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CLINICAL CASE

Drug related colonic perforation: Case report☆

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KEYWORDS
Intestinal perforation;
Drugs;
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Multiple medications

Abstract
Background: Acute pseudo-obstruction of the colon is a disorder characterised by an increase in intra-luminal pressure that leads to ischaemia and necrosis of the intestinal wall. The mechanism that produces the lesion is unknown, although it has been associated with: trauma, anaesthesia, or drugs that alter the autonomic nervous system. The pathophysiology of medication induced colon toxicity can progress to a perforated colon and potentially death.
Objetive: Present a case of a colonic pseudo-obstruction in a patient with polyfarmacy as the only risk factor and to review the medical literature related to the treatment of this pathology.
Clinical case: The case is presented of a 67 year old woman with colonic pseudo-obstruction who presented with diffuse abdominal pain and distension. The pain progressed and reached an intensity of 8/10, and was accompanied by fever and tachycardia. There was evidence of free intraperitoneal air in the radiological studies. The only risk factor was the use of multiple drugs. The colonic pseudo-obstruction progressed to intestinal perforation, requiring surgical treatment, which resolved the problem successfully.
Conclusion: It is important to consider drug interaction in patients with multiple diseases, as it may develop complications that can be avoided if detected on time.
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PALABRAS CLAVE
Perforación intestinal;
Fármacos;
Pseudo-obstrucción colónica;
Polifarmacia

Perforación colónica secundaria a polifarmacia: reporte de caso

Resumen
Antecedentes: La pseudo-obstrucción colónica aguda se caracteriza por la dilatación masiva del colon, con aumento de la presión intraluminal que condiciona isquemia y necrosis de la pared intestinal. No se conoce el mecanismo que produce la lesión, aunque se ha asociado con: traumatismo, anestesia o agentes farmacológicos que alteran el sistema nervioso autónomo. La patofisiología de la toxicidad colónica por fármacos puede progresar hasta la perforación colónica y potencialmente a la muerte.
Objetivo: Comunicar el caso de una paciente con polifarmacia como único factor de riesgo para la pseudo-obstrucción colónica, y presentar la revisión de la bibliografía médica relacionada con el tratamiento.
Caso clínico: Presentamos el caso de una mujer de 67 años con distensión y dolor abdominal difuso, progresivo de intensidad 8/10 por pseudo-obstrucción colónica, acompañado de febrícula y, taquicardia. En los estudios de gabinete se observó aire libre en cavidad. El único factor de riesgo que tenía la paciente fue el uso de múltiples fármacos. El cuadro de pseudo-obstrucción evolucionó hasta la perforación intestinal, que requirió tratamiento quirúrgico, con resultado exitoso.
Conclusión: Es importante tener en cuenta las interacciones farmacológicas en los pacientes con múltiples enfermedades, ya que pueden condicionar complicaciones como la perforación colónica, que de ser detectadas a tiempo se podrían evitar.
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Background

Acute pseudo-obstruction of the colon is a disorder characterised by massive dilatation of the colon, where there is no evidence of mechanical obstruction, and by definition is associated with a secondary or base disease. Pseudo-obstruction, also known as Ogilvie syndrome, often occurs in elderly, patients who are being treated with a great many drugs, and although rare, drug-induced colonic toxicity is a disorder which should be recognised in time.[1,2]

Colonic pseudo-obstruction is always secondary to underlying disease such as: infectious, cardiac, neurological or drug-induced processes. Spontaneous perforation presents in 3–15% of cases with 40% mortality.[3]

The pathophysiology of drug-related colon toxicity starts as a pseudo-obstruction of the colon where the ileus or colonic paresis which results in massive dilatation, is secondary to the use of drugs which act on colonic innervation or motility. The drugs which are most usually associated with this disease include: narcotics, phenothiazines, antidepressants, and calcium channel-blockers. Despite the fact that the association of drugs with this disease is based on case reports, an obvious causal relationship has been established with some drugs such as loperamide, narcotics, phenothiazines and vincristine. Probable association with: atropine, nifedipine, procainamide, tricyclic antidepressants, amphetamines, barbiturates, chlonidine, dicumarol and verapamil.[1]

The clinical spectrum of drug-related colonic toxicity varies between: constipation, pseudo-obstruction, ischaemia and necrosis. Clinical suspicion of this disorder is important, as timely discontinuation of the drugs can prevent complications which result in a high morbimortality rate.[1,2] Initially the treatment guideline is conservative, colonic decompression can be effective although it carries with it a risk of perforation. Surgical treatment is reserved to cases presenting possible complications such as necrosis or perforation.

Objective

To present a review of the subject and the case of a female patient with polypharmacy, who presented with colonic pseudo-obstruction and evolved torpidly, until she presented perforation with peritonitis. She was managed surgically, and after medical management due to sepsis the patient responded favourably with no complications.

Clinical case

A 67-year old female patient who was admitted with distension and progressive diffuse abdominal pain of 8/10 intensity, with no signs of peritoneal irritation, accompanied by a difficulty in passing wind, and her last bowel movement was 2 days prior to admission. It was decided to hospitalise the patient with a diagnosis of colonic pseudo-obstruction. The patient's medical history included, arterial hypertension treated with nifedipine 20 mg/tid, dyslipidaemia treated with atorvastatin 10 mg/daily. In addition, the patient was taking quetiapine 300 mg/daily, levetiracetam 500 mg/bid, desvenlafaxine 50 mg/day, piracetam and raloxifene 60 mg/day for depression. She had no history of abdominal surgery; she only reported resection

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