

PROVIDING CARE FOR THE PATIENT WITH UNCLEAR DIAGNOSIS

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OBJECTIVE: this case study explores the management of the pregnant patient for whom presenting symptoms do not correspond with final diagnosis and for whom no causative pathogen is found.

CASE: In 2020, a 26-year-old primigravida presented at 29+0 weeks gestation with a history of worsening back and lower abdominal pain, pelvic pressure, diarrhea, mild photophobia, tachycardia, tachypnea, and fever of 38.6C. She reported clear per vaginal loss 2 days prior and no uterine activity. Relevant medical history included untreated obstructive sleep apnea, asthma, recurrent urinary tract infections and a body mass index of 43.

Examination revealed no focal infective signs and a long and closed cervix. Fetal fibronectin, actimPROM, genital swabs, urinalysis and blood cultures were negative. Inflammatory markers were elevated. Differential diagnoses included sepsis, gastroenteritis, pyelonephritis, possible chorioamnionitis and unlikely preterm labour. Treatment included analgesia, intravenous fluids and empirical antibiotics. Fetal tachycardia noted on cardiotocography responded to this management.

Hours later, she developed right iliac fossa and flank pain with positive Rovsing sign. Imaging showed increased pancreatic echogenicity, mild bilateral hydronephrosis, a normal appendix, and fetal wellbeing. Collaborative review by the general medical and surgical teams. The following day, the patient developed a cough, chest pain, tachypnea, and oxygen saturations of 88% on room air. Resuscitative measures including oxygen therapy were commenced. Covid PCR was negative. Chest Xray prior to acute deterioration was negative. To exclude pulmonary embolism (PE) and pneumonia, a prompt CTPA was done. CTPA showed multilobar pneumonia, and no PE.

On transfer to a tertiary hospital, she was admitted to the intensive care unit where she was intubated and ventilated. Bronchial washings from bronchoscopy did not identify a true causative organism. Successful extubation occurred after 4 days. She was discharged and returned at term for her delivery.

DISCUSSION: This case highlights recognition and timely escalation of a deteriorating patient with a focus on multidisciplinary team collaboration. The final diagnosis was hypoxic respiratory failure secondary to community acquired pneumonia with acute respiratory distress. Admission of the patient for observation while monitoring/managing symptom progression, and providing resuscitative care ameliorated the underlying condition even though the diagnosis was unknown.

CONCLUSION: Management of multisystem symptomatology is guided by returning to basic principles, applying a wide range of differential diagnoses, observing and managing presenting/localizing symptoms, and collaboration of multiple teams. Also consider hospital setting, and available resources.