Atypical Presentations of Sheehan’s Syndrome

Sir,

Sheehan’s syndrome, first described in 1937, is an adenalin pituitary insufficiency from hypovolemia secondary to excessive blood loss during or after delivery. It may present in post-partum period or several years after delivery.1 Patients of Sheehan’s syndrome present in emergency due to situations like coma, hypothyroidism, hypoglycemia or hyponatremia following a stressful event.2 Patients also presents with anaemia, dry and light colour skin. Ozkan and Colak reviewed 20 cases of Sheehan’s Syndrome; 3(15%) presented with hypoglycemia, 3(15%) with hypothyroidism, 1(5%) with hyponatremia, 6 had empty sella and 9 had partial empty sella.1

We report two cases of Sheehan’s syndrome with uncommon presentations - paralytic ileus and acute psychosis. The first patient was a 32 years female; presented with loose motions, vomiting and giddiness. On examination, she had fever, pallor, dry coarse skin, hoarse voice and madarosis, BP of 80/60 mm Hg; peristaltic sounds were absent. Serum Na+ 127 mEq/L, K+ 3.9 mEq/L, BSL® was 61mg%. X-ray abdomen erect showed multiple air fluid levels. Provisional diagnosis of acute gastroenteritis with paralytic ileus was made and treated accordingly. Peristalsis returned and air fluid levels on X-ray disappeared after 2 days. Repeat serum Na+ and K+ were 137mEq/L and 4.5mEq/L. Serum T₄, T₃, TSH levels were done, all of which were low. Obstetric history was reviewed; she had history of post partum hemorrhage 13 years ago followed by lactation failure, amenorrhea and loss of secondary sexual characteristics. She also gave history of increased lassitude, giddiness, vague indigestion and fatigue. Serum cortisol levels were low. Due to financial constraints, other hormonal levels could not be done. A diagnosis of Sheehan’s syndrome was made and she was put on oral steroids, followed by L-thyroxine and estrogen supplements.

The second patient was a 25 years female presenting with acute psychosis. She had multiple episodes of altered sensorium with frequent loss of consciousness since past one year. There was history of postpartum hemorrhage five years ago followed by amenorrhea. Her investigations one year ago showed subnormal levels of serum FSH, LH, HPRL, cortisol, T₄, T₃ and TSH. She was receiving oral L-thyroxine for hypothyroidism since then. One week ago she had been put on 60mg of oral prednisolone daily. On examination she was intermittently rowdy; had retrograde amnesia. A diagnosis of Sheehan’s Syndrome with acute psychosis was made. She was treated with antipsychotic drugs; dose of prednisolone was tapered slowly over a week and maintained at 7.5 mg/day. Thyroxine and estrogen supplements were given. In both the patients, USG abdomen-pelvis showed small atrophic uterus with shrunken ovaries and CT scan brain showed partially empty sella. The psychosis recovered within a week and after 10 days of presentation, she was off antipsychotic medications.

In the first patient, paralytic ileus despite normal serum K+ levels was due to hypothyroidism with acute gastroenteritis. Pseudo-obstruction of the intestine can occur in conditions like scleroderma, myxedema, diabetic autonomic neuropathy and amyloidosis. However, after extensive review of literature we have not come across any report of paralytic ileus as the presenting feature in Sheehan’s syndrome. We would like to highlight how we investigated the patient with high index of suspicion and arrived at the diagnosis and also emphasize the importance of a detailed past and obstetric history which sometimes takes a back seat in acute emergencies. In the second case, while the patient was on treatment outside, low TSH and cortisol levels were overlooked. Ideally, steroid replacement should precede thyroxine replacement. Also the recommended dose of steroids in a hemodynamically stable patient is 5 mg A.M and 2.5 mg P.M. Behavioral disorders can occur with high dose of steroids which probably happened in our case.
Sabharwal reported a case of Sheehan’s syndrome that developed acute psychosis following a single tablet of 5 mg of prednisolone. Patients with adrenal insufficiency are extremely sensitive to steroids. Acute psychotic reactions are rare and occur during initial days of therapy. Reduction in the dose of steroids helps recovery which is usually rapid.

Sheehan’s syndrome is rare in developed countries, but is a significant cause of maternal morbidity and mortality in developing countries like ours. Timely and efficient management of the condition requires high index of suspicion and awareness among the general practitioners, obstetricians and physicians.

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API Expert Consensus Document on Management of Ischemic Heart Disease

Sir,

There are two issues which need additional clarification

1. Routine CAG after thrombolysis -
   Can data from CAPITAL AMI, GRACIA 1 and SIAM III be extrapolated to Indian settings? In all these trials a fibrin specific agents were used for fibrinolysis, i.e. either TNK, RPA or tPA. In India streptokinase remains the most commonly used agent, which has systemic lytic action, also no trial with SK and immediate angioplasty has shown benefit. (SWIFT and TIMI IIb trials and SIAM)

   Why should a stable patient with small infarct with stable LV function should undergo CAG (coronary angiography)? Patient can always undergo noninvasive testing prior to CAG. These patients if catheterized routinely may show borderline lesions, leading unnecessary interventions without documented objective ischemia.

   Also the apparent coronary stenosis a few days after MI is well documented to reduce in severity and stabilise at the end of 3 months. So early CAG will again lead to unnecessary intervention.

2. 80 mg dose of Atorvastatin

   Dyslipidemia in Indian patients is different from western population with low HDL, high TG with relatively normal LDL also high Lp(a). High dose of statins is not been studied in this subset, additionally worry about side effects with such a high dose always remains. Even with smaller doses many patients complain of myalgia without rise in enzymes, which subside with stoppage of drug. Lastly cost of 80mg dose will burden patient economically to already burdened patient. It is our impression that the vast majority of physicians and cardiologists use much smaller doses (even as low as 5 mg) in view of above factors. In fact, it would interesting to know how many members of this expert committee use 80 mg dose.

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REFERENCES


Reply from the Authors

Sir,

We thank Dr. Y Lokhandwala and Dr. S Deshpande for interest in “API Expert Consensus Document on Management of Ischemic Heart Disease”, published in JAPI, 54, 469–480, June 2006. Drs. Lokhandwala and Deshpande raise two issues and our answers to the same are as follows :

1) The first issue is regarding Routine Coronary Angiography (CAG) after thrombolysis.

The management of ST-elevation myocardial infarction (STEMI) after thrombolysis has undergone a major change. We have recommended routine coronary angiography after thrombolysis in every case on the basis