

Melting Cancer: A Case ReportG Vishwa Reddy^{1*}, Ashima Shama², Raghu Kondle³¹Assistant Professor, Department of Emergency Medicine, Nizam's Institute of Medical Sciences, Hyderabad Telangana State, India²Professor & HOD, Department of Emergency & Critical Care Medicine, Nizam's Institute of Medical Sciences, Hyderabad Telangana State, India³Head of Clinical Services & Senior Consultant, Department of Emergency & Critical Care Medicine, Narayana Medical College and Hospital, Nellore, Andhrapradesh, India***Corresponding author**

G Vishwa Reddy

Article History

Received: 02.06.2018

Accepted: 13.06.2018

Published: 30.06.2018

DOI:

10.36347/sjmcr.2018.v06i06.006



Abstract: We present a case of a patient who developed tumor lysis syndrome with neurological complaints since 2 week. He recently diagnosed as a case of Non Hodgkins lymphoma and was started on Chemotherapy. Risk factors for the development of tumor lysis syndrome were studied. High index of suspicion and early recognition of associated metabolic and renal complications on this case was supported to make easy to manage this condition in the emergency department. A 46 year aged male patient came to Emergency department presenting (chief) complaint(s) with swelling in the neck and axilla region since two weeks; decreased urine output since 3 days; pedal edema since 2 days and shortness of breath since 2 days.

Keywords: Tumor lysis syndrome, Hodgkins lymphoma, chemotherapy.

INTRODUCTION

Tumor lysis syndrome (TLS) is a potentially life-threatening metabolic disorder characterized by an elevated uric acid level, elevated serum potassium and phosphorus levels, and a decreased calcium level.

Primary

Airway – patient: breathing is tachypneic, spo2 is 83% (RA), circulation-WNL and disability is GCS- 15/15.

Interventions done

Oxygen administration – 4L /min

Investigations like ABG, Chest X ray, ECG were done.

Focused history of present illness

Patient was apparently asymptomatic two weeks ago later he had swelling in the neck and axilla region which was localised, nontender, and not associated with itching and local discharge, the patient was treated in a local hospital for the swelling and it was followed by pedal edema decreased urine output and shortness of breath which progressed to the present state. There was no history of chest pain, palpitations and PND, no history of fever cough, vomiting, loose motions, no history of pain abdomen, no history of bleeding manifestations, no history of joint pains.

Relevant past history

No history of similar complaints in the past. Patient was recently diagnosed as a case of Non Hodgkins lymphoma and was started on Chemotherapy-CHOP regimen. No history of Hypertension, Asthma,

Epilepsy and Tuberculosis. No prior history of CAD, CKD and CVA.

Personal history

Chronic smoker and alcoholic, mixed diet, normal appetite. Normal bowel and decreased bladder habits.

DIFFERENTIAL DIAGNOSIS BASED ON HISTORY

Non Hodgkins lymphoma with A.K.I

Non Hodgkins lymphoma with LRTI -Sepsis

EXAMINATION**Vital signs**

Pulse 116/min, B.P- 110/70 mmHg, RR 32/min, Spo2- 95 % on 4 L of O2, and Temperature is 99.6⁰ F.

General physical exam

O/E pt tachypneic, conscious, coherent and cooperative
Pallor present, pedal edema present -pitting type, generalized lymphadenopathy present
No icterus, cyanosis and clubbing.

Focused systemic exam

CNS- GCS- 15/15, No neurological deficit
 CVS- S1, S2 present, No murmurs
 RS- BAE present, basal rales present,
 GIT – P/A Soft, Hepato splenomegaly present, no
 tenderness

Provisional diagnosis/ differentials

Non Hodgkins lymphoma with A.K.I
 Non Hodgkins lymphoma with LRTI - Sepsis
 Non Hodgkins lymphoma with Tumour lysis syndrome.

Relevant investigations/adjuncts

Test	Observation/report
ABG	
Ph,	7.02
Pco2	23
HCO3	8
Po2-	96
ECG	S/o Ventricular bigeminy, prolonged QT interval
Chest X-ray	S/O Mild Pleural Effusion
Blood Urea	126 mg/dl
Se creatinine	4.6 mg/dl
Hb	10.5 gm%
TWBC	36,700
Platelet Count	2,00,000
Serum electrolytes-	
Na+	150 mmol/dl
K+	5.8 mmol/dl
Cl-	116 mmol/dl
Ca -	6.8mg/dl
Phosphorous	6.8 mg/dl
Uric acid	18mg/dl
Serum L.D.H	366 IU/L..
Cytology report	Smear with features of Non Hodgkins lymphoma
Peripheral smear	S/o leukocytosis with lymphocytosis and atypical lymphocytes
Final diagnosis:	Non Hodgkins lymphoma with tumour lysis syndrome.

Tumor lysis syndrome is a common emergency presentation and a potentially lethal complication among patients undergoing anticancer treatment [1, 2]. High index of suspicion and early recognition of associated metabolic and renal complications [3] in the E.D and prompt administration of supportive care will save many lives [4, 5].

REFERENCES

1. Scott CH, Deborah P, Ching-Hon P. The tumor lysis syndrome. Current concepts. N Engl J Med. 2011;364(19):1844–1854
2. Ñamendys-Silva SA, Arredondo-Armenta JM, Plata-Menchaca EP, Guevara-García H, García-Guillén FJ, Rivero-Sigarroa E, Herrera-Gómez A. Tumor lysis syndrome in the emergency department: challenges and solutions. Open access emergency medicine: OAEM. 2015;7:39.
3. Givens M, Crandall J. Renal complications in oncologic patients. Hematol Oncol Clin North Am. 2010;24(3):567–575.
4. Mirrakhimov AE, Ali AM, Khan M, Barbaryan A. Tumor lysis syndrome in solid tumors: an up to date review of the literature. Rare Tumors. 2014;6(2):5389.
5. Jessica S. Prevention and management of tumor lysis syndrome in adults with malignancy. J Adv Pract Oncol. 2013;4(2):101–106.