LETTER TO THE EDITOR

Critical Illness Polyneuromyopathy and the Diagnostic Dilemma

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ABSTRACT

Critical illness polyneuromyopathy is a growing concern in intensive care units, but its presentation within 24–48 hours of admission is very unusual. Such presentations should be carefully scrutinized, especially in the presence of severe hypokalemia.

Keywords: Critical illness polyneuromyopathy, Diabetic ketoacidosis, Hypokalemia.

Sir,

We read with immense interest the article titled “An Unusual Case of Critical Illness Polyneuromyopathy” by Mahashabde et al.¹ We appreciate that critical illness polyneuromyopathy is a growing concern in intensive care units leading to difficult weaning with prolonged hospitalisations. But there are some major concerns in this case report which we want to bring to notice:

• The patient was diagnosed with diabetic ketoacidosis (DKA) precipitated by infection. Dyselectrolytemia in the form of hyperchloremic acidosis, hypokalemia, and hypophosphatemia are known complications of DKA management. The potassium level of 1.9 mEq/L with pH of 6.9 at admission suggests severe potassium depletion. Hypokalemia further worsens as the acidosis gets corrected with fluid and insulin therapy due to transcellular shift. Severe hypokalemia may itself present as acute flaccid paralysis.²
• Nerve conduction studies in severe hypokalemia have shown severe reduction in amplitudes of the compound muscle action potential with rarely reduced sensory nerve action potential.³ These electrophysiological findings mimic axonal neuropathy.
• According to one study, serum CPK was elevated in 68% of cases of hypokalemic paralysis with significantly higher values in the secondary group compared to the primary hypokalemic paralysis group.⁴
• The authors themselves quoted that critical illness polyneuropathy may present as early as 72 hours of ICU admission, but the flaccid paralysis requiring intubation was evident on the second day of admission itself in the present case report.⁵
• Whether magnesium levels were checked and corrected in case of persistent hypokalemia?
• What were the phosphate levels as diabetic ketoacidosis is often associated with hypophosphatemia leading to weaning difficulties?
• Thus the flaccid paralysis with associated laboratory and electrophysiological study findings presenting between 24 to 48 hours of admission with low potassium levels are better explained by hypokalemia rather than an early onset variant of critical illness polyneuromyopathy. However, critical illness polyneuropathy cannot be denied in the later phase of illness when the patient had ventilator-associated pneumonia due to prolonged ventilation.

REFERENCES


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How to cite this article: Sulakshana S, Naik BK. Critical Illness Polyneuromyopathy and the Diagnostic Dilemma. Indian J Crit Care Med 2020;24(7):603.

Source of support: Nil

Conflict of interest: None

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