Rhabdomyolysis Induced by Rhinovirus: A Case Report

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Abstract

The occurrence of rhabdomyolysis in pediatric patients is considered a rare complication that can follow certain viral infections in a syndrome better defined as virus-associated rhabdomyolysis. In this research, we will present the case of a ten-year-old male patient who presented to the emergency department with chief complaints of severe bilateral leg pain and inability to walk. Furthermore, the patient complained of dysphagia for both solid and liquid along with dark-colored urine. Initial investigations showed an increase in creatine kinase (CK), C-reactive protein (CRP), and liver enzymes. Additionally, urine analysis was obtained with positive traces of blood, protein, and white blood cell. X-ray was ordered with no significant finding. Finally, the diagnosis was reached in accordance to the results of the respiratory panel multiplex (PCR) as the third case of rhinovirus-induced rhabdomyolysis. He was treated with isotonic intravenous fluids, and he was discharged on hospital day 20 with a CK of 2062 IU/L. The patient was discharged fully recovered, was able to stand and walk alone, and with no complications. In this third to be reported case of rhinovirus-induced rhabdomyolysis, we aim to increase the knowledge among the general pediatric field regarding the possible presentation and treatment of any similar case.

Case Presentation

A ten-year-old Saudi male patient presented to the emergency department (ED) with severe bilateral leg pain and an inability to walk for three days. Ten days prior to the presentation, the patient complained of rhinorrhea, cough, severe right leg pain and swelling that started after a long period of running. In addition, it was accompanied by dark-colored urine. Three days later, he started to have the same presentation in his left leg. He also complained of mild difficulty in swallowing solids and liquids, with no history of choking. Upon arrival to the ED, the patient looked very sick, coughing, crying from pain, tenderness all over his body, and was unable to walk. He was evaluated and found to be tachycardic (heart rate 120 bpm), afebrile (36.5°C), normotensive (121/70 mmHg), and had normal oxygen saturation (100% on room air). On physical examination, he was conscious, alert, and oriented. The patient had decreased power in the lower limbs and trunk (3/5) since rhabdomyolysis cause generalized weakness. Also, he was unable to move both of his legs. Besides, there was no history of any drug ingestion. The patient presented in the ER with high creatine kinase (CK), C-reactive protein (CRP), and liver enzymes. Creactive protein (CRP) was elevated at 35892 IU/L, CRP was 24.5 mg/L, and liver enzymes were 869 U/L. In addition, normal renal function with no sign of acute kidney injury. Furthermore, urine analysis was indicating hematuria and positive myoglobin. Additionally, rheumatology serology labs were positive and microscopic hematuria. Three days later, he started to have the same presentation in his left leg. He also complained of mild dysphagia for both solid and liquid along with dark-colored urine. Initial investigations showed an increase in creatine kinase (CK), C-reactive protein (CRP), and liver enzymes. Additionally, urine analysis was obtained with positive traces of blood, protein, and white blood cell. X-ray was ordered with no significant finding. Finally, the diagnosis was reached in accordance to the results of the respiratory panel multiplex (PCR) as the third case of rhinovirus-induced rhabdomyolysis. He was treated with isotonic intravenous fluids, and he was discharged on hospital day 20 with a CK of 2062 IU/L. The patient was discharged fully recovered, was able to stand and walk alone, and with no complications. In this third to be reported case of rhinovirus-induced rhabdomyolysis, we aim to increase the knowledge among the general pediatric field regarding the possible presentation and treatment of any similar case.

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### Discussion

Rhabdomyolysis is a syndrome that is characterized by the breakdown of skeletal muscle fibers, resulting in a subsequent release of intracellular contents into the circulatory system [6]. Thus, an increase of the levels of cell content in the blood such as CK, glutamic oxalacetic transaminase, lactate dehydrogenase, aldolase, the haemoglobin myoglobin, potassium, phosphates, and uric acid [4]. However, rhabdomyolysis is clinically defined as muscle symptoms with serum CK of more than 10 times the upper limit of the normal value, with a creatinine elevation consistent with pigment nephropathy and usually with brown urine with myoglobinuria [7]. Rhabdomyolysis in the pediatric population can be caused by any kind of muscle damage, such as traumatic injuries, connective tissue or metabolic disorders, exercise, drug overdose, or exposure to toxins [8]. In addition, infections have been reported to be associated with rhabdomyolysis, such as influenza and severe acute respiratory syndromes [9,10]. Also, in children below nine years, viral infection is the most common cause [11]. A case report published in 2016, described the association of human rhinovirus with rhabdomyolysis [4]. The patient presented with a cough lasting for a week and fever for one day [4]. It was found that his creatine kinase, alanine transaminase, and aspartate transaminase levels were elevated, and his urine myoglobin was 10,024 µg/L [4]. The patient was managed with intravenous fluid hydration after a diagnosis of rhabdomyolysis was made. On the sixth day, he was weaned off oxygen and was discharged home well with improved musculoskeletal pain [4]. Our patient, on the other hand, presented with severe bilateral leg pain with inability to walk that began 10 days prior to hospital admission; he was also having a mild difficulty swallowing solid and liquid meals. The initial laboratory results showed an increase in CK, CRP, and liver enzymes. Additionally, urine analysis revealed very few WBCs, a large amount of blood, and traces of protein. In terms of treatment, the patient received a hydration bolus of normal saline in the ED as well as maintenance intravenous fluid. Furthermore, acetaminophen was given to him to ease the chest pain. In his follow-up after one month of his discharge, his CK level was decreased to 2062 IU/L, his liver function tests were normal.

### Conclusions

In conclusion, our patient presented with a classical rhabdomyolysis symptoms triad. His initial investigations showed elevated CK, CRP, and liver enzymes. After excluding other causes, PCR test was done and detected positive human rhinovirus. The patient then underwent supportive treatment with fluid and analgesics. Although the incidence of rhabdomyolysis caused by rhinovirus is rare, thorough medical treatment is recommended. Early detection, intravenous hydration, and continuous monitoring should be applied for such cases.

### Additional Information

#### Disclosures

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