

Case History

A 45 year old female with Type 1 diabetes mellitus presented to the Emergency Department with complaints of abdominal pain, nausea and vomiting for 3 days. She had a history of chronic abdominal pain for 2 years. She described her current symptoms as a worsening of her chronic conditions. Three months previously, she was admitted for hypoglycemia which resolved without treatment. She reports that she has had increasing episodes of hypoglycemia over the past 6 months despite decreasing doses of insulin. She denied any recent medication changes, herbal medication use, changes in her diet, exercise pattern, or weight change.

Past Medical History:

- ❖ Type I diabetes mellitus diagnosed in 2005
- ❖ Chronic abdominal pain and diarrhea: EGD in 2005 revealed atrophic gastritis
- ❖ Hypothyroidism
- ❖ Hypertension
- ❖ Depression
- ❖ Iron-deficiency anemia
- ❖ B-12 deficiency
- ❖ Traumatic brain injury with resultant short-term memory loss and seizure disorder
- ❖ Oligomenorrhea
- ❖ Chronic low back pain
- ❖ h/o Ovarian cyst rupture

Past Surgical History:

- ❖ Carpal tunnel surgery
- ❖ Appendectomy
- ❖ Cholecystectomy
- ❖ Cesarean section
- ❖ Eye surgery as a child

Social History:

- ❖ Married, lives with her husband in Richmond, VA. Has three teenage children. Previously worked as a nurse in the Orthopedic Surgery department.
- ❖ Tobacco use, approximately 1 pack per day for 25 years.
- ❖ No alcohol or illicit drug abuse.
- ❖ No recent travel.
- ❖ No tattoos

Family History:

- ❖ Mother with hyperthyroidism and hypertension
- ❖ Brother with diabetes
- ❖ Sister with hypothyroidism.

Medications:

- ❖ Glargine insulin once daily
- ❖ Aspart insulin with meals
- ❖ Venlafaxine SA 75 mg daily
- ❖ Carbamazepine SA 500 mg BID
- ❖ Hydrochlorothiazide 25 mg daily
- ❖ Lisinopril 20 mg daily
- ❖ Metoclopramide 10mg ac TID
- ❖ Levothyroxine 150 mcg daily
- ❖ Levorphanol 16mg TID
- ❖ Aspirin 81mg daily
- ❖ Docusate 100mg daily

Allergies:

- ❖ Sulfa, Codeine, Trazodone

Physical Exam

Vital signs:	BP: 112/42 mm Hg, Pulse: 92/minute, RR: 16/minute, T: 98.5°F, O2: 98% on room air Wt: 165 lb. Ht 68 in.
General:	Overweight female in no distress.
HEENT:	Pupils equal, round and reactive to light; sclera non-icteric, normal conjunctiva; no oral thrush, lesions or petechiae, normal posterior oropharynx
Neck:	No thyromegaly or masses
CV:	Regular rhythm, normal S1/S2, no murmur, rub or gallop
Lungs:	Clear to auscultation bilaterally.
Abdomen:	Normal bowel sounds, non-tender, non-distended, soft, no organomegaly or masses. Navel ring present.
Extremities:	2+ peripheral pulses; no edema; no synovial thickening
Neurologic:	No focal deficits.
Lymph:	No cervical, axillary or inguinal lymphadenopathy
Derm:	No rashes or other skin lesions

Laboratory Studies

Sodium 131 mmol/L, Potassium 3.7 mmol/L, Chloride 89 mmol/L, Bicarbonate 30 mmol/L, BUN 11 mg/dL, Creatinine 1.0 mg/dL, Glucose 42 mg/dL, Ca 10.1mg/dL

WBC $12.1 \times 10^9/L$ with 56% neutrophils, 37% lymphocytes, 9% monocytes, 0% eosinophils
Hemoglobin 14.1 g/dL, Platelets $271 \times 10^9/L$

Hemoglobin A1c 7.2%

Total cholesterol 176 mg/dL, LDL 99mg/dL, HDL 60 mg/dL, Triglycerides 77 mg/dL

GAD-65 autoantibody positive (January 2007)

Urinalysis unremarkable

Hospital Course

The patient was admitted to the internal medicine service for further evaluation. She continued to have multiple low blood glucose levels during her admission, despite withholding her insulin medications.

A diagnosis was made.

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**A 45 year old woman with
hypoglycemia**
