A 42 years woman, a known case of type 2 diabetes for past one year, presented with right lumbar pain and cloudy urine for seven days and shortness of breath for three days. She had recurrent urinary tract infection due to *E. coli* in last five months, that was inappropriately treated. On examination, she was afebrile, dehydrated, and had pulse rate 110/min regular, BP 90/60 mmHg and respiratory rate 30/min. She had tenderness in right lumbar region. Other systemic examination was normal. Her laboratory work-up showed: Hb 67 gm/L; TLC 24 x 10⁹/L with 79% polymorphs, urine albumin++, pus cells -full field, few erythrocytes and no ketones, serum creatinine 665µmol/L, blood glucose 11.6 mmol/L and arterial blood gas analysis was suggestive of metabolic acidosis (pH 7.2, HCO₃ 9 mEq/L, pO₂ 11.9 kPa, pCO₂ 2.9 kPa). Repeated urine and blood cultures were sterile possibly because of prior antimicrobial therapy. NCCT abdomen showed air within right pelvicalyceal region while left kidney was normal. Coincidentally, gall bladder showed thickened wall with intraluminal air (Fig. 1). Bile aspirate for analysis could not be obtained because of her morbid condition. She was treated with intravenous saline, insulin, cefaperazone, amikacin, crystalline penicillin, metronidazole and supportive hemodialysis. Two weeks later, her lumbar pain subsided, serum creatinine decreased to 308 µmol/L, and metabolic acidosis reversed (pH 7.4, HCO₃ 22 mEq/L). Her repeat NCCT abdomen two weeks later showed near complete disappearance of air both within gall bladder and kidney. Multiple hyperdense specks noted within gall bladder are suggestive of calculi (Fig. 2). She received antimicrobial therapy for six weeks and is doing well.

*Final diagnosis*: Type 2 diabetes mellitus with acute renal failure, emphysematous pyelonephritis and emphysematous cholecystitis.

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