



Pill Induced GI Bleed in a Case Rheumatoid Arthritis

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ABSTRACT

A 60 year old female presented to our hospital with chief complaints of generalised weakness and passage of black coloured stools. She was known case of Rheumatoid arthritis diagnosed outside and was on treatment with hydroxychloroquine and prednisolone. Workup for gastrointestinal bleeding was done and OGD scopy revealed evidence of erosive esophagitis, gastritis with duodenitis. On basis of this report cause of GI bleed was found to be Pill induced and offending agent i.e. steroid was stopped and patient responded well after stopping steroid. Steroid was responsible for her GI bleed. One should always keep this drug history as Pill esophagitis can convert into worst prognosis.

Keywords: Pill esophagitis, GI bleed, prednisolone, rheumatoid arthritis.

INTRODUCTION

Rheumatoid arthritis (RA) is a chronic systemic inflammatory illness with prevalence of approximately 0.75% in India ^[1]. To avoid development of irreversible joint deformity and symptomatic relief patient is treated using DMARD, NSAIDs, steroids and biological therapy². Steroids are frequently used in the initial part of treatment of RA and in case of disease flare-ups. Gastrointestinal bleeding arising secondary to mucositis is a worrisome complication of steroid therapy which can be life threatening in old age.

CASE REPORT

A 60 years old female patient presented to our hospital with chief complaints of generalised

weakness and black coloured stools since 10 days. she was diagnosed case of rheumatoid arthritis since 8 years and was on treatment since 3 months. She was taking prednisolone 40mg OD and hydroxychloroquine 200mg B.D.

We started her workup for black colored stool. There was no history of hemoptysis or hematemesis. Her platelets were normal (2lakh/mm³), liver function test were within normal range, ultrasound abdomen was normal.

Upper GI endoscopy was done which showed evidence of esophagitis, gastritis and duodenitis. These changes were attributed to ongoing treatment with prednisolone. We stopped prednisolone, she was already started on proton pump inhibitor (pantoprazole 40mg) and syrup

sucralfate. Thereafter, she started feeling symptomatically better.

DISCUSSION

Upper gastrointestinal bleeding includes hemorrhage originating from the esophagus to the ligament of Treitz. Peptic ulcer bleeding causes more than 60 percent of cases of upper gastrointestinal bleeding^[3]. Other etiologies include arteriovenous malformations, Mallory Weiss tear, gastritis and duodenitis, and malignancy^[3].

Gastrointestinal mucosal injuries (i.e. erosions, ulcers and perforations) caused by steroids, NSAIDs and DMARDs are common in RA patients. Although perforations are typical severe gastrointestinal complications, Curtis et al^[4] reported that the frequency of perforations is about 0.1% in RA patients.

Epidemiological studies have proved that NSAIDs are significantly more ulcerogenic than steroids but that the association of the two types of drugs has a truly synergic and lethal effect, increasing of 3 to 6 times the relative risk^[5,6]. Yet corticosteroids themselves can become ulcerogenic if treatment lasts for more than one month, with a total intake more than 1 gm of prednisolone^[7]. Elderly people (aged more than 65 years) seem to be more exposed to the risk of developing peptic ulcers.

In animal studies both gastric mucus production and gastric bicarbonate secretion are impaired by steroid administration, which results in a weakening of gastric mucosal defences^[8]. In addition steroids impair both angiogenesis and epithelial repair mechanisms in experimental ulcers^[9-11].

Glucocorticoids inhibit COX-2 without hampering COX-1, supports studies that found no increased risk of upper GI bleed. In other studies a relative risk of serious upper GI complications of about 2 was found. But with glucocorticoids and NSAIDs together had relative risk of 4^[12].

Relative Risk of Upper Gastrointestinal Bleeding Associated with NSAIDs^[13]: Ibuprofen (2.7), Naproxen (5.2)

Early upper endoscopy (within 24 hours of presentation) is recommended in most patients with upper gastrointestinal bleeding because it confirms the diagnosis and allows for targeted endoscopic treatment, resulting in reduced morbidity, hospital stays, risk of recurrent bleeding, and need for surgery^[14].

In conclusion, upper GI bleed in patients of rheumatoid arthritis, drug history is important (especially in elderly patients). Long term treatment of rheumatoid arthritis with steroids, NSAIDs and DMARD is associated with increased risk of upper GI bleed.

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