Complications of myxedema coma

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What is myxedema coma. What are the symptoms of myxedema coma. What happens in myxedema coma.

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However, this capacity of the body to compensate for the deficiency of T4 and T3 can however be overwhelmed â € "for example by infections, drugs, other diseases or hypothermia. The coma can be considered as a form of disappeared hypothyroidism in which the body adaptation at untreated hypothyroidism fails the body's adaptation at untreated hypothyroidism. Keep homeostasis and become overwhelmed from hypothermia, infection or other precipitable factors. These adaptations include peripheral vasoconstriction to maintain internal body temperature.This adaptation process and, possibly, failure of function, affects all organs, including brain, heart, lungs, kidneys and gastrointestinal tract (see Â Â «Clinical features found in mixedemaÃ coma », hereinafter) .Ipotermia (common precipitant) .Infezioni: InfluenzaPneumoniaInfezioni of routes urinarieFarmaci: AmiodaroneAnestesiaBeta-bloccantiDiureticiFarmaci that act on the nervous system centraleLitioFenitoinaRifampicinaAltre significant physiological challenges: IpoglicemiaEmorragia gastrointestinaleMalattia cerebrovascolareChirurgia, traumaAcci anesthesia or respiratory depression and coma carbonicaIl dioxide retention of Mixedema is about four times more common in women than in men (reflecting the greatest incidence of hypothyroidism in women, who has a prevalence of 8% in ages than 50 years old). The coma of Mixedema occurs almost exclusively in patients aged over 60 years old. Regions of Asia, of Africa and South America) The prevalence of hypothyroidism is higher. The pathology is more often in the winter months (90% of the cases occurs during the winter). [3, 4] This seasonal variation is probably related to the loss of the temperature direction linked to the age, combined with a minor Heat production due to hypothyroidism. Patients with long-lasting hypothyroidism, which can not be diagnosed or treated inappropriately due to lack of monitoring or poor adherence. Other known factors to precipitate the coma from mixedema include hypoglycemia, infection, trauma, hemorrhage and change of treatment. Most Patients does not present NÃ © coma nÃ © edema not acute and the term â € ™ coma from mixedema 'is therefore a sort of improper name. Patients who develop the Coma from Mixedema are usually suffering from long-standing hypothyroidism. Patients have the classic characteristics of weight gain, fatigue, constipation and cold intolerance. They can also show coarse hair, deep voice and dry, pale and cold skin. However, elderly patients with hypothyroidism can have atypical symptoms. They can simply present themselves with a small mobility, and some patients with plywood hypothyroidism are asymptomatic. The long-standing hypothyroidism can therefore be easily missed. The coma from Mixedema usually affects the mental state: patients can show up with apathy, low mood, cognitive decline, confusion and even coma. THE CHANGES CAN BE SUBTLE AND MAY BE MISDIAGNOSED AS DEMENTIA OR DEPRESSION.PATIENTS WITH MYXOEDEMA COMA ARE COMMONLY HYPOTHERMIC WITH CORE TEMPERATURES LESS THAN 35.5Ã‚Â ° CPATIENTS WITH MYXOEDEMA COMA ARE COMMONLY HYPOTENSIVE AND BRADYCARDIC.HYPOVENTILATION Two to Diaphragmatic Weakness and Altered Ventilatory Response CAN LEAD TO SLEEP APNOEA.The Effects Are Widespread: Central Nervous SystemDeteriation in Mental State Is the Cardinal Symptom.A Largely Unknown Mechanism Disrupts Brain Function.Reduced Cerebral Blood Flow, Reduced Oxygen and Glucose Consumption Are All Involved.confusion.apathy.psychosis - All Patients Will Display This to Some Degree.it May Also Produces Lethargy, Stoupor OR (Very Rarely) Coma.Reflexes Will Show A Slow Relaxation Phase.other Metabolic Effects May Compound These Effects (for example, hyponatraemia) .metabolicreduced metabolic rate causes weight Gain, Growth Reduction, Lower Energy Production and Many Other Effects.significantly, The Metabolic Effects Imp Air Drug Metabolism (EEA increased diastolic pressure and normal systolic pressure. The hypotension can occur later Counts can show nomocytic or macrocytic anemia. They can coexist pernicious anemia. Gastrointestinal Constipation (can be presented with fecal impact). The most dramatic manifestations of reduced motility are the megacolon mixedema and the paralytical ileo. Gastric atonia may occur. The ascite can occur with different mechanisms. Renal and bladder Low cardiac output and other metabolic changes help reduce the rate of glomerular filtration. There may be bladder distension. Respiratory The depression of the function of the respiratory muscles, reduced ventilation capacity and reduced oxygen consumption contribute to hypoventilation. Hypoventilation, hypoxia and hypercarbia are further complicated by weight gain and obesity. The differential diagnosis of coma mixedema includes other causes of deterioration of the mental state: A patient in which a diagnosis of coma mixedema is suspected should undergo the following investigations:[4]TFTs:TSH Level: almost always high, but it can be normal if hypothyroidism is due to hypophysical pathologies. Biochemistry routine: U&E shows reduced sodium levels (iponatriemia): sodium reabsorption is reduced by enzymatic deficiencies. Osmolality is reduced, creatinine is generally increased, and hypoglycemia may result from reduced metabolic activity. However, coexisting diabetes or adrenal failure can contribute to this. FBC often reveals nomocytic anemia and mild leukopenia. Blood gases reveal hypoxia, hypercapnia and respiratory acidosis. Serum enzymes: Increase in creatinchinasis (generally of musculoskeletal origin, except in myocardial infarction) There are often increases in transaminers. Lipid profile reveals hyperlipidemia. ECG. Possible changes include:Bradicardia. Other specific changes in ST and T.Tensioni waves. Variation of the heart block and extension of the QT range. Myocardial infarction – attention to possibility. The CXR can reveal: Pleural effusions with or without cardiomegaly. Pericardial effusion. Sierial cortisol levels: This is done to exclude the possibility of adrenal failure as a consequence of hypopolytarianism. Screening of infection: This can identify the trigger to the coma mixedema. Patients with coma mixedema should be admitted into an intensive or high-dependence therapy department for careful monitoring and treatment. In case of hypercapnia or significant hypoxia, mechanical ventilation is required. It is possible to use non-invasive ventilation as the continuous positive pressure of airways (CPAP). Hypovolemia, hypoglycemia and electrolytic alterations must be correct. The cardiovascular state must be carefully monitored: ECG monitoringAvoid myocardial infarction. Hypothermal patients must be heated slowly without the use of heating blankets, as peripheral vasodilation can aggravate or induce hypotheside. Considered the number of hypothermia patients, it is advisable to slowly heat i Hypothermal patients without the use of heating blankets, as peripheral vasodilation can aggravate or induce hypotension. The EDEME coma is relatively small, there are few clinical studies on the treatment of these patients. It is mandatory an immediate intravenous thyroid replacement intervention. The gastrointestinal absorption is compromised. You discuss if it should be T4 alone, in combination with T3 or T3 alone. More common in adults Use T4 alone, with an initial T4 load dose intravenous by 100-500 micrograms. To this follows a dose of 75-100 micrograms a day until the patient is able to take an oral substitute. It can be associated with T3 in younger patients with a minor cardiovascular risk. That many patients have had the Their disease precipitated by the infection, many claim the addition of a broad-spectrum antibiotic to the therapeutic regime. All patients must receive hydrocortisone intravenously at the dose of 100 mg every 8 hours until the results of the random level of cortisol will be available before treatment.Crisi SurenhalicaInfarto myocardicarthythemias cardiac prognosis for each patient will depend on his general conditions at the time of Presentation, and other comorabilities. The mortality rate can also be high with treatment. The greater risk is in elderly, hypothermic and bradicardial patients. However, in another study conducted on 11 patients, the presence of a coma at the time of hospitalization, the score of the staircase of Glasgow Coma and the Apache II scores were better indicators of survival. [7] The most important factors in the prevention of mortality in cases of Coma from Mixedema are early recognition, supposed to replace the thyroid hormone, hydrocortisone and support care. [4] It is important, general practical, to be vigilant and to diagnose early hypothyroidism. There should be a low threshold to start the test of thyroid functionality in older people, especially in older women who present mental state changes in the winter months. [4, 8] Sheu DC, Cheng MH, Tsai Jr, et al; MyXedema coma: a medical emergency note but unknown. Thyroid. 2007 Apr17 (4): 371-2.Kearney T, Dang C; Diabetic and endocrine emergencies. Postgrad Med J. 2007 Feb83 (976): 79-86.Wartofsky L; Myxedema coma. Endocrinol Metab Clin North Am. 2006 DEC35 (4): 687-98, VII-VIII.WALL CR; MyXedema coma: diagnosis and treatment. Am Pham Physician. 2000 DEC 1Rimar D, Kruzel-Davila E, Dori G, et al; Iperamonemic coma - bark on the wrong tree. J Gen Intern Med. 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