

Acitrom Induced Pseudo-Obstruction: A Case Report

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Abstract:- Bleeding is the most serious complication of oral anticoagulation in the prevention and treatment of thromboembolic complications. Even after NOACs discovery, Acitrom or acenocoumarol is the most common oral anticoagulant used in practice. Here we present a case report of acitrom causing bleeding into intestinal sub mucosa causing acute pseudo-obstruction.

I. CASE REPORT

A 70-yr old female presented with complaints of abdominal bloating, nausea, early satiety, hematuria, increased belchings, and severe generalized weakness since 3 days, constipation, bilateral pedal edema, abdominal pain and recurrent vomiting's since 2 days. She is a known case of Diabetic, Hypertensive, CRHD, status post PBMV and Atrial Fibrillation and is on acitrom since 5 yrs. At the time of admission she is Conscious and Coherent. BP: 170/70 mm Hg PR: 96/min, irregularly irregular rhythm, RR: 22/min RBS: 339 mg/dl. TEMP: 98.6°f, SpO2: 98% at room air. CVS: S1, S2+ Mid diastolic murmur+. RS: B/L AE+, Clear airways. P/A: Diffuse vague tenderness+. CNS: NAD. Lab evaluation shows – Hemogram is s/o microcytic hypochromic anemia, relative neutrophilia. HbA1c is 8%. Renal function tests and Electrolytes were within normal limits. CUE shows sugar 2+,

protein 1+, plenty of RBC's. INR is >100 [N -0.8 - 1.2]. CECT Abdomen done and is s/o ill defined non- enhancing hypodensity measuring 8.1 x 2.6 x 3.9 Cm (coronal x sagittal x axial) is seen in endometrial cavity extending into the anterior and posterior wall myometrium, predominantly in the distal body and cervical region without extension into parametrium and vaginal S/o Carcinoma. 2D Echo study is s/o moderate mitral stenosis, EF – 52%, atrial fibrillation. Cardiologist, Surgeon, Gastroenterologist and Gynecologist consulted. Upper GI Endoscopy done and is s/o ulceration at GE junction, sub mucosal hemorrhages with edematous mucosa at D1, Cap and D2 region with duodenal obstruction - acitrom induced (Fig.1). She is kept on Nil by mouth. Acitrom is withheld in view of high PT/INR. Injection Vitamin K 10mg IV once in a day for 3 days given. She is treated with Empirical Antibiotics, Insulin, Cordarone, Metoprolol, Paracetamol, PPI s, IV fluids and Supportive measures. She responded well to the above treatment and passed stools 2 days later. INR improved to 3.5 on day 3. Hematuria subsided. She is being discharged in stable condition with advised to attend surgical oncologist. Here our patient is presented with clinical features suggestive of, but radiological features not consistent with intestinal obstruction – making it atypical presentation.



Fig 1:- UGIE study shows sub mucosal hemorrhages with oedematous mucosa.

II. DISCUSSION

Pseudo-obstruction can be Primary or idiopathic and Secondary¹. It present in acute or chronic form. Clinical features are abdominal pain, distension, nausea, vomiting, constipation, or diarrhea and obstipation. It often affects colon more than small intestine and duodenum. It arises from disordered gut motility and is more common in dysmotility states, such as diabetes, amyloidosis, and scleroderma.

Acute colonic pseudo-obstruction, also known as Ogilvie syndrome, most commonly affects the large intestine from the cecum to the splenic flexure. The exact pathophysiology is unknown, but it has been linked to dysregulation of the autonomic nervous system. It is more common in men and patients over the ages of

➤ It is commonly found in hospitalized patients after surgery or after a severe illness. Medications, metabolic imbalances, non-operative trauma, surgery, and cardiac disease have all been associated with intestinal pseudo-obstruction.

Chronic intestinal pseudo-obstruction is a more rare form of pseudo-obstruction. Autoimmune disorders like scleroderma, lupus etc, Porphyria, Disorders that affect nerves like Diabetes, Parkinson's disease, Medications like Opiates, TCAs, Atropine etc, Paraneoplastic syndromes, Radiation treatment and some viral infections like EBV are known to cause Chronic intestinal pseudo-obstruction.

Pseudo-obstruction is diagnosed based on symptoms, clinical findings, and tests to rule out the presence of a mechanical obstruction.⁴

Drug-related pseudo-obstruction remains underreported, but is of importance in modern society where drugs are endemically abused. Thorough evaluation is needed to rule out mechanical obstruction and initial management includes bowel rest, nasogastric decompression, intravenous fluid resuscitation, and treatment of the underlying cause.

Acenocoumarol and the coumarin anticoagulants are structurally similar to vitamin K and competitively inhibit the enzyme vitamin K-epoxide reductase. Hence, they are called vitamin K antagonists.

Oral anticoagulation has become safer in recent years, especially if monitored regularly. Tolerability of acenocoumarol was similar in younger and elderly population (aged >70 years), with acenocoumarol being well-tolerated in both the populations. Caution is required especially in elderly patients to prevent bleeding complications and anticoagulation intensity should be closely monitored to reduce periods of overdosing.³ The INR should be reduced to a safe level (<5) if excessive increase in prothrombin time and/or INR occur without bleeding or prospective surgery. If serious bleeding is present, the INR should be reduced to 1 as soon as possible. If elective surgery or urgent surgery is required, the INR can be reduced to 1 to 1.5 at the time of surgery. INR can be reduced temporarily by withdrawing anticoagulant therapy and, if necessary, administering oral or

parenteral vitamin K. When immediate restoration of clotting factors is necessary for serious overdose or life-threatening bleeding, transfusion of fresh frozen plasma or prothrombin (factor IX) complex concentrate along with vitamin K may be necessary.⁵

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