Duodenal perforation in women 60 years of age following receipt of a non-steroidal anti-inflammatory drug

Opinion

Treatment with non-steroidal anti-inflammatory drugs (NSAIDs) is associated with an increased risk of peptic ulcer complications, but it is not clear whether some drugs are more likely than others to cause such complications.

Interventions to reduce the morbidity and mortality from upper gastrointestinal disease caused by the widespread use of non-steroidal anti-inflammatory drugs include educational methods aimed at reducing prescribing, co prescription of a mucosal protective drug such as misoprostol, and the use of paracetamol as an alternative analgesic. Another approach is to prescribe a drug associated with a comparatively low risk of gastrointestinal toxicity and use more toxic compounds only in the event of a poor clinical response to the first line drug. However, evaluation of the data on comparative risk is difficult. Published epidemiological studies have provided variable coverage of individual drugs, making them unsuitable for meta-analytical approaches that attempt to pool data across all studies.

12 studies that examined relative risks of gastrointestinal complications with a total of 14 nonsteroidal anti-inflammatory drugs and satisfied our criteria for inclusion. Twelve drugs had been included in two or more studies and 11 studies provided comparative data on ibuprofen and other agents. Two reports were unpublished at the time of writing: one was an update and reanalysis of a previously published paper; the other had been published only as an abstract. Three other studies were updated by the authors at the investigators’ workshop or in subsequent correspondence.

A 60-year-old woman weighing 70 pounds with a history of chronic obstructive pulmonary disease as well as a serious smoker has been vomiting for four days and two days before going to the hospital received a non-steroidal anti-inflammatory drug disc for a back pain. The patient was diagnosed with a duodenal perforation at her arrival at the hospital, as her vital signs were disturbed with a blood pressure of 80/60 mmHg and a cardiac frequency of 118. Ringers Lactate fluid was given for volume replenishment (deficit -10.7). Anesthesia with propofol 200 mg, Fentanyl 0.1 mg, Esmeron 100 mg, maintenance of anesthesia with Sevo 2.5 %, and maintenance and control of analgesia with an epidural catheter as originally 3 ml Naropaine 0.75% was given. The surgery had duration of 2.5 hours, during which time the patient began metabolic acidosis. Five minutes after awakening, the patient experienced faint breathing and a drop in blood pressure for follow-up in an increased care unit.

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Appropriate clinical strategies could prevent many episodes of peptic ulcer bleeding: NSAIDs should be used only in patients who do not respond to other analgesics; the lowest possible doses should be used; and the least toxic NSAIDs should be selected.

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Conflicts of interest
Author declares there is no conflict of interest.

References
