Case Report

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Acute Pancreatitis Following Thiocolchicoside Use: A Case Report

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ABSTRACT

Acute pancreatitis (AP) is an inflammatory disease with high mortality and morbidity, characterized by elevated amylase and lipase, accompanied by typical abdominal pain. In this case, we present a case of acute pancreatitis developed after the use of thiocolchicoside in a 52-year-old patient with a history of cholecystectomy. There was no history of intrahepatic and choledochal stones or enlargement, hyperlipidemia, and alcohol use on magnetic resonance cholangiopancreatography (MRCP). After excluding the possible cause, a diagnosis of AP caused by thiocolchicoside, a rare side effect of this drug, was made. There are case reports about the development of AP secondary to drugs in the literature, but the development of AP after thiocolchicoside is extremely rare. It is important to determine the etiology in AP cases. It is aimed to raise awareness on this issue with this case, which shows that thiocolchicoside, which is frequently prescribed in primary and secondary health care institutions, may rarely cause AP.

Keywords: Acute pancreatitis, thiocolchicoside, cholecystectomy

Acute pancreatitis (AP) is an inflammatory disease with high mortality and morbidity, characterized by elevated amylase and lipase level, accompanied by typical abdominal pain. [1]

The incidence of AP ranges from 5 to 80 per 100,000 year. While the most common causes of AP are gallstones and alcohol, one of the rare causes is drugs.[2] In this case, we present a case of acute pancreatitis following the use of thiocolchicoside in a 52-year-old patient with a history of cholecystectomy.

CASE REPORT

A 52-year-old female patient was admitted to the emergency department with abdominal pain for 12 hours. In her history, she was admitted to the hospital 3 days ago with the complaint of low back pain and was prescribed thiocolchicoside 4mg intramuscular (IM) twice daily (BID) and etofenemate 1000 mg IM (1x1) with the diagnosis of lumbalgia. She used these drugs for two days and on the morning of the third day, she had severe abdominal pain radiating to the back accompanied by nausea and vomiting. She had a history of cholecystectomy three years ago. She was on metoprolol 50 mg tablet 1x1 with a diagnosis of arrhythmia and metformin 500 mg tab BID with a diagnosis of insulin resistance for three years. The patient had no alcohol consumption, no smoking, and no family history of pancreatitis. Physical examinations were such follows; fever: 36.7C, heart rate: 90/min, BP: 110/70 mmHg, saturation: 96%, respiratory rate: 16/min. In her abdominal examination, there was diffuse tenderness, no defense, and no rebound. Other system examinations were normal. Laboratory tests were follows; WBC:13.3 x103/uL (4.6-10.2 x10^3/uL),

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HCT: 38% (37.7-53.7%), PLT:356 x10^3/uL (142-424 x10^3/uL), AST:13 u/L (11-25 U /L), ALT:14 u/l (7.0-22 U/L), GGT:16 u/L (0-65 U/L), ALP:62 u/L (25-100 U/L), Total bilirubin:0.24 mg/dL (0.0 -1.2 mg/dL), Amylase: 1224 u/L (34-119 u/L) and Lipase: 1602 u/L (70 < u/L) other tests were within normal limits. Her electrocardiogram was in normal sinus rhythm and there was no ST-segment change.

In the whole abdominal ultrasonography: the gall bladder was not observed (operated), there was no pathology in the liver and spleen, and slight expansion of the pancreas is observed. The patient was admitted to the ward with the suspect of acute pancreatitis. The patient was NPO and parenteral hydration and nutritional support were administered. Oral intake was started after 48 hours. A diet low in cholesterol was given. Two days after hospitalization, MRCP was performed. The common bile duct diameter was measured as 6 mm and it was within the normal range. No dilatation was observed in the intrahepatic bile ducts. No obvious stone was observed in the common bile duct tracing. Laboratory results performed in the service were follows: calcium: 8.7 mg/dL (8.4-10.2 mg/dL), Triglyceride: 199 mg/dL (50-200 mg/dL), Total cholesterol: 244 mg/dL (110- 200 mg/dL), HBsAg (-), Anti-HBs (-), Anti-HCV (-), and Anti-HIV (-). Viral serologies (including Mycoplasma IgM, Mumps IgM, and Rubeola IgM) and autoimmune antibodies ANA, ASMA, IgG levels were found to be normal. After excluding hypercalcemia, hyperlipid, absence of stones in MRCP, and other etiological reasons, a diagnosis of AP was made after the use of thiocolchicoside. Blood amylase values returned to normal as 768 U/L, 363 U/L, and 166 U/L on days 2, 3, and 4, respectively. 48 hours after the patient's hospitalization, her general condition improved and her symptoms resolved. When the laboratory values and symptoms returned to normal levels on the 5th day of hospitalization, the patient was discharged with recommendations

DISCUSSION

Acute pancreatitis is an inflammatory condition of the pancreas characterized by nausea, vomiting, typical abdominal pain, and elevated levels of amylase and lipase in the blood.[1] As etiological factors, gallstones and alcohol occur in 80% of the cases in the literature.[3] While alcohol occupies the first place in the etiology of AP in Western societies, biliary causes are the first in Turkey.[4-7] Abdominal trauma, high triglyceride levels, ampulla of vater or pancreatic tumor, drugs, HIV, endoscopic retrograde cholangiopancreatography (ERCP), or surgical procedures can be among other possible causes.[8, 9] In our case, the patient had gallbladder surgery 3 years ago. There were no intrahepatic and common bile duct stones or enlargement in the MRCP, and there was no history of hyperlipidemia and alcohol use. Following exclusion of possible cause AP caused by thiocolchicoside, which is a rare side effect of this drug, was diagnosed. There are case reports about the development of AP secondary to drugs in the literature, but the development of AP after thiocolchicoside is extremely rare. It is important to determine the etiology in AP cases. Although the most common causes are gallstones and alcohol, it is important to know the rare causes and to examine and determine them in the patient's history. With this case, it has been aimed to raise awareness on this issue, which shows that thiocolchicoside, which is frequently prescribed in primary and secondary health care institutions, can cause AP, albeit rarely.

CONCLUSION

Authors' Contribution

Study Conception: İS,; Study Design: İS, SÖ,; Supervision: İS, MO,; Materials: İS, MO,; Data Collection and/or Processing: İS,; Statistical Analysis and/or Data Interpretation: MO,; Literature Review: MO; Manuscript Preparation: JK,; and Critical Review: İS, JK.

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