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A Sheehan's Syndrome Revealed by Profound Hypoglycemia: A Case Report

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Abstract **Case Report**

A sheehan's syndrom is characterized by ischemic necrosis of the anterior pituitary gland after postpartum hemorrhage hypopituitarism immediately or after several years. The late discovery of this disease shows that it is not well known and that its clinical and the lack of specificity of its clinical picture. We report the case of a patient whose diagnosis of sheehan's syndrome was delayed and revealed by a profound hypoglycemia. A 30 year old femele patient, admitted to the intensive care unit in a state of disturbed consciousness with profound hypoglycemia at 0.2 g/l according to the family felt by tremor and sweat not yielding to resucration, and sweat septic shock due to pyelonephritis, was intubated, ventilated and put on noradrenaline in SAP and antibiotic therapy, in view of the non-improvement and low blood pressure figures despite the filling and vasoactive drugs, with a hyponatremia of 119 mmol/l and hyperkalemia of 6 .1 mmol/l on the ionogram, acute adrenal insufficiency was suspected and the 8-hour cortisol level confirmed the diagnosis (0.3 ug/dl), patient put on intravenous hydrocortisone hemisuccinate. The evolution was marked by an improvement, patient extubated and weaned from vasoactive drugs, the interrogation revealed an antecedent hemorrhagic childbirth with absence of milking and absence of return of childbirth, and the patient kept an important asthenia in postpartum but and consulted each time for a digestive picture made of abdominal pains and nausea put under symptomatic treatment without the diagnosis of adrenal insufficiency being suspected. The patient was then admitted to the endocrinology department for further management with evidence of a gonadotropic, corticotropic and thyrotropic deficit, the somatotropic axis was not explored, the pituitary MRI was without anomalies. The disease is manifested by corticotropic insufficiency is one of the most important endocrine imbalances because it threatens the vital prognosis. Thus, early replacement therapy can prevent the risk of can prevent the risk of acute decompensation.

Keywords: syndrome's sheehan, hypoglycemia, vascular collapse, corticotropic insufficiency.

INTRODUCTION

A sheehan 's syndrome and postpartum pituitary necrosis is a rare disease but potentially serious complication of postpartum and a difficult diagnosis in the acute phase and is often over looked. Sheehan's syndrome can present during the postpartum period or several months or years following delivery. The most common initial symptoms of Sheehan's syndrome are amenorrhea. Uncommonly, it can present as an emergency condition with circulatory collapse, severe hyponatremia, diabetes insipidus, hypoglycemia, congestive cardiac failure, or psychosis [1]. Women with Sheehan's syndrome have varying degrees of hypopituitarism, ranging from panhypopituitarism to only selective pituitary deficiencies [2]. The underlying process leading to Sheehan's syndrome is the infarction of the physiologically enlarged anterior pituitary lobe (due to hyperplasia of prolactinsecreting cells as a result of elevated estrogen secretion) and secondary to the compression of the blood vessels.

Supplying the gland by the enlarged gland it self or due to grossly decreased blood supply during intrapartum. Although other étiologies including vasospasm, autoimmunity, small sella size, and disseminated intravascular coagulation may also play a role in the development of Sheehan's syndrome, none has been conclusively proven [3]. In some cases, the diagnosis is not made until years later, when features of hypopituitarism, such as secondary hypothyroidism or secondary adrenal insuffciency, become evident in a woman who had a postpartum hemorrhage

CASE PRESENTATION

A 30 year old female patient, admitted to the intensive care unit in a state of disturbed consciousness

with profound hypoglycemia at 0.1 g/l according to the family felt by tremor and sweat not yielding to resucration, and sweat septic shock due to pyelonephritis, was intubated, ventilated and put on noradrenaline in SAP and antibiotic therapy, severe hypoglycemia that has been corrected by intravenous dextrose administration. in view of the non-improvement and low blood pressure figures despite the filling and vasoactive drugs, with a hyponatremia of 119 mmol/l and hyperkalemia of 6 .1 mmol/l on the ionogram, acute adrenal insufficiency was suspected and the 8-hour cortisol level confirmed the diagnosis (0.3 ug/dl), patient put on intravenous hydrocortisone hemisuccinate.

The evolution was marked by an improvement, patient extubated and weaned from vasoactive drugs, the interrogation revealed an antecedent hemorrhagic childbirth with absence of milking and absence of return of childbirth, and the patient kept an important asthenia in postpartum but and consulted each time for a digestive picture made of abdominal pains and nausea put under symptomatic treatment without the diagnosis of adrenal insufficiency being suspected. The patient was then admitted to the endocrinology department for further management with evidence of a gonadotropic, corticotropic and thyrotropic deficit, the somatotropic axis was not explored, the pituitary MRI was without anomalies.

DISCUSSION

Sheehan ‘s syndrom in the form of a hypoglycemic coma unusual, and is rarely reported in the literature very rarely described [4]. The thyrotropic and gonadotropic axes were intact, with the exception of a decrease in FSH stimulation by the LHRH test (currently of no clinical relevance) were intact, especially as normal cycles had set in. The diagnosis of Sheehan’s syndrome is determined by the patient’s history and physical examination, and confirmed by laboratory tests. Hemorrhagic shock during pregnancy is a key leading point in diagnosis. Failure to lactate is often a common initial complaint in patients with Sheehan syndrome [5]. Sheehan’s syndrome presents with varied symptoms depending on the specific anterior pituitary hormone deficiencies. Prolactine deficency can cause lactation failure. Gonadotropic deficency will often cause amenorrhea or genital hair loss. The patient had isolated adrenocorticotropic axis insufficiency with consequent adrenocortical insufficiency. Symptoms may be similar to those of primary adrenocortical insufficiency, but are generally much lower Corticotrophin deficency can result in generalized. Growth hormone deficency causes fatigue, decreased quality of life, and weight loss. Symptoms of central hypothyroidism are clinically similar to primary hypothyroidism, but patients with central hypothyroidism have low triiodothyronine and thyroxine levels, with normal or even inappropriately low thyroid-stimulating hormone levels. Diagnosis of panhypopituitarism is straight forward, but partial deficiencies are often difficult to determine [6]. The symptoms of Sheehan’s syndrome significantly improved with appropriate hormone replacement treatment. The presence of severe headaches on the day of delivery may indicate intracranial hemorrhage, but if that can be ruled out, the obstetrician should remain alert for the possible onset of acute Sheehan’s syndrome.

CONCLUSION

We have described a typical observation of Sheehan's syndrome, both in its clinical presentation and in the diagnostic errors that it can cause. It is important to suspect the diagnosis in any patient who has had a collapse during delivery, whatever the cause, in front of the appearance of a deep hypoglycemia with early headaches or a meningeal syndrome, and/or in front of the later appearance of the classic signs of pituitary insufficiency (absence of lactation, weight loss, asthenia, arterial hypotension, secondary amenorrhea).

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Conflict of interest

I declare no conflict of interest.

Statement of ethical approval

Informed consent was obtained from all individual participants included in the study.

REFERENCES

1. Abbott, J., & Kirkby, G. R. (2004). Acute visual loss and pituitary apoplexy after surgery. *Bmj*, *329*(7459), 218-219.
2. Lakhdar, A. A., McLaren, E. H., Davda, N. S., McKay, E. J., & Rubin, P. C. (1987). Pituitary failure from Sheehan's syndrome in the puerperium. Two case reports. *British Journal of Obstetrics and Gynaecology*, *94*(10), 998-999.
3. Keleştimur, F. (2003). Sheehan's syndrome. *Pituitary*, *6*, 181-188.
4. Bala, M., Brünnler, T., Guralnik, V., Schölmerich, J., & Schäffler, A. (2009). Hypoglykämisches Koma bei einer 36-jährigen Patientin. *Der Internist*, *5*(50), 606-611.
5. Rajasekaran, S., Vanderpump, M., Baldeweg, S., Drake, W., Reddy, N., Lanyon, M., ... & Wass, J. (2011). UK guidelines for the management of pituitary apoplexy. *Clinical endocrinology*, *74*(1), 9-20.
6. Robalo, R., Pedroso, C., Agapito, A., & Borges, A. (2012). Acute Sheehan's syndrome presenting as central diabetes insipidus. *Case Reports*, *2012*, bcr2012007022.