

A case of disseminated intravascular coagulation following multiple wasp stings

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Various complications of wasp sting have been reported, such as anaphylaxis, ischemic stroke, and acute kidney injury. However, coagulopathy following wasp sting has been rarely reported less than 10 cases. We experienced a case of wasp stings, with clinical manifestation of increased bleeding tendency by progressively deteriorated disseminated intravascular coagulation (DIC), which was recovered following combined therapy of anti-histamine, steroid and transfusion. A 77-year old man with no history of any disease was admitted to emergency department after multiple wasp stings by *Vespula vulgaris* on the both hands, wrists and forearms (figure 1). At admission, gingival bleeding and multiple purpura were observed. Initial laboratory findings showed severe thrombocytopenia (8000/ μ L), prolonged prothrombin time (> 60 sec) and activated partial thromboplastin time (> 120 sec) and low level of fibrinogen (< 60 mg/dL). Fibrin degradation products (> 120 μ g/L) and D-dimer (16990 ng/ml) increased. The patient was treated with steroid, anti-histamine, and blood products transfusion daily including platelets, fresh frozen plasma, and cryoprecipitate. Thereafter, laboratory parameters related to DIC were normalized at fifth day from admission and gingival bleeding was stopped. This case is the first report of coagulopathy by wasp sting in Korea.



Figure1. Both hands were swollen with ecchymosis and heating sensation after more than 40 wasp bites.

Multiple Simultaneous Arterial Infarction in a Multiple Myeloma Patient Undergoing Hemodialysis

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While multiple myeloma (MM) patients treated with thalidomide are known to be at a high risk for venous thromboembolism (VTE), arterial complications are not common. Some recent studies have identified an increased risk of arterial complications in MM patients treated with thalidomide. We report a rare case of multiple simultaneous arterial infarction in a 46-year-old MM patient undergoing hemodialysis (HD). The patient had risk factors of thrombosis including malignancy, combination chemotherapy with thalidomide and steroid, HD, erythropoietin stimulating agent (ESA) application, central venous catheterization, and immobilization. Renal infarction, necrotizing pancreatitis by arterial thrombosis, and dual-toe necrosis by microembolism occurred about four months after initiating thalidomide therapy. The patient died of septic shock due to the aggravation of necrotizing pancreatitis.



Figure 1. Abdominal computed tomography
(A) Peripancreatic fluid collection and necrosis of pancreatic parenchyma were noted in enhanced phase.
(B) Both kidneys were not totally enhanced.
(C,D) Blue-toe syndrome due to microembolism.