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ACUTE PANCREATITIS UNDER METHYLPREDNISOLONE BOLUS: A CASE REPORT

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ABSTRACT

Drug involvement in the onset of acute pancreatitis (AP) is rare (less than 2%)[1] but not exceptional in adults. Corticosteroids are very rarely reported as a possible cause of pancreatitis. We report a clinical observation of recurrent acute pancreatitis during infusions of methylprednisolone for multiple sclerosis (MS).

KEYWORDS: Pancreatitis, multiple sclerosis, methylprednisolone.

INTRODUCTION

Drug involvement in the onset of acute pancreatitis (AP) is rare (less than 2%)[1] but not exceptional in adults. Corticosteroids are very rarely reported as a possible cause of pancreatitis.

PATIENTS AND METHODS

We report a clinical observation of recurrent acute pancreatitis during infusions of methylprednisolone for multiple sclerosis (MS).

CLINICAL CASE

We report the observation of a 32-year-old female patient with a history of relapsing-remitting multiple sclerosis under disease-modifying interferon therapy. She was admitted twice for sensitive flare-ups of her disease of numbness in the left lower limb, for which she was treated with a bolus of methylprednisolone at a rate of 1 g / d for 3 days. On the 3rd day of each hospitalization, the patient presented with transfixing epigastric pain, associated with nausea vomiting with an increase in pancreatic enzymes. The abdominal scan revealed a

stage B pancreatitis of balthazar without collection, nor flow of necrosis. In the absence of any demonstrated aetiology for her 2 episodes of acute pancreatitis. The role of corticosteroid therapy was retained. The outcome was favorable for the 2 episodes of pancreatitis.

During her 3rd outbreak, a reduction in the dose of metylprednisolone was recommended. Thus the patient received 500 / mg day for 6 days on alternate days with close clinical monitoring and daily dosage of pancreatic enzymes. No digestive event was noted during this 3rd hospitalization. Neurologically, there is an almost complete improvement in sensory disorders.

DISCUSSION

The incidence of drug-induced pancreatitis seems difficult to determine as it varies between studies from 1.6% to 44%, depending on the populations studied and the countries.[2,3] There is no current data on the prevalence in Morocco.

No semiological criterion is formally specific to a drug AP. The clinical presentation of PA is not unequivocal. Classically, drug-induced APs tend to be of the edematous type and develop relatively little over time, provided that taking the offending drug has been suspended.[4] Apart from the context of its occurrence, there is nothing to distinguish clinically, biologically or morphologically, drug-induced AP from AP of another origin. In 10 to 15% of cases, drug-induced AP may have signs of severity and develop in a necrotico-hemorrhagic mode.

The drug origin of pancreatitis is more difficult to establish. It is primarily based on eliminating the potential causes of pancreatitis. The biliary origin is probably the most difficult cause to eliminate and it is often necessary to have recourse to invasive examinations, such as retrograde cholangiography, or non-invasive tests, such as ultrasound endoscopy, or even to look for microcrystals in the bile.[5] The absence of recurrence over a prolonged period (more than a year) and a normal pancreatic and biliary morphological workup distant from the outbreak are not in favor of a biliary origin.[6] If no classic etiology is found, it will be necessary to think of a drug cause which should be sought by careful examination. The precise analysis of the chronology of drug intakes compared to that of pancreatic events will allow individualization of the suspect drug (s). On the other hand, the recurrence of symptoms upon involuntary reintroduction of the drug constitutes proof of the drug origin. The first general therapeutic measures are common to the different causes of AP.

CONCLUSION

Acute drug-induced pancreatitis can be induced by corticosteroids; To date, it is not known to have any predictive factors. However, healthcare professionals must report any case attributed or attributable to corticosteroids to a pharmacovigilance center.

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