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A CASE REPORT ON PATENT DUCTUS ARTERIOSUS WITH EISENMENGER SYNDROME

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Abstract
Patent Ductus Arteriosus is a persistent opening where the ductus arteriosus fails to close after the birth and this condition leads to Eisenmenger's syndrome. This syndrome is evident with ventricular septal defects and other congenital heart defects which is left untreated that leads to pulmonary hypertension, reversal of flow and cyanosis. A 40 year old female patient admitted with the complaints of shortness of breath and chest pain she is a known case of Eisenmenger syndrome, severe suprasystemic PAH and biventricular failure. She was on Tab.sildenafil 50 mg,Tab.ambrisentan 5 mg .On lab investigations ,Hb (17 gm%) and creatinine (1.3 mg/dl) found to be elevated. ECG report - right and left atrial enlargement, incomplete right bundle branch block, possible right and left ventricular hypertrophy, ST deviation and moderate T wave abnormality. Based on the objective data patient was diagnosed with Right and Left heart failure along with Eisenmenger's syndrome. The condition was managed with the help of inj furosemide 20 mg TID, T.spironolactone 25 mg BD, Inj.Ceftriaxone 1 gm BD along with past medications and condition were symptomatically managed. The prevalence of ES is 1-9 cases out of 10 lakh. ES requires regular cardiac monitoring as it can affect multiple organ system.

Keywords: Patent ductus arteriosus, Eisenmenger's syndrome, Pulmonary artery hypertension.

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A CASE REPORT ON EVANS SYNDROME

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Abstract
Evans syndrome is a very rare autoimmune disorder characterized by either simultaneous or sequential development of Autoimmune Haemolytic Anaemia (AIHA) and Idiopathic Thrombocytopenic Purpura (ITP) in absence of known underlying aetiology. A 60 year old male patient presented with the complaints of low grade fever since 3-4 days, loss of appetite, constipation, yellow coloured urine. On lab Investigation Hb, Platelet, PCV were found to be very low and serum bilirubin (indirect) was elevated. On further evaluation Direct Coomb's test was positive, increased serum iron and reticulocyte count. The peripheral smear report showed Haemolytic anaemia possibly of autoimmune aetiology. Based on the objective data the patient was diagnosed with Evans syndrome. The condition was initially treated with corticosteroid - prednisolone 60 mg OD, platelet transfusion. Later on azathioprine 50 mg was added, but the patient developed leucopoenia and the drug was switched over to monoclonal antibody rituximab. The patient was clinically better. The patient was maintained on prednisolone 2.5 mg OD. Evans syndrome is a rare chronic, relapsing and refractory disease sometimes may present acutely. It is diagnosed in less than 5 % of all patients with either ITP or AIHA at onset. Mean age at the time of diagnosis is 52 and is more prevalent in females.

Keywords: Evans syndrome, Autoimmune Haemolytic Anaemia

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A CASE REPORT ON OXALIPLATIN INDUCED ANAPHYLACTIC SHOCK

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Abstract
Oxaliplatin is a third generation platinum compound which is used as an antineoplastic agent. It interacts with DNA to form intra-strand/inter-strand cross linking and thereby affect DNA base pairing, replication, gene transcription and finally leads to cell death. Anaphylactic reactions related to platinum compounds are potentially life threatening. Comparing with other platinum compounds, oxaliplatin is less frequently associated with these reactions. A 67 year old female patient, a known case of Carcinoma Ovary ,previously underwent surgery and multiple lines of chemotherapy is now presented with progressive disease.Patient had history of allergy to carboplatin. After pre chemo evaluation, 1st cycle of chemotherapy with cyclophosphamide + oxaliplatin + bevacizumab was administered. Sudden after the administration of oxaliplatin patient had developed fatigue, weakness along with breathing difficulty, change of sound and cyanosis. Patient was diagnosed with anaphylactic shock induced by oxaliplatin. Patient was shifted to MICU and managed with Inj. Adrenaline (1/1000),salbutamol nebulizer, Inj. Magnesium Sulphate 1 amp in 100 ml NS, Inj. Calcium Gluconate 1 amp in 100 ml NS. Patient was improved and shifted to ward. At the time of discharge patient was better and hemodynamically stable. According to previous studies, the estimated incidence of oxaliplatin induced serious anaphylactic reactions was less than 2%.

Key words: Oxaliplatin, Anaphylactic shock, Antineoplastic agent

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