

Multiple Small Bowel Ulcerations After Short Term Indomethacin Treatment. A Case Report

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Özet: KISA SÜRELİ INDOMETAZİN TEDAVİSİ SONRASI G2ELİŞEN MULTİPL İNCE BARSAK ÜLSERASYONLARI. OLGU SUNUSU

Bu yazıda, kısa süreli indometazin tedavisi sonrası ince barsakta diffüz ülserasyon gelişen bir olgu sunuldu.

Anahtar kelimeler: Indometazin, ülserasyon, ince barsak.

It is a well known fact that Indomethacin (IN) may have deleterious effects on upper gastrointestinal mucosa (1, 2). But there is little information on the effect of the drug in other parts of the gut. Only a few cases of solitary small bowel ulcerations resulting from long term IM therapy have been reported (3, 4). In this report we present a case of disseminated ulceration of the entire small bowel associated with the short term use of IM.

CASE REPORT

A 50 year old man was admitted with a two day history of abdominal pain, nausea and vomiting. He had been taking 200 miligrams of IM for rheumatoid arthritis for four days. There was no evidence of any gastrointestinal disorder in his medical history. His physical examination revealed a tender abdomen with peritonitis signs. His temperature was 39.5 degrees centigrade and he had tachycardia. Nasogastric aspirate and rectal examination was normal . Results of the laboratory tests were unremarkable except for mild leucocytosis. Abdominal paracentesis showed purulent peritonitis. At surgery he was found to have generalized peritonitis but no perforation was encountered. The entire small bowel was full of ulcers ranging from one to three centimeters in diameter and increasing in number and

Summary: In this report a case of diffuse ulceration of the small intestine resulting from the short term use of indomethacin is presented.

Key words : Indomethacin, ulceration, small intestine.

size towards the ileocecal valve. The small intestine between the ulcers was normal. The stomach, duodenum and the colon was free of disease. The extent of the disease prevented resection. Abdomen was washed and closed after putting in four sump drains. Cultures of faeces and blood were negative for salmonella species. The patient was placed on a parenteral nutrition schedule and at the third postoperative day he developed a low output enterocutaneous fistula. The patient did well until massive haemorrhage from the fistula and melena started 20 days after the operation. Reoperation became inevitable because of failed medical therapy. During surgery he was found to be bleeding diffusely from the entire small bowel. Extensive adhesions with multiple internal fistulas and hemodynamic instability of the patient prevented us from performing a radical operation. The patient died two days later with multiple system organ failure. The biopsies obtained in the two operations revealed a normal mesenteric lymph node and nonspecific ulceration of the small bowel.

DISCUSSION

In our patient a causal relationship between IM and acute ulceration of small bowel is strongly suggested by the sudden outbreak of the symptoms shortly after starting treatment and

the complete absence of digestive signs of any gastrointestinal disease before the administration of IM.

Experimental study in animals showed that IM is capable of inducing multiple ulcerative lesions in the small intestine of rats (5). Until now a small number of IM induced lower gastrointestinal tract lesions which are reported in humans were solitary and benign in course (3, 4). The disseminated ulcerations in line with the catastroph-

hic outcome of our patient should increase the awareness of this potentially avoidable condition. Although the prostoglandin theory is still the only logical explanation, the definite ethiopathogenesis is yet to be defined. Therefore every physician familiar with the use of IM should not underestimate the potential hazardous effects of the drug and should bear in mind that IM induced gastrointestinal lesions may occur without predictable extension and distal to the stomach and duodenum.

KAYNAKLAR

1. Somerville K, Faulkner G, Langman M: Non-steroidal anti-inflammatory drugs and bleeding peptic ulcer. *Lancet* 1: 462-464, 1986.
2. Rampton DS: Non-steroidal anti-inflammatory drugs and the lower gastrointestinal tract. *Scand J Gastroenterol* 22: 1-4, 1987
3. Sturges HF, Krone CL: Ulceration and stricture of the jejunum in a patient on long term indomethacin therapy. *Am J Gastroenterol* 589: 162-169, 1973
4. Saverymuttu H, Grundy TA, Maxwell JD: Ileal stricturing following indomethacin therapy. *Postgrad Med J* 62: 967-968, 1986
5. Kent TH, Cordelli RM, Stampler FW: Small intestinal ulcers and intestinal flora in rats given indomethacin. *Am J Pathol* 54: 237-245, 1969.