A case report on drug induced pancreatitis due to levofloxacin and methylprednisolone

Balwinder Kaur Rekhi, Srinath Reddy Mannem, H. S. Rekhi, Sushil Kumar Mittal, Sahil Arora, Sathya P., Ravitej Singh, Kaushal Seth

ABSTRACT

Introduction: Acute pancreatitis is the acute inflammation of the pancreatic gland, attributed to a wide range of etiological factors. It is a well-known fact that approximately 80% of the causes are associated with choledolithiasis and alcohol abuse [1]. However, the exact incidence of drug induced pancreatitis is difficult to determine due to the rare presentation, it requires larger, case-controlled studies to determine its incidence and prevalence. Up to 2% cases may be caused by drug [2]. Case Report: This is a case report focusing on a 26-year-old female patient who developed acute pancreatitis following administration of Levofloxacin and Methylprednisolone for treatment of pneumonitis in intensive care unit. Both the drugs appear to be responsible for pancreatitis because of temporal relationship between the administration of drug, onset of symptoms and improvement of clinical symptoms when drugs were stopped. Conclusion: Levofloxacin and methylprednisolone appears to be responsible for pancreatitis because of the temporal relationship between the administration of drug, onset and improvement of clinical symptoms when drugs were stopped.

Keywords: Acute pancreatitis, Drug induced pancreatitis. Levofloxacin, Methylprednisolone

How to cite this article

Rekhi BK, Mannem SR, Rekhi HS, Mittal SK, Arora S, Sathya P, Singh R, Seth K. A case report on drug induced pancreatitis due to levofloxacin and methylprednisolone. Int J Case Rep Images 2017;8():**–**.

Article ID: Z01201701CR10747BR

doi:10.5348/ijcri-201708-CR-10747
INTRODUCTION

Acute pancreatitis is the acute inflammation of the pancreatic gland associated with varying involvement of the surrounding regional tissues or remote organ system; it is characterized by deep seated abdominal pain radiating to back, nausea and elevated pancreatic enzymes.

Acute pancreatitis has been attributed to a wide range of etiological factors. Approximately 80% of the cases are associated with cholelithiasis or alcohol abuse [1]. Approximately 1% develop pancreatitis following endoscopic retrograde cholangiopancreatography (ERCP). Several drugs are casually related to pancreatitis particularly corticosteroids, thiazide diuretics, estrogens, azathioprine, and furosemide. Furthermore, in approximately 10% of cases, no cause can be identified. Pancreatic toxicity of drugs is of relatively recent knowledge through the publication of isolated cases or small series. Up to 2% of cases may be caused by drugs [2].

We report a case of acute pancreatitis in a young female receiving levofloxacin and methylprednisolone.

CASE REPORT

A 26-year-old female was admitted in intensive care unit as a case of pneumonitis. She presented with history of respiratory distress, cough for 7 days and with fever for 3 days. There is no family history of pancreatic diseases. There is no history of alcohol abuse. There is no history of drug abuse. On examination: respiratory rate was 30 per min, pulse 128 per min, blood pressure was 118/82 mm of Hg. Chest examination showed bilateral diffuse crepts and ronchi with the use of accessory muscles. SpO2 of 92% with venturi fio2 40%. After routine hematological and radiological investigations, she was diagnosed as pneumonitis and put on:

1. Injection ceftriaxone and sulbactum 1.5 g i.v bd
2. Injection azithromycin 500 mg i.v od
3. Injection omeprazole i.v od
4. Nebulization with salbutamol and budesonide

Patient general condition didn’t improve and further deteriorated, saturation dropped to spo2 of 82% with oxygen and there after patient was shifted to ICU put on volume controlled mechanical ventilation and was put on:

1. Injection ceftriaxone and sulbactum 1.5 g i.v bd
2. Injection levofloxacin 500 mg i.v od,
3. Injection solumedrol 50 mg iv od.
4. Injection omeprazole i.v od
5. Nebulization with salbutamol and budesonide

After two days of treatment patient started responding to treatment, was weaned off from ventilator and put on venture mask. On third day patient developed acute abdominal pain which is radiating to back and loose stools, for which ultrasonography was done showing free fluid in the upper peritoneal recess and in between gut loops with left sided pleural effusion. Surgery call was sent and patient was diagnosed as a case of acute pancreatitis clinically, we advised serum amylase and lipase apart from routine investigations. Serum amylase was 346 U/L and serum lipase was 1432 U/L. Patient was advised contrast CT Abdomen which showed acute pancreatitis with modified CTSI of 6/10. Total leucocyte count raised from 11,600/mm3 to 20,400 /mm3 on same day, the next day it increased to 52,000 /mm3 and then to 70,300/mm3. The initial antibiotics were stopped and patient was put on:

1. Injection meropenem 1 g i.v tds,
2. Injection metronidazole 100 ml iv tds

After 3 days patient responded well, serum amylase and lipase levels came back to normal range with normal ultrasonographic findings. Patient was later discharged and advised for follow-up.

DISCUSSION

Drug induced pancreatitis is relatively a less know concept in acute pancreatitis, as it is a relatively rare occurrence considering the small number of patients who develop pancreatitis compared to the large number of patients who receive potentially toxic drugs. Its incidence varies among different studies between 0.1% and 5.3% of all acute pancreatitis cases [3]. The clinical presentation and mechanisms of injury to the pancreas are not well understood or controversial. The diagnosis of drug induced pancreatitis remains possible or probable in many patients. The resolution of pancreatitis after discontinuation of drug , could improve the diagnosis of drug induced pancreatitis. However, it is difficult to establish the direct correlation between resolution of symptoms and drug withdrawal sometimes.

Pancreatic toxicity of drugs is of relatively recent knowledge through the publication of isolated cases. According pancreatix file prepared by the Paris Regional Centre - Saint-Antoine, the number of offending drugs reached 261, representing potentially 1-2% of acute pancreatitis [4]. More than 500 different drugs are listed in the World Health Organization (WHO) database suspected to cause acute pancreatitis as a side effect. Many of them are widely used to treat highly prevalent diseases [5].

Levofloxacin belongs to the new fluoroquinolones group. The most commonly reported adverse reactions are minor digestive disorders and elevated liver transaminases [6].

Mennecier et al. [7] suggest a possible pancreatic toxicity of levofloxacin used alone or with steroids and therefore encourages us to recommend pancreatic biological tests before the onset of abdominal pain during treatment with levofloxacin. They also stated that there istemoral relationship between the drug intake and development of acute pancreatitis as well as resolution of acute pancreatitis upon discontinuation of drugs in a short interval.
In our case, the time criteria are based on the evolving profile of acute pancreatitis according to the administration and medication discontinuation.

Re-administration of drug has not been made. The temporal relationship between drug intake and the occurrence of pancreatitis is suggestive because the time between the administration of treatment and the occurrence of acute pancreatitis is short. Upon discontinuation of treatment, resolution of acute pancreatitis is suggestive as the clinical and laboratory abnormalities decreased within hours. The problem here is, what is the offending drug? Several cases of acute pancreatitis have been reported with methylprednisolone is a well-established fact [8]. In acute pancreatitis secondary to taking methylprednisolone, the time frame is 3 days to 22 weeks with a dose-dependent mechanism assumed. The mechanism of corticosteroid-induced pancreatitis is complex and currently unknown [9]. In a case report of Seneviratne et al. [9], the pancreatitis started after 8 days of high-dose (250mg) steroid treatment. In our patient, we started 50 mg dose of methylprednisolone. In our observation, the speed of the onset of acute pancreatitis can argue more in favor of an immunological mechanism. This suggests that the already incriminated Levofloxacin in elevated pancreatic enzymes can cause acute pancreatitis. However, further observations are needed to confirm this hypothesis.

CONCLUSION

In the case reported levofloxacin and methylprednisolone appears to be responsible for pancreatitis because of temporal relationship between the administration of drug, onset of symptoms and improvement of clinical symptoms when drugs were stopped.

********

Author Contributions

Balwinder Kaur Rekhi – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published
Srinath Reddy Mannem – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published
Sushil Kumar Mittal – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published
Sahil Arora – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published
Sathya P. – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published
Ravitej Singh – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published
Kaushal Seth – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published

Guarantor

The corresponding author is the guarantor of submission.

Conflict of Interest

Authors declare no conflict of interest.

Copyright

© 2016 Balwinder Kaur Rekhi et al. This article is distributed under the terms of Creative Commons Attribution License which permits unrestricted use, distribution and reproduction in any medium provided the original author(s) and original publisher are properly credited. Please see the copyright policy on the journal website for more information.

REFERENCES

1. Spanier BW, Dijkgraaf MG, Bruno MJ. Epidemiology, aetiology and outcome of acute and chronic pancreatitis: An update. Best Pract Res Clin Gastroenterol.2008; 22(1):45-63. doi: 10.1016/j. bpg.2007.10.007. Review. PubMed PMID: 18206812.
2. Lankisch PG, Dröge M, Gottesleben F. Drug induced acute pancreatitis: incidence and severity. Gut. 1995 Oct; 37(4):565-7. PubMed PMID:7489946; PubMed Central PMCID: PMC1382911.
3. Nitsche CJ, Jamieson N, Lerch MM and Mayerle JV. Drug induced pancreatitis. Best Pract Res Clin Gastroenterol 24(2): 143-155, 2010. PMID: 20227028.
4. Bi'ur million Delcenserie R, Grange JD, J.Weissenburger Pancreatoxicite drugs. Gastroenterol Clin Biod 2001; 25: 1S22-7.
5. Nitsche C, Maertin S, Scheiber J, Ritter CA, Lerch MM and Mayerle J. Drug-induced pancreatitis. Curr Gastroenterol Rep 14(2): 131-138, 2012. PMID: 22314811.
6. Douadi Y, X Lescure, JL Schmit. A new antibiotic: levofloxacin. Presse Med 2000; 21: 1184-5.
7. Menneclier D, Thiolet C, Bredin C, Potier V, Vergeau B, Farret O. Acute pancreatitis after treatment by levofloxacin and methylprednisolone. Gastroenterol Clin Biol. 2001 Oct; 25(10):921-2. PMID: 11852403
8. Kimura T, Zuidema GD, Cameron JL. Steroid administration and acute pancreatitis: studies with
an isolated, perfused canine pancreas. Surgery. 1979 May; 85(5):520-4. PubMed PMID: 432812.

9. Seneviratne DR, Mollan SP, Elsherbiny S, Worstmann T. Giant cell arteritis complicated by acute pancreatitis: a case report. Journal of Medical Case Reports. 2008; 2: 346. Doi: 10.1186/1752-1947-2-346.