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Severe Hyponatremia from Undiagnosed Sheehan's

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Case Report

A 53-year-old woman was admitted via Emergency Room on 04/10/2018 with confusion and general malaise. Had been admitted to another hospital on the 29/09/2018 for treatment of chest infection and was found to have a serum sodium of 103 mEq/L and discharged 3 days after with a serum sodium of 132 mEq/L but without improvement in her symptoms. As the correction of the hyponatremia had been too rapid the initial concern was to exclude central pontine demyelination and she had an urgent brain MRI that was normal. Her serum sodium had spontaneously decreased to 120 mEq/L. She was managed with water restriction and given sodium chloride via nasogastric tube initially.

On the 5th October a more detailed history established that she had been feeling unwell for some time and had only one day of vomiting before her admissions. Had received antibiotics for 2 weeks for suspected chest infection. On questioning she had history of 6 successful pregnancies, but the last delivery had been complicated by severe bleeding with admission to the intensive care unit at another institution 14 years before. This history was corroborated by her relatives. She had no further menstrual periods since then. On examination she weighed 40 Kg blood pressure 90/50 mmHg, had slow speech and movements and looked hypothyroid.
Investigations showed normal serum creatinine 0.75 mg/dL low serum osmolality at 245 mOsm/Kg (normal range 275-295) and urine osmolality also low at 280 mOsm/Kg (normal range 300-1300). Inappropriate urine sodium 149 mmol/L (normal range 40-220). Thyroid function showed low Free T3 at 1.50 pg/mL (normal range 1.88-3.18), low Free T4 at 0.42 ng/dL (normal range 0.7-1.48) and TSH normal at 2.96 mIU/mL (normal range 0.35-4.94). Cortisol level of 4 ug/dL (normal morning range 3.7-19.4) which was interpreted as inappropriately low. Gonadotrophins LH 4.34 IU/L (postmenopausal range 15.9-54) and FSH 10.50 mIU/mL (postmenopausal range 26.72-133.41) were low and all consistent with panhypopituitarism. Also had urinary tract infection due to Klebsiella pneumoniae sensitive to Amikicin that responded well to this treatment.

She was treated with corticosteroids and thyroxin replacements. Soon after her confusion resolved, and her sodium levels gradually improved to 134 mEq/L and remained normal after discharge home. Blood pressure 121/61 mmHg and weight up to 46 Kg when last seen in

January 2019 when she appeared very well and mentioned to be more active than had been for years.

Discussion

Years of delay in diagnosing Sheehan's does produce significant morbidity with hypoglycemia and hyponatremia [1] that can also produce cardiac arrest [2] and mortality. In a recent review of 10 years of 260 cases of panhypopituitarism from an Endocrine Unit, 25 patients (9.6%) had hyponatremia that in 80.7% was the key to diagnose the panhypopituitarism, although only 2 cases were due to Sheehan's [3].

This case shows that correction of hyponatremia is achieved by steroid replacement that along with thyroid replacement was associated with rapid improvement of hypotension, complete resolution of confusion, improvement of generalized weakness and weight gain in a malnourished woman. This brings to attention the need of taking a good clinical history especially in female patients presenting with hyponatremia bearing in mind that even elderly patients [4,5] can suffer from this also more likely when obstetric care was less advanced that todays.

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