A case of renal tubular disease

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1st year post graduate,

General medicine

KIMS , narketpally

Chief complaints & history

1st Admission

Patient name : xxx

Age/sex : 30 Years/male

Address : chandupatla (village)
suryapeta (mandal)
Nalgonda (district)

Occupation :daily labour

DOA :14/11/2014

DOD :25/11/2015

Chief complaints & history(continued)

- Chief complaints of Vomitings since 4 days

History of present illness

- He developed vomitings ,4 -5 episodes ,non-projectile , not blood stained,non-bilious, vomitus has food material.
- Not associated with loose stools , pain abdomen
- No h/o jaundice,fever,head ache
- No h/o abdominal distension
- No h/o sob , chest pain, vertigo,ear ache
- No h/o head injury ,seizures
- No long term drug usage
- No h/o abnormal skin pigmentation
- No h/o polyuria, pedal edema, decreased urine output

Past history

- He is a k/c/o hypokalemic paralysis since 2 years ,h/o hospital admissions for the same
- H/o peptic ulcer disease, since 2 years
- Not a k/c/o HTN, DM, TB, Asthma ,Epilepsy

- Family history

No similar complaints in the family

No h/o parental consanguinity

His marriage is a consanguinity (1st degree)

He has two male children,they are normal

Drug history

No h/o long term drug usage

No known drug allergies

- Personal history
- Pt is a chronic alcoholic for 10 years,stopped 2 years back
- He is a chronic smoker for 10 years,1 pack/day(10 pack years)
- Takes mixed diet
- Apettite is normal
- Bowel and bladder habits are regular

- History diagnosis

chronic gastritis

General examination

Pt is conscious ,coherent,well oriented to time place & person

Moderately built& nourished

Temp: 98.4 F

B.P : 90/70 mm of hg

PR: 76 /min, regular, normal volume

RR : 15 / min

No pallor , icterus , cyanosis , clubbing , lymphadenopathy , pedal odema

systemic examination

CVS- S1,S2 heard,no murmurs

RS- bilateral air entry present ,equal,normal vesicular breath sounds present

P/A -soft ,no distension, no tenderness, no organomegaly

CNS-Higher mental functions are normal, No focal neurological deficit

- Provisional diagnosis

  acute on chronic gastritis

INVESTIGATIONS

RBS -98 mg/dl

CBP: Hb%- 11.2gm/dl

Total count: 5,600/cumm

Platelet count :2.5 lakhs/cumm

CUE : normal limits

RFT :blood urea : 40 mg/dl

Creatinine : 0.9 mg/dl

LFT :Total serum bilirubin -1.1mg/dl

Albumin – 3.3 gm/dl

T3, T4, TSH - within normal limits

Upper GI Endoscopy: mild erosive gastritis

INVESTIGATIONS(continued)

Serum Electrolytes:

Sodium:	121mmol/l	(135-155)
Potassium :	**2.1 mmol/l**	(3.5-5.5)
Chloride:	85 mmol/l	(98-109)
Phosphorus:	1.5 mg/dl	(2.5-5.5)
Calcium :	**7.5 mg/dl**	(8.5-11.0)
Magnesium:	**1.2 mg/dl**	(1.8-2.9)

urinary electrolytes:

potassium:	**300mmol/24h**	(25- 125)
chloride:	650 mmol/24h	(110-250)
calcium:	**1.0mmol/24h**	(2.5-7.5)

INVESTIGATIONS(continued)

ABG:

Ph: 7.63

Pco_2: 44 mm of hg

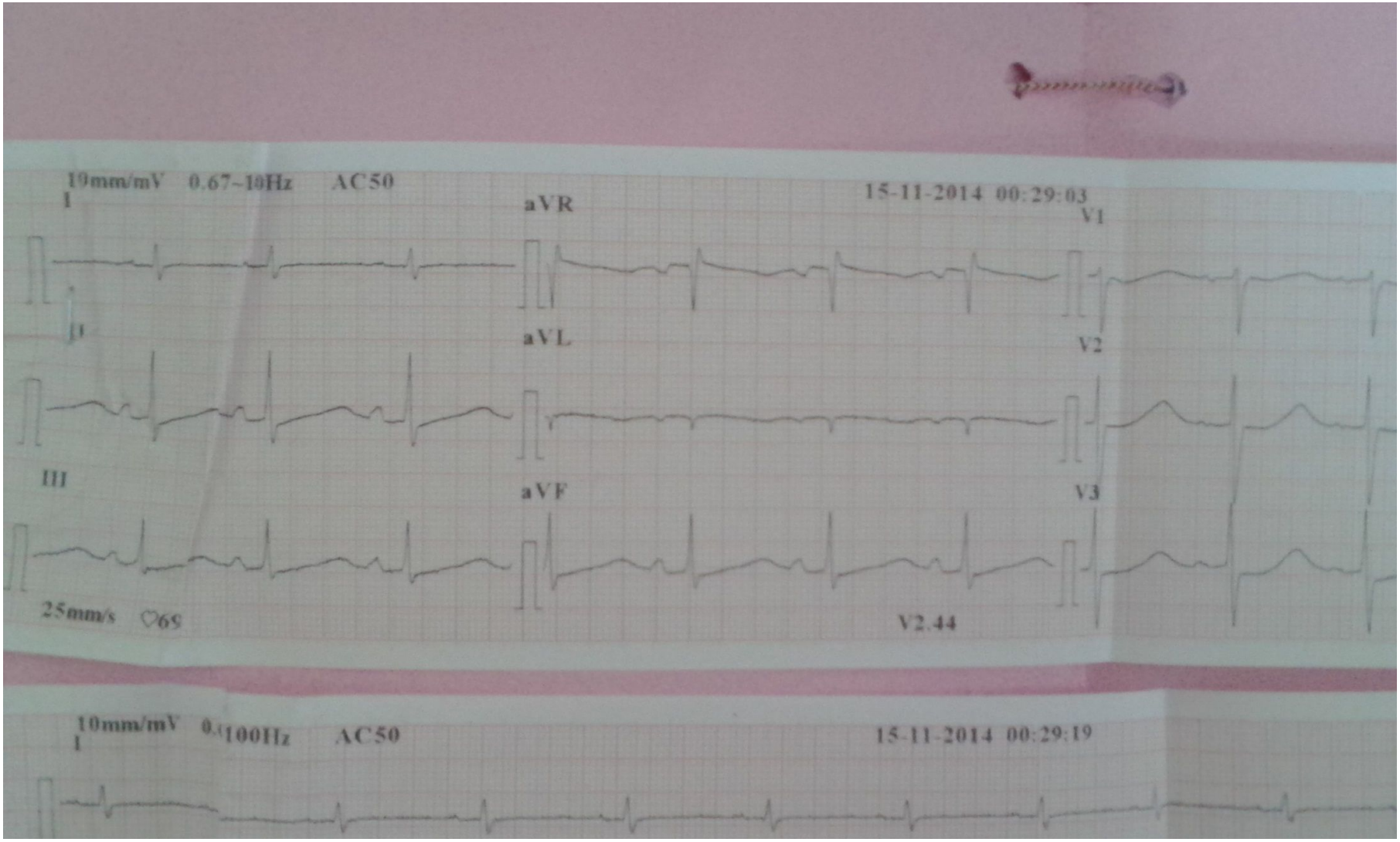
Po_2 : 95 mm of hg

HCO_3 : 46.8

O_2 Sat : 97.5

s/o : metabolic alkalosis

ECG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II
aVL
V2
III
aVF
V3
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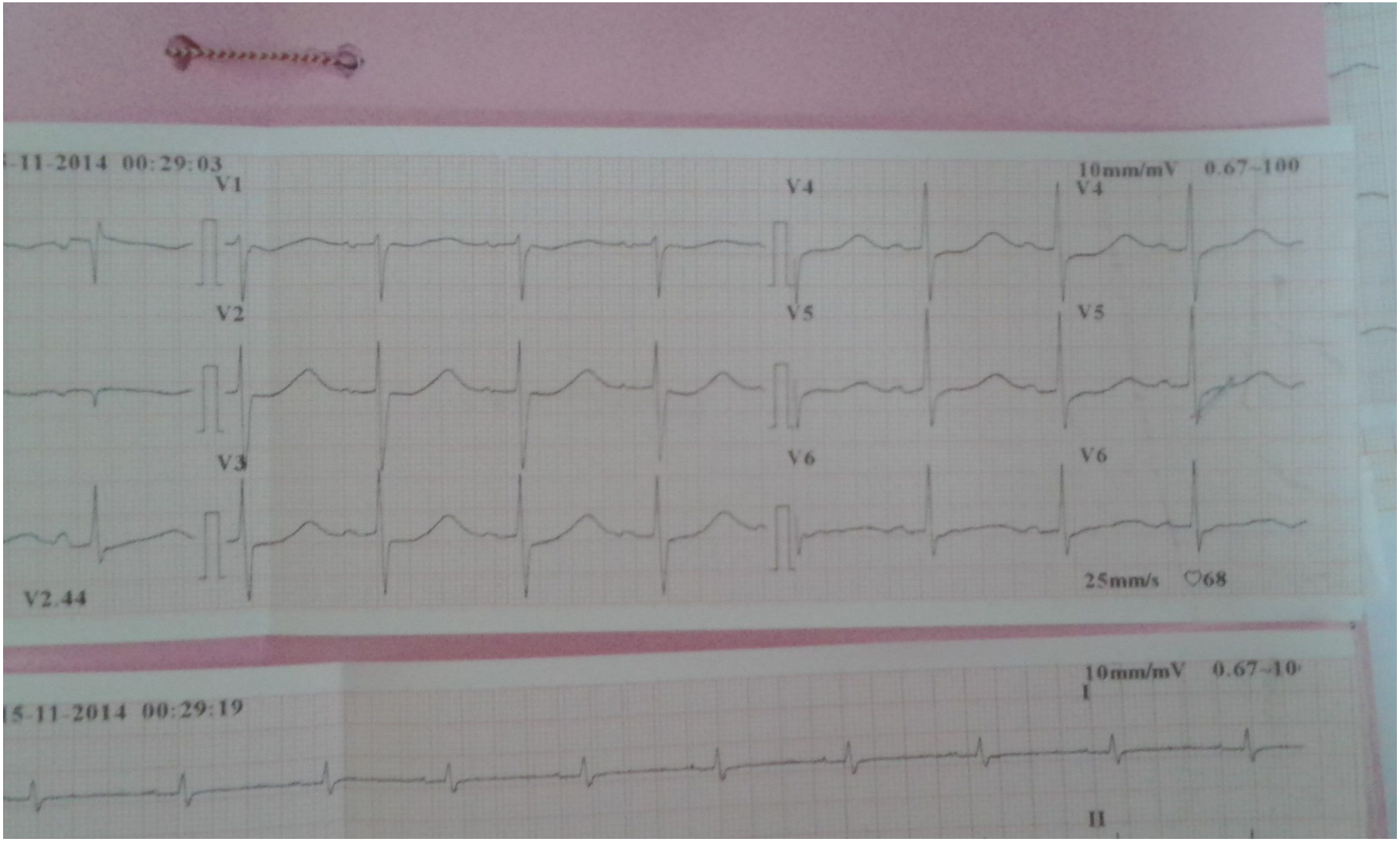
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V1
V4
10mm/mV 0.67~100
V4
V2
V5
V5
V3
V6
V6
V2.44
25mm/s ♡68
10mm/mV 0.67~10
I
5-11-2014 00:29:19
II

Differential diagnosis

1) Hyperaldosteronism
2) Primary hypokalemic periodic paralysis
3) Gittelmans syndrome
4) Bartters syndrome
5) Liddle syndrome
6) Thyrotoxicosis

FINAL DIAGNOSIS

GITELMAN'S SYNDROME

recurrent episodes of hypokalemia metabolic alkalosis , hypomagnesemia, hypocalciuria , hypermagnesuria with normal blood pressure

TREATMENT

1)Inj. KCl 40mEq in 500 ml NS over 6 hours BD
2)Iv fluids - 2◎NS
1◎DNS
2◎RL
3)Inj.pan 40 mg iv BD
4)Inj. zofer 4 mg iv TID
5)Tab. spironolactone 25 mg BD
6)Cap. indomethacin 25 mg BD
7)Tab shelcal 500 mg OD
8)Tab. Magnesium lactate 84 mg BD
9)Syrup sucralfate 10 ml TID

Patient discharged with symptoms free and advised to take

1)Syp.potchlor15ml in half galss of water TID
2)Plenty of coconut water ,
3)Cap indomethacin 25 mg BD
4)Tab pantop 40 mg BD
5)Syp sucralfate 10 ml TID

2nd time admission

DOA: 27/01/2015

pt came with same complaints vomitings since 2 days , with vitals in normal limits

INVESTIGATIONS

Serum Electrolytes:

Sodium:	125mmol/l	(135-155)
Potassium :	2.2 mmol/l	(3.5-5.5)
Chloride:	90 mmol/l	(98-109)
Phosphorus:	2.0 mg/dl	(2.5-5.5)
Calcium :	8.0 mg/dl	(8.5-11.0)
Magnesium:	1.2mg/dl	(1.8-2.9)

TREATMENT

1)Inj. KCl 40meqi in 500 ml NS over 6 hours BD
2)Iv fluids - 2◎NS
1◎DNS
2◎RL
3)Inj.pan 40 mg iv BD
4)Inj. zofer 4 mg iv TID
5)Tab spironolactone 25 mg BD
6)Cap indomethacin 25 mg BD
7)Tab shelcal 500 mg OD
8)Syp sucralfate 10 ml TID
9)Tab magnesium lactate 84 mg BD

TREATMENT (CONTINUED)

Patient discharged with symptoms free
and advised to take
1)Syp.potchlor 15ml in half galss of water TID
2)Plenty of coconut water ,
3)Cap indomethacin 25 mg BD
4)Tab pantop 40mg BD
5)Syp. Sucralfate 10ml TID

discharged on 30/1/2015

3rd time admission

DOA: 01/02/2015

c/o vomitings and weakness since 1 week

pt came for vomitings and weakness has recurred , weakness of non progressive nature and muscle cramps are present

vitals : Temp: 98.4

BP : 100/70 mm of hg

PR : 80/ min

CVS: s1s2 heard

RS: b/l air entry present

PA: soft and non tender

CNS: Tone is decreased ,

Power – 3/5 in all limbs

Reflexes- hyporeflexia,

plantar –flexor response

Investigations

Serum Electrolytes:

Sodium:	129 mmol/l	(135-155)
Potassium :	2.6 mmol/l	(3.5-5.5)
Chloride:	88 mmol/l	(98-109)
Phosphorus:	1.8 mg/dl	(2.5-5.5)
Calcium :	7.8 mg/dl	(8.5-11.0)
Magnesium:	1.4 mg/dl	(1.8-2.9)

TREATMENT

1)Inj. KCl 40meqi in 500 ml NS over 6 hours BD

2)Iv fluids - 2◎NS

1◎DNS

2◎RL

3)Inj.pan 40 mg iv BD

4)Inj. zofer 4 mg iv TID

5)Tab spironolactone 25 mg BD

6)Cap. indomethacin 25 mg BD

7)Tab shelcal 500 mg OD

8)Syp. Sucralfate 10 ml TID

9)Tab . Magnesium lactate 84 mg BD

he was discharged on 10/02/2015

4th time admission

DOA : 16/02/2015

pt again came with same complaints ,

vomitings , generalised weakeness , muscle cramps with vitals in normal limits

Investigations

Serum Electrolytes:

Sodium:	121mmol/l	(135-155)
Potassium :	1.5 mmol/l	(3.5-5.5)
Chloride:	82 mmol/l	(98-109)
Phosphorus:	1.2 mg/dl	(2.5-5.5)
Calcium :	7.0 mg/dl	(8.5-11.0)
Magnesium:	1.5 mg/dl	(1.8-2.9)

Treatment

1)Inj. KCl 40 meqi in 500 ml NS over 6 hours BD
2)Iv fluids - 2◎NS
1◎DNS
2◎RL
3)Inj.pan 40 mg iv BD
4)Inj. zofer 4 mg iv TID
5)Tab spironolactone 25 mg BD
6)Tab. Celecoxib 100 mg BD
7)Tab shelcal 500 mg OD
8)Syp. Sucralfate 10 ml TID
9)Tab. Magnesium lactate 84 mg BD

discharged on 27/02/2015

Patient was discharged, symptom free
and advised to take
1)Syp.potchlor 5ml in half glass of water TID
2)Plenty of coconut water ,
3)Tab. Celecoxib 100mg BD
4)Tab. Pantop 40 mg BD

Pt is still under follow up and
genetic study was adviced for this patient