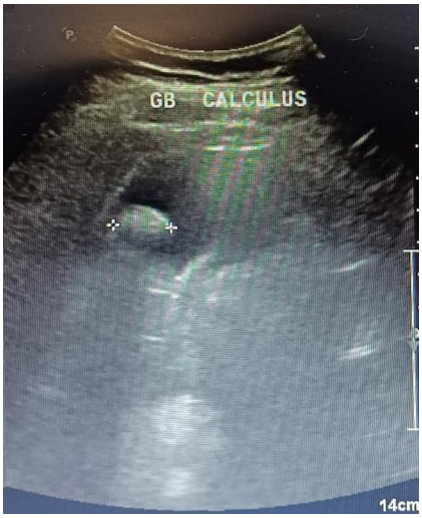

Fig 1

OGD Scopy showing Erosive gastritis and foreign body in stomach.

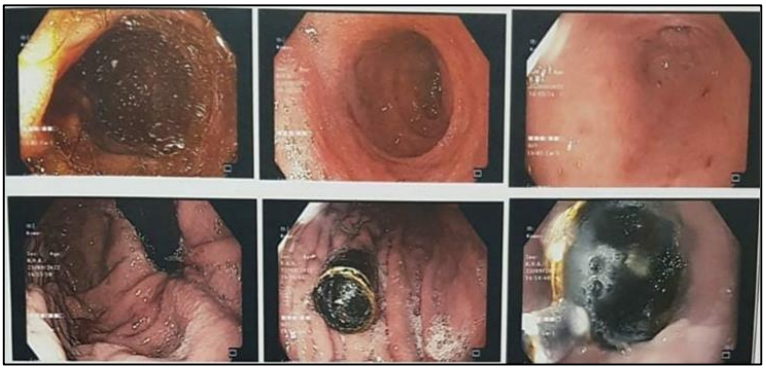

Fig 2

So, much to our consternation, a straightforward (1) erosive gastritis suddenly metamorphosed into
(2) Foreign body in stomach.

We thought that was the end of the matter. However, Next morning, patient had a fever spike, was lethargic, SPO2 dropped to 94% on RA and there was slight hypotension. The WBC count (previously normal) shot up to 13,000. The CRP was elevated at 122. He was started on IV antibiotics and we renewed our search for other possibilities. Creatinine-0.9, sgot-34, sgpt-37, Trop-I-negative, amylase-113, lipase-158.

We'd have liked to do MRCP, but were thwarted by his pacemaker and it being a weekend. So we had to opt for a CT abdomen and chest, which denoted an over distended GB with a large solitary calculus of size 2.2 cm with thickened GB wall (4-5 mm) with surrounding fat standing and a thin rim of collection.

The pacemaker technician was summoned, he did the necessary adjustments to the pacemaker and MRCP was done.

MRCP denoted an over distended gallbladder showing diffuse edema, a 41*26mm calculus and significant intraluminal sludge within with IHBR dilation.

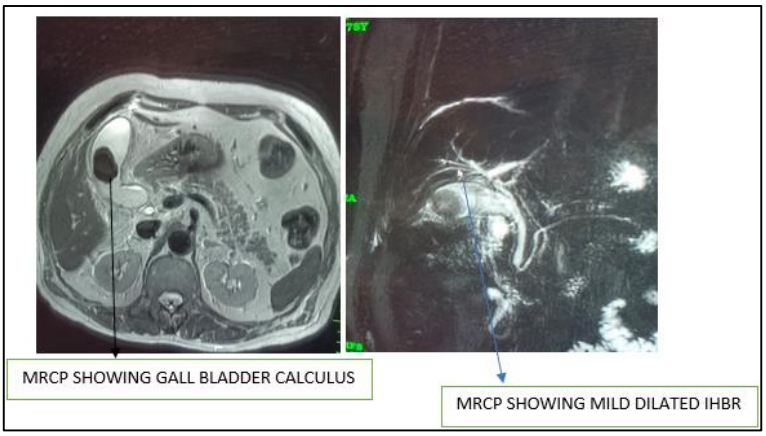

Fig 3

So, to the list of maladies was added- (3) Acute cholecystitis on chronic cholelithiasis. Surgical refernce was given for cholecystectomy.
The very next morning, there was a mionor emergency as patient complained of palpitatiopns with discomfort. His pulse was high (135-150) with hypotension and he had to be shifted to the ICCU.
Ecg suggested a V-PACED rythym with pacemaker related tachycardia.

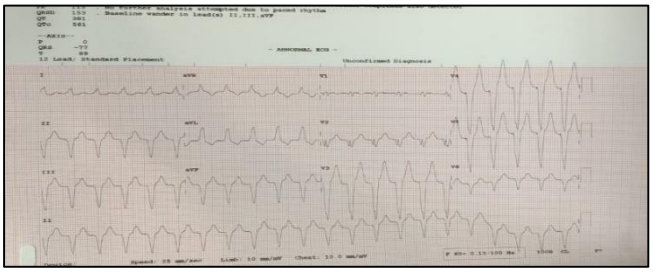

Fig 4

After keeping magnet for few seconds, the patient had sinus rythym. BP got corrected.

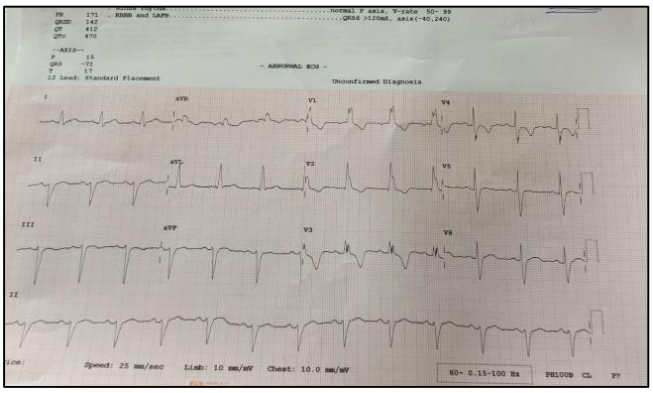

Fig 5

NTROP BNP being slightly raised, LOW MOLECULAR HEPARIN 0.4 SC was given. So, diagnosis number (4) got added on, which was Pacemaker malfunction causing tachycardia and Number (5) unstable angina.
For the laproscopic cholecytectomy that was planned under GA, the pacemaker technician had to be summoned again for necessary caliberation with arrangement of a special cautery (bipolar Cautery) which would'nt interfere with the pacemaker. However his pain continued. A careful examination revealed tenderness in right lower rib cage. Pt said he'd fallen down in past with trauma there, which piled on points number (6) musculo skeletal pain +/- osteoporosis. Fortunately the procedure went off well and he was discharged soon after.

Discussion

Erosive gastriits was a red herring here especially as he was on dual anti platelets, but could'nt be ignored either. There may not be any definite correlation between the number of erosions and the duration of symptoms [1-2].
Cholecystitis is defined as an inflammation of the gallbladder that occurs most commonly because of the presence of stones in the gallbladder or an obstruction of the cystic duct from cholelithiasis. Ninety percent of cases involve stones in the gallbladder (ie, calculous cholecystitis), with the other 10% of cases representing acalculous cholecystitis [3, 4, 5].
Foreign body ingestion isn't uncommon in elderly and edentulous. Eighty percent of times, ingested foreign bodies will pass through uneventfully. In a small minority of cases, there may be obstruction, perforation or hemorrhage [6, 7].
A pacemaker-mediated tachycardia (also called endless-loop tachycardia) can be defined as any condition in which a pacemaker paces the ventricles at rates that are inappropriately fast. This can be due to (1) a rate response setting that is too sensitive, (2) tracking of atrial noise (such as what may occur with electromagnetic interference), (3) inappropriate pacemaker manipulation with rate response turned on, or (4) tracking of an atrial tachyarrhythmia related to upper rate settings [8, 9, 10].

Conclusion

This is a case that typically underlines the complex/ overlapping scenario that we Internal Medicine specialists typically face. It was almost like unpealing of an onion, where each layer reveals something more underneath. Lots of confusing features interdigitated with each other. So, a wise and mature insight and a broad outlook is most important for a succesful outcome.

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