www.jmscr.igmpublication.org
Impact Factor 5.84
Index Copernicus Value: 83.27
ISSN (e)-2347-176x ISSN (p) 2455-0450
crossref DOI: https://dx.doi.org/10.18535/jmscr/v5i2.162

IGM Publication
Journal Of Medical Science And Clinical Research
An Official Publication Of IGM Publication

Pheochromocytoma: Presenting As Urinary Tract Infections

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ABSTRACT
Pheochromocytoma are rare, catecholamine secreting neuroendocrine tumour of adrenal medulla [1]. We present a case of an 80 year old male complaining of recurrent urinary tract infection diagnosed as pheochromocytoma on further investigation.

Case Presentation

A 80 year old man came with complains of recurrent urinary tract infections since 6 months with on off urinary incontinence and left lumbar pain since 7 months. Patient was a known case of HTN and DM was newly diagnosed with concomitant urinary tract infection was present. PET scan showed low grade FDG uptake noted in solid cystic left adrenal mass measuring 9 x 8 x 8 cms. No other significant findings. On physical examination his vitals were normal, 24 hour urinary metanepherine levels was grossly elevated along with a high serum metanephrine to creatinine ratio with high VMA levels. Urine cytology suggestive of no malignanat cells and pus culture showed no growth. On histopatholgy an encapsulated cystic tumour with residual compressed tumour in the wall was present. Cells were arranged in nests, containing an amphophilic cytoplasm and malignant changes. After preparing with prazosin and metoprolol pre operatively and phentolamine drip during surgery, a left sided adrenelectomy was performed. The post op period was identified in marked reduction of symptoms of DM and HTN.

Discussion

Pheochromocytoma presents with a triad of diaphoresis, paraxosymal headache and tachycardia [2] and few may develop hypertensive crisis. Hence, a multidisciplinary approach is necessary to improve patient outcome[3]. as the tumour could be life threatening due to the catecholamine storm after the resection. The mainstay of treatment is surgical removal of the tumour. [4,5] In our case we began with a laproscopic approach but due to large tumour size, we had to do an open left sided adrenelectomy. Preop preparation with alpha blockers helped in minimizing the hypertension complications. Our patient came with urinary incontinenece and UTI and a series of investigation and prompt history led to our diagnosis. Excessive adrenergic stimulation due to release of catecholamines resulted in elevated blood pressure and hyperglycemia which normalized after tumour resection. Therefore, the key to best patient outcome is early

diagnosis and prompt screening of various genetic mutations in patients.

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