Polycythaemia may be primary which is known as PV or secondary. PV results from clonal expansion of a transformed haematopoietic stem cell. This is associated with a prominent overproduction of erythrocytes and to a lesser extent, expansion of the granulocytic and megakaryocytic elements. PV is usually associated with genetic mutations such as JAK2V617F and JAK2Exon12.

There are case reports of PV associated with glomerulonephritis such as FSGS, membranous GN and IgA nephropathy [3-7]. But there are no reported cases of PV associated with MPGN to our knowledge.

Some case reports on PV and GNs show improvement of cell counts and proteinuria after repeated venesections alone. The improvement of cell counts in our patient with repeated venesections was not sustainable and there was no improvement of proteinuria. However once she was commenced on oral prednisolone, she showed a sustained improvement in cell counts with dramatic improvement in her proteinuria. She did not require any more venesections thereafter. Long-term follow-up of this patient will be required to show whether the remission of proteinuria indicates resolution of the renal changes and a good prognosis.

References

An unusual cause for shock in dengue fever

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Introduction

Dengue shock syndrome carries poor prognosis. Shock in dengue may not always be due to shock syndrome. Spontaneous splenic rupture can mimic shock syndrome, which is rare but potentially fatal. We report a case of spontaneous splenic rupture in a dengue patient treated by emergency splenectomy, which was curative.

Case report

An otherwise healthy 30-year old man was admitted with six days fever and malaise. He was haemodynamically stable on admission and capillary refilling was less than 2 seconds. His platelet count was 99 × 10⁶/ ml and packed cell volume was 43%. On the following day he experienced abdominal discomfort and distension. Few hours later patient collapsed and systolic blood pressure was 80 mmHg.

His haemoglobin dropped from 15.6 g/dl to 6 g/dl and he went into refractory shock despite resuscitation with blood and volume expanders in the intensive care setting. Further, he developed features of intra-abdominal hypertension with anuria and low cardiac output. Ultrasonography showed gross ascites and hepatomegaly. Needle paracentesis showed frank blood in the peritoneal cavity. Resuscitative laparotomy was decided upon.

There was about 3 liters of blood in the peritoneal cavity on laparotomy. Splenic capsule was found to have torn exposing the raw oozing surface. Splenectomy was performed and the patient recovered and went home after 14 days of hospital stay. Pathological examination of the

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spleen showed capsular tear with normal parenchymal architecture. Dengue viral serology (ELISA Ig G and Ig M) was positive in two samples. Epstein-Bar and Cytomegalo viral serology were negative.

Discussion

Dengue fever is currently the most serious public health issue in Sri Lanka. It has claimed 213 deaths, and more than 29,000 infected cases from January to September 2010 [1]. Approximately 50 to 100 million people are infected with the virus per annum worldwide [2].

Direct injury by dengue virus to various organs, such as skin, lung, heart muscles, bone marrow, lymph nodes and liver has been documented [3]. The spleen, which is frequently congestive, bears subcapsular haematomas in 15% of cases [4]. Splenic rupture is rare but a potentially fatal complication of dengue. It may be a spontaneous rupture or following minor trauma, which is usually unnoticed. Typical presentation is acute, but progressive forms have been described. The splenic rupture can be misdiagnosed due to misinterpretation of the shock syndrome in dengue haemorrhagic fever [5]. Failure of early intervention can be fatal. The index case had a sudden collapse followed by features of abdominal hypertension and refractory shock. The diagnosis of splenic rupture could be made by abdominal ultrasound or CT scan. The bed-side ultrasonography of the index case however failed to show evidence of splenic rupture but gross ascites. General condition of the patient hindered computerised tomography. Therefore diagnostic needle paracentesis was performed which showed frank haemoperitoneum.

Haemodynamic stability and the general condition of the patient determine the treatment option in splenic rupture. Conservative management has been used successfully for traumatic rupture of the spleen and several teams have reported good results in patients with infectious mononucleosis [6]. In cases of transfusions larger than two red cell concentrates or clinical aggravation, a splenectomy is necessary [7]. Our patient had refractory shock with developing abdominal hypertension despite transfusion of 6 units of blood, which indicated continuing exsanguination. Hence resuscitative laparotomy was obligatory.

References


Uterine rupture at 33 weeks following previous B-lynch suture

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Case report

A 31-year old woman in her third pregnancy with one previous lower segmental caesarian section (LSCS) and one first trimester miscarriage came to the antenatal ward at 33 weeks gestation with a 24 hour history of lower abdominal pain. In 2004 her first delivery required an emergency LSCS due to lack of progression. She subsequently developed severe primary post partum haemorrhage (PPH) due to uterine atony. Medical management with uterotonics failed and B-Lynch...