Unusual presentation of wheeze

Abstract

This case report is regarding 6yr old male child who presented with breathlessness ,fever and cough which was worsening on presentation.

At the time of presentation skiagram of chest showed chest infiltrations and cardiomegaly with a respi.rate of 54cycle/min was stabilised on oxygen support and with medications , after few days child had increased respiratory distress , increased bilateral wheeze and peripheral cyanosis then 2D Echo was done s/o moderate PAH. Child was treated symptomatically and discharged after relieving of symptoms.

Keywords wheeze, respiratory distress, PAH

Introduction

Recurrent wheezing is common in young infants and toddlers wit 27% of all chidlren having at least one wheezing episode by the age of 9 years [1,2]. Congenital conditions causing wheezing disorders should not be missed and--not all wheezy bronchitis is or will become asthma [3-5].

CASE REPORT

A 6 year old child was brought for admission to paediatric emergency ward of a tertiary care institute of uttarakhand, India with chief complains of fever and cough since 2 days and breathlessness since 1 day. Child developed breathlessness along with fever today , he was taken to a local hospital , where he was diagnosed as LRTi given symptomatic treatment and oxygen support and reffered to study institution. Child had h/o recurrent nebulization since last 8months for similar symptoms.

Child also has developmental delay in achieving milestones for age like started walking at age of 2 years, pincer grasp at 4 years, says bisyllables at age of 2 years. On admission, the child had H.r – 108 bpm , R.R- 54 cycle/min, saturation – 98% with 4 ltr of 02 support, RBS – 148 mg/dl , Temperature – 98.1F along with General examination findings – Almond shaped eyes , small hands and feet, obese, micropenis and on systemic examination- respiratory system findings of Air entry equal in both lungs along with inspiratory and expiratory wheeze in both lungs. Rest of the systems had no abnormal findings. CXR was suggestive of cardiomegaly and infiltrates in lower lobes of both lungs. Child weight - 38kg, height – 110cm and B.M.I – 30 (obese). Arterial blood gas findings ph- 7.4 , pCo2 – 46.94mmhg, Hco3 – 30.76 . Patients Hb- 14.3g/dl , tlc – 16.75, eosinophils - 0.3% , sgot- 444U/ltr ,sgpt- 233U/ltr, Sr. Sodium – 138mmol/ltr, Sr. Pottasium- 4.8mmol/ltr, Sr.calcium- 1.15mmol/ltr.

A Provisional diagnosis of Morbid obesity with acute LRTi ? WALRI ? BRONCHIAL ASTHMA ? BROCHOPNEUMONIAE with cryptorchidism with micropenis was made.

Patient was given Inj. Hydrocort 100mg i.v. stat. , Nebulisation with budecort and duolin respules, inj. Amikacin @15mg/kg/dose , Inj. Amoxyclav @100mg/ kg/ dose , for persistently low urine output patient was given inj. Lasix 1mg/kg.

On Day2 of admission child general condition was improved ,had u.output of 0.55ml/ltr/hr, B.P > 95th centile, chest-

bilateral wheeze present, Lasix infusion was given I/v/o raised B.P. and praderwilli MS -PCR was sent I/v/o general examination and developmental delay and morbid obesity.

On Day 5 of admission morning 1 am child had respiratory distress with peripheral cyanosis while child was asleep ? Obstrutructive sleep apnea R.R- 56cycle/ min i.v.o. respiratory distress inj. Lasix was given slow i.v. infusion @0.5mg/kg over 20minute and nebulisation was done. ECG was taken s/o Right axis deviation and rsr' pattern.2D echo was done s/o moderate PAH then child was given Inj. Sildenafil and Diuretics. Patient was stabilized and was being treated symptomatically and was discharged after 15 days of admission

DISCUSSION

Prader-willi is a genetic imprinting disorders. Imprinting disorders result from an imbalance of activecopies of a given gene. Prader-willi is caused by microdeletion of chromosome **15q11-12** , deletion is always on the paternally derived chromosome 15. [1]

Prader-willi can also occur due to paternal disomy , inheriting both chromosome 15 from mother is functionally the same as deletion of the paternal 15q12. [2]

Prader-willi presents with neonatal hypotonia , slow infant growth, small hands and feet, mental retardation, hypogonadism , hyperphagia leading to severe obesity, paradoxically elevated Ghrelin. [3]

CONCLUSION

In conclusion , in this case report is that in case of childhood obesity we should rule out both endogenous and exogenous causes. Obesity can present with cardiac asthma and hypertension.[4]

Consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient parents have given their consent on his images and other clinical information to be reported in the journal. The patients parent understand that their ot their child's name and initials will not be published and due efforts will be made to conceal their identity.

Ethical Approval:
As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

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Nil

CONFLICTS OF INTEREST

There are no conflicts of interest.

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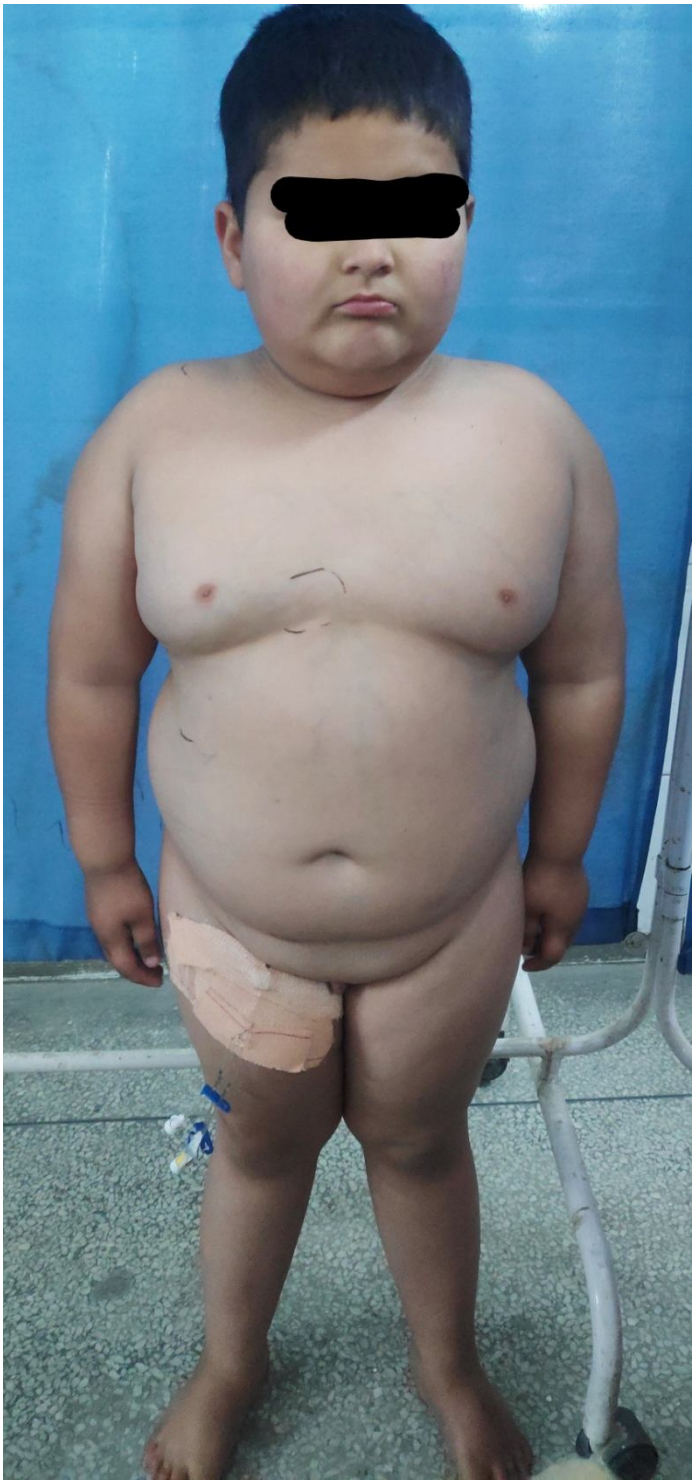

Fig. 1. Disease morphology

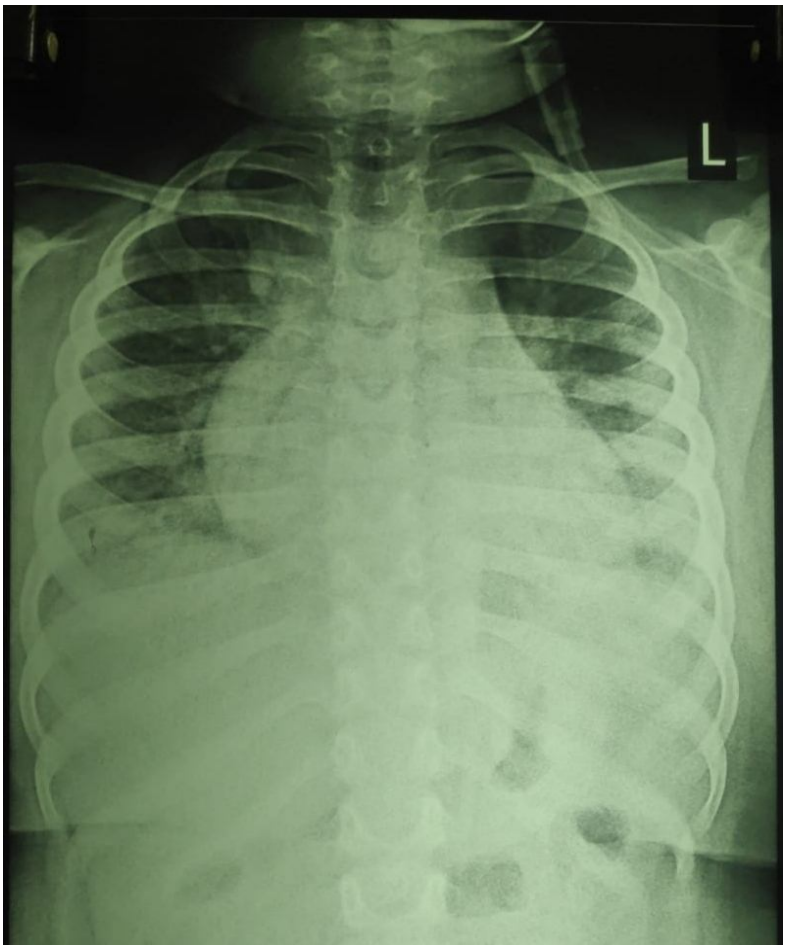

Fig. 2. Xray image

Fig. 3. ECG report