A case of reversible heart failure and rhabdomyolysis caused by primary hypoparathyroidism during lactation

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Hypocalcemia can be rarely complicated by congestive heart failure and is associated with labor and lactation. We report a 30-year-old woman with hypocalcemia-induced heart failure secondary to primary idiopathic hypoparathyroidism precipitated by lactation. She presented with chest pain and paresthesia in both arms and legs during breast-feeding after her second delivery. She had severe hypocalcemia and low parathyroid hormone level. Rhabdomyolysis further aggravated her hypocalcemia. Echocardiogram showed global hypokinesia with ejection fraction 47%. After calcium and vitamin D replacement, her symptoms and ventricular function showed improvement. Hypocalcemia should be considered in patients with heart failure because it is readily reversible. To the best of our knowledge this is the first report of a patient with heart failure and rhabdomyolysis caused by primary hypoparathyroidism during lactation.

Tuberculous sacroiliitis in a thyroid cancer patient presenting with mimicking bone metastasis

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The diagnosis of bone and joint tuberculosis is difficult because of relative rarity of the diseases, various clinical presentation and rare diagnostic findings on radiographs. Furthermore sacroiliac joint infections are rare and diagnosis is often delayed. We report a rare case of tuberculous sacroiliitis mimicking bony metastasis in a patient with papillary thyroid carcinoma. A 29-year-old woman admitted with fever, chills which started three days ago. She complained limping gait and right hip pain. Initial vital signs were temperature, 40.3°C; blood pressure, 120/80 mmHg; pulse rate, 80 beats/minute and respiratory rate, 22 times/minute. She underwent total thyroidectomy for papillary thyroid cancer two months ago and treated with radioactive iodine therapy one month later. On examination, she had tenderness over the right hip joint on palpation. There were no reflex, sensory, or motor changes of the lower limbs. Range of motion of the hips was normal, although flexion and external rotation of elicited pain. In initial laboratory findings, ESR (56 mm/h) and hs-CRP (1.96 mg/dL) were elevated whereas the complete blood cell count was normal except mild normochromic normocytic anemia (10.8 gm/dL). Chest X-ray was normal and blurring of the right sacroiliac joint space was visible on a plain radiograph of pelvis. Pelvic CT showed multiple osteolytic lesions on right iliac bone, sclerotic changes of the joint margin, sequestrum within osteolytic lesion and the swelling on right iliacus muscle. Lymphadenopathy with central necrosis in the porta, portacaval, pericaval, paraaortic and iliac regions was showed. We tried to open biopsy of the bone in order to rule out the metastasis of thyroid cancer. Histology showed chronic granulomatous inflammations with necrosis which were compatible with tuberculosis, though AFB staining was negative. She was treated with anti-tuberculosis medication which included isoniazid, rifampin, pyrazinamide and ethambutol. Two month later, her bony culture revealed Mycobacterium tuberculosis and all of symptoms were resolved. She was treated with anti-tuberculosis agents during 12 months successfully.