

# THERE IS STILL TIME TO TREAT?

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## INTRODUCTION

The hypovolemic shock is a clinical emergency condition in which rapid fluid loss results in multiple organ failure due to inadequate circulating volume and subsequent inadequate perfusion. It leads to progressive hemodynamic instability and has a high mortality. Given the multiplicity of causes that are associated, it is crucial to quickly diagnose the trigger factor, in order to try solving the problem. Each minute counts in this race against time.

## CASE DESCRIPTION

We describe a case of an eighty-five-year old woman, who appealed to the Emergency Department of our hospital.

### SYMPTOMS:

↻ **Low back pain** beginning **three days ago**, which was progressively worsening, associated with **nonspecific malaise** and **vomiting**.

### PREVIOUS HISTORY

- **Coronary bypass surgery (CABG)** in **2004** for ischemic heart disease;
- Heart failure class II/III NYHA;
- **Hypertension; dyslipidemia; obesity;**
- Chronic renal failure.

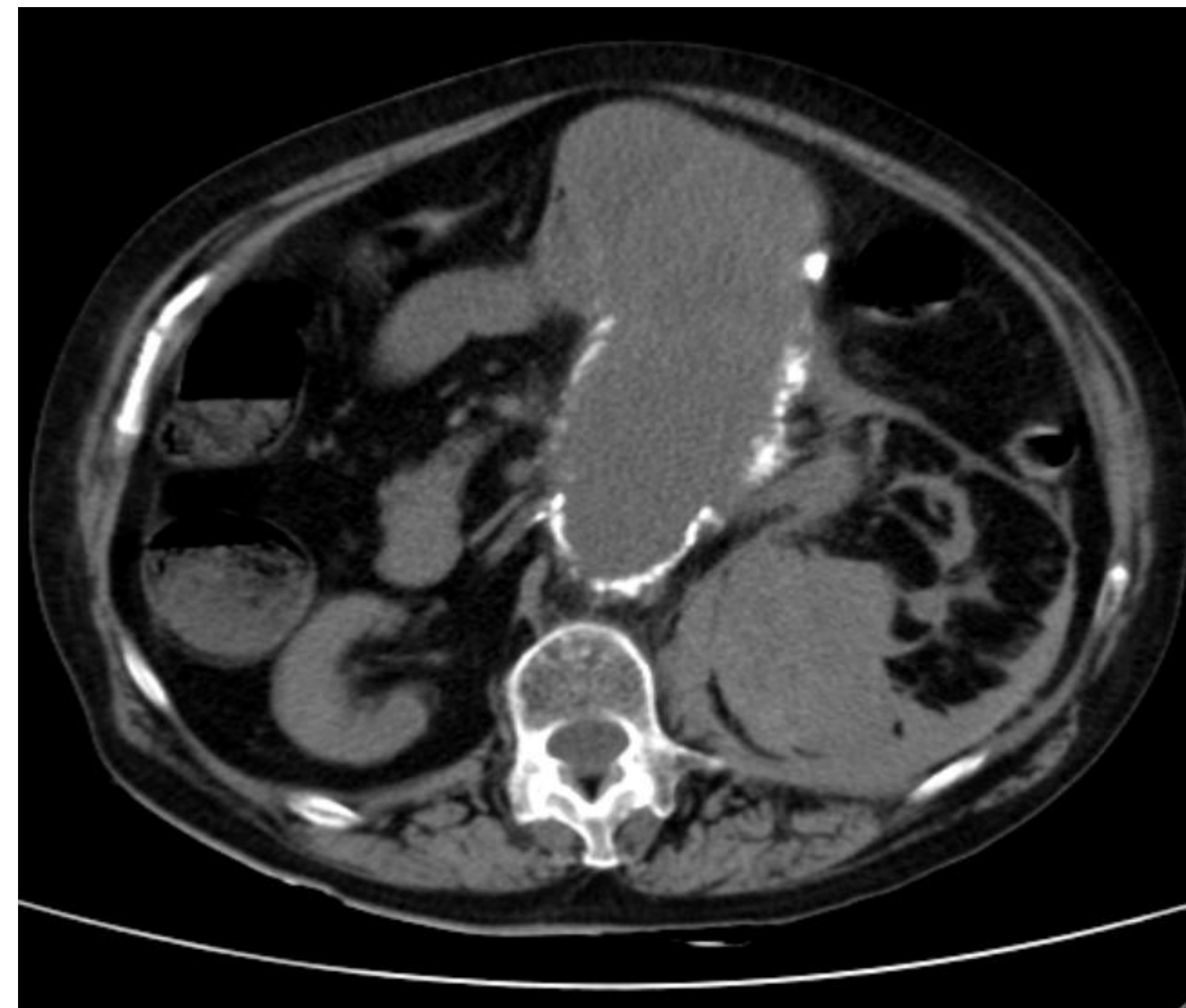


The patient was agitated, pale, sweaty and had a high respiratory frequency. The blood pressure was not measurable. There were no heart murmurs, the lungs were clear. The *abdomen* revealed ***a large, non-painful, pulsatile, palpable mass at the level of epigastrium/periumbilical region***. The *Murphy's sign* was positive on the left. The extremities were cold and the foot pulses were diminished.

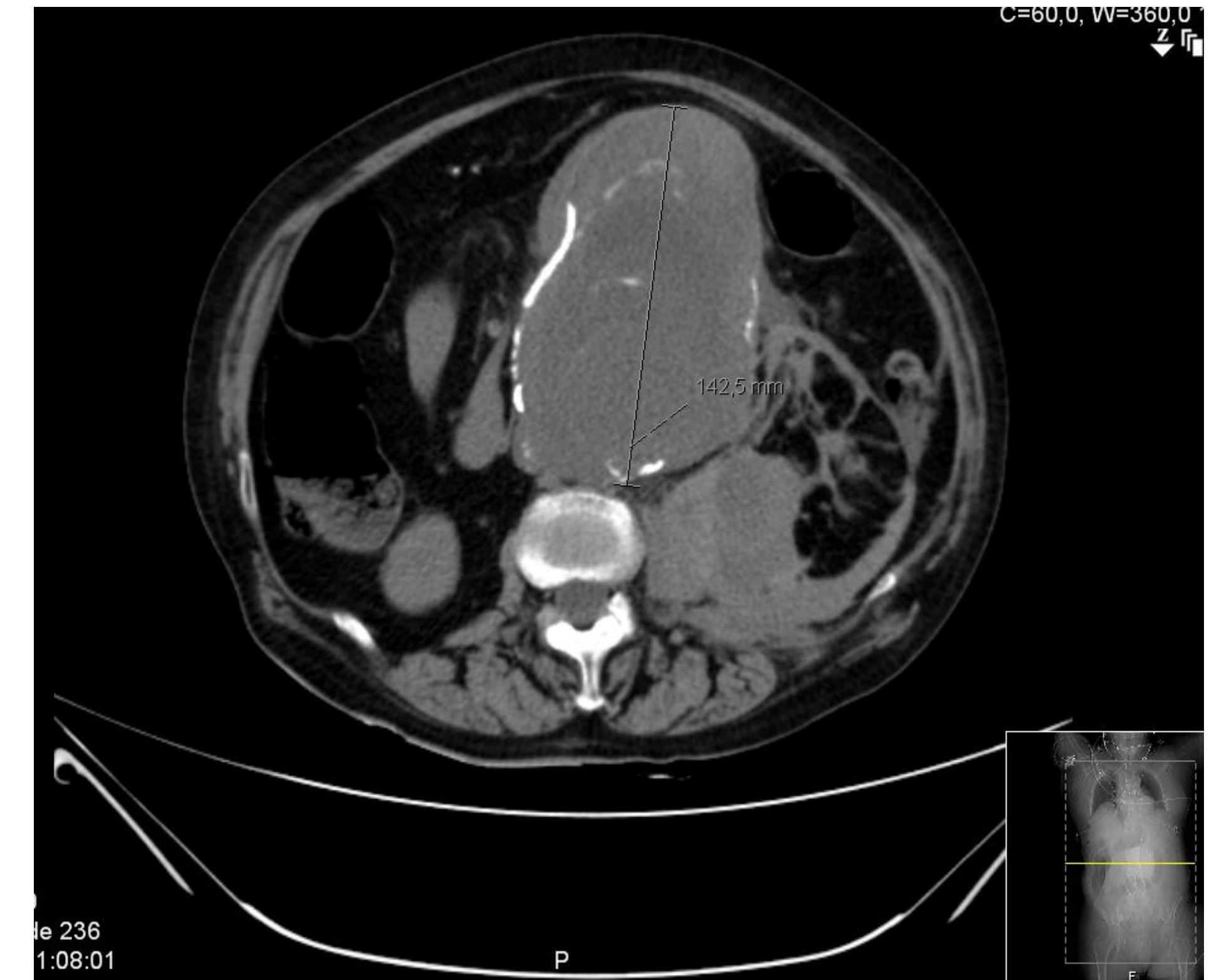
### EXAMS PERFORMED

Variable	Reference value	Value determined	Evolution in few hours
Hemoglobin	11.9-15.6 g/dl	<b>8.5 g/dl</b>	<b>5,7 g/dl</b>
Leukocytes	4.0-11.0 10 <sup>3</sup> /ul	9.9 10 <sup>3</sup> /ul	9.0 10 <sup>3</sup> /ul
Platelets	150-400 10 <sup>3</sup> /ul	257 10 <sup>3</sup> /ul	<b>133 10<sup>3</sup>/ul</b>
Urea	15-39 mg/dl	<b>85 mg/dl</b>	100 mg/dl
Creatinine	0.6-1.2 mg/dl	<b>1.9 mg/dl</b>	<b>1.9 mg/dl</b>
Troponine I	< 0,1 ng/mL	0.03 ng/mL	
Mioglobin	13-71 ng/mL	232 ng/mL	
C-Reactive Protein	< 3mg/L	20,60 mg/L	21,50 mg/L
Pro-BNP	< 450 pg/mL	1437 pg/mL	

Variable	Reference value	Value determined	Evolution in few hours
pH	7.35 -7.45	<b>7.242</b>	<b>7.241</b>
PCO2	35-45 mmHg	<b>28.4 mmHg</b>	36.9 mmHg
PO2	70-100 mmHg	124 mmHg	108.9 mmHg
HCO <sup>3-</sup>	21-26 mmol/L	<b>12 mmol/L</b>	<b>15,5 mmol/L</b>
SATO2	>96 %	98 %	97 %
Lactates	0.5-2.0 mmol/L	<b>8.32 mmol/L</b>	<b>5.01 mmol/L</b>



**Figure 1:** Thoracic-abdominal-pelvic computed tomography showing a large abdominal aortic aneurysm, reaching 14.24 cm in anteroposterior diameter. The left renal artery was leaving the aneurysm, which was in rupture and there was a massive retroperitoneal hematoma on the left.



**Figure 2:** Thoracic-abdominal-pelvic computed tomography showing a large abdominal aortic aneurysm, reaching 14.24 cm in anteroposterior diameter.

PROGRESSIVE HEMODYNAMIC INSTABILITY

VASCULAR SURGEON CONSIDERED A IRREVERSIBLE SITUATION

THE PATIENT DIED DAYS LATER

## DISCUSSION

The aortic aneurysm rupture is a rare cause of hemorrhagic shock, which is highly catastrophic. Mortality increases by 1% to 2% each hour after the onset of symptoms. Because every minute counts, early diagnosis is crucial for urgent surgical intervention. Once the prognosis is closely related to the size of the aneurysm and patient comorbidities, there are situations where even diagnosed in a short time, the outcome is fatal.