



Leading to the Diagnosis

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Clinical image description

A 3-year-old girl was referred to the Emergency Room (ER) of Brookdale Hospital Medical Center, NY for an evaluation of suspected lead intoxication. She was found to have venous blood lead level 37 mcg/dl on a routine well child visit. There was no history of abdominal pain, constipation, vomiting, anemia, intellectual disability, seizures, and encephalopathy. She lives with parents and 2 siblings in old NYC city apartment. No History of PICA. Her development was appropriate for age. Her vitals and general physical examination were normal. Abdomen was soft, not tender or distended, no organomegaly with normal bowel sounds. There was nothing significant on other system physical examination. Initial workup including Complete Blood Count (CBC), Complete Metabolic Panel (CMP), and iron studies were not significant.

Initial plain abdominal radiograph shows radio-opaque lead deposits interspersed throughout the colon and small intestine (Figure 1).

The patient was given Fleet enema in the ER and discharge to home on Mira LAX (polyethylene glycol) 1 g/kg/day twice daily for 1 month with a follow up appointment to the primary care physician and pediatric gastroenterologist for further management.

Repeat follow up abdominal radiograph on day 4 after initial presentation shows most of the radiopaque lead deposits in the colon demonstrated on the prior abdominal radiograph has passed with only a small residual in the rectosigmoid colon (Figure 2).

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Figure 1: Plain Abdominal radiograph showing radiopaque lead deposits interspersed throughout the colon and small intestine.



Figure 2: Plain Abdominal radiograph suggests that most of the radiopaque lead deposits in the colon demonstrated on the prior abdominal radiograph has passed with only a small residual in the recto sigmoid colon.