A Diagnostic Puzzle: Occult Thoracic Dermatomal Pain in a High-risk Pregnancy

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CLINICAL BACKGROUND

25-year-old G1P0 at 30w6d

Past medical history: postural orthostatic hypotension, idiopathic intracranial hypertension; anxiety/depression; right lower-extremity CRPS with T10 spinal cord stimulator deactivated at conception.

Presented with severe right flank/RUQ pain and was diagnosed with adrenal infarct and intrahepatic cholestasis of pregnancy then re-presented with a clear right sided dermatomal neuropathic pain as well as acute pancreatitis.

WHY THIS CASE WAS CHALLENGING

Pregnancy
Limited medication options and fetal considerations.

Therapeutic enoxaparin
Initially constrained interventional neuraxial procedures.

Multiple possible pain generators
Adrenal infarct, cholestasis, elevated transaminases, pancreatitis, elevated lipase

KEY EXAM FINDING

T5–6 dermatomal allodynia

The pain distribution was inconsistent with pancreatitis or hepatobiliary disease and redirected management toward a neuropathic pain generator.

MULTIDISCIPLINARY CARE

Acute Pain Medicine • Obstetrics • Endocrinology • Ethics • Gastroenterology • Chronic Pain

Treatment decisions evolved as the diagnostic picture changed and pregnancy/anticoagulation constraints shifted.

CLINICAL COURSE

30w6d — Initial admission

Severe right flank/RUQ pain → adrenal infarct + cholestasis diagnosed. Therapeutic enoxaparin initiated given concern for contralateral infarct. Pain treated as visceral/nociceptive; with high dose opioids and was never well-controlled

Discharge — Persistent pain

Patient declined ketamine (fetal concerns), lidocaine and nerve block (bleeding risk); continued scheduled hydromorphone. Clinically improved but pain persisted.

+2 weeks — Readmission

Worsening pain now migrated to RUQ at the T5-6 dermatomes and burning/elective/unremitting in nature with concomitant elevated transaminases, lipase 617 and elevated bile acids.

Diagnostic pivot

Focused examination demonstrated T5–6 dermatomal allodynia inconsistent with presumed pancreatitis.

Treatment — Neuropathic-directed therapy

Empiric treatment for zoster sine herpete; gabapentin, nortriptyline and lidocaine patches. A few days without significant improvement. Prednisone added; low-dose ketamine trial accepted after extensive multidisciplinary discussion.

34w3d — Preterm labor → cesarean delivery

General anesthesia was requested by patient. Transervus abdominus plane nerve block was provided. Incisional pain improved; dermatomal pain persisted.

POD 2 — T6 paravertebral block

Diagnostic block with bupivacaine produced significant, sustained relief.

DIAGNOSTIC PUZZLE

Visceral clues	Neuropathic clues
Adrenal infarct	T5–6 distribution
Cholestasis	Allodynia
Lipase 617	Persistent despite standard treatment for pancreatitis
↑ transaminases	Response to T6 block

PERIPARTUM ANALGESIA

Before delivery
Gabapentin • nortriptyline • lidocaine patches • prednisone • low-dose ketamine

Cesarean delivery
GA • TAP block • methadone • hydromorphone PCA • ketamine infusion

Postoperative diagnostic intervention
T6 paravertebral block with sustained relief

TAKE-HOME MESSAGE

When laboratory and imaging abnormalities do not explain the character or distribution of pain, return to the physical examination.

Recognition of dermatomal allodynia redirected management toward a distinct neuropathic pain generator and enabled targeted therapy.

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