內科醫學會東部地區地方月會

日　　期：2018 年 06 月 02 日
時　　間：10:40-11:30
地　　點：花蓮慈濟醫院大愛樓七樓 701 教室

演講主題

中文：流感臨床案例討論

英文：**Influenza participating thyrotoxicosis**

演講摘要：

Thyroid storm is an emergency with mortality rate of up to 8%-15%. About 80% of these patients have known precipitating events. Virus infection also could be the trigger of thyrotoxicosis. Here we report 2 cases of thyroid storm who needed intensive care were proven to be having concurrent influenza.

Case-1

A 33-year-old female retailer presented to our hospital due to dyspnea for five days.

She was in good status of health until 5 months ago when she developed progressive enlarged neck mass, palpitation, heat intolerance and body weight loss of about 20 Kg. Gravie's disease with hyperthyroidism was diagnosed at a local hospital, and she did not take medication regurlarly thereafter. Five days before this admission, she started to have cough with scanty sticky sputum, orthopnea and generalized myalgia. She denied nausea and vomiting.

She came to our ER due to spiking fever up to 39 degree Celsius and progressing dyspnea. She was admitted to ICU through our ER. At arrival, her blood pressure was 175/71 mmHg, temperature was 38 Celsius degree, pulse rate was 127 bpm, respiratory rate was 26 time/minute. She was oriented. There was bilateral lungs crackle. Heart beats were regular and rapid.Chest plain film showed airspace infiltrations in bilateral lower lungs. There was no pretibial pitting edema. Anti-TPO was

202.8 IU/mL (0-60). Free T4 was 4.01 ng/dL (0.89-1.76). T3 was 634.29 ng/dL (60-181). TSH was 0.005 mcIU/mL (0.55-4.78). Modified Akamizu score was 45.

Treatment of propranolol, methimazole, Amoxicillin/Clavulanic acid, Azithromycin, Oseltamivir and Furosemide initiated. Her resting dyspnea and orthopnea improved gradually. Fever subsided. She was discharged uneventfully on Day 5 and received regular propranolol and methimazole therapy thereafter. Later the throat swab influenza PCR test reported positive influenza A.

Case-2

A 47-year-old house wife visited our gastrointestinal out-patient department 2 weeks before admission due to intemittent abdominal dull pain with nausea and vomiting, bilateral legs weakness and palpitation for one month. She had body weight loss of 16 kg within 2 months. Thyroid gland was enlarged. Anti-TG was 79 IU/mL(0-60). Anti-TPO was 1875 IU/mL (0-60). Free T4 was 7.33 ng/dL (0.89-1.76). TSH was 0.006 mcIU/mL (0.55-4.78). She was diagnosed with Graves' disease and started to receive Methimazole. Her symptoms were still progressing during the subsequent 1 week. Productive cough with white sputum than developed 1 week before admission. 3 days before admission, she had fever up to 38.8 degree Celsius, was disoriented and hallucinated. She was brought to our emergency department.

At our ER, her blood pressure was 143/88 mmHg. Pulse rate was 112 bpm. Temperature was 36.8 Celsius degree. Respiratory rate was 24 time/minute. Heart beats were regular with systolic murmur over tricuspid area. Auscultation heard right lower lung crackle. Four limbs muscle power was scored 4 in 6. There was no pretibial edema. Chest film revealed right lower lung airspace opacity. Modified Akamizu score was 65. She was diagnosed with thyroid storm and admitted to our medical intensive care unit.

At MICU, Influenza A Nucleic Acid Amplification reported positive result. We prescribed Hydrocortisone, Bisoprolol, Propylthiouracil, Moxifloxacin and Oseltamivir on

admission day1. On day 3, her fever and tachypnea subsided and was transferred to general ward. On day 4, we changed propylthiouracil to methimazole, Bisoprolol to Propranolol and intravenous Moxifloxacin to oral Amoxicillin/Clavulanic acid. On day13, She against-advice discharge.