COCAINE-INDUCED ISCHEMIC COLITIS RESEMBLING ACUTE PANCREATITIS

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CASE REPORT

54-year-old AAF with PMH of pancreatitis, HTN, type 2 DM, blindness 2/2 retinitis pigmentosa and poly-substance abuse (alcohol and cocaine) was brought to the hospital by EMS with complaints of abdominal pain, radiating to the back, vomiting, and weakness. Patient was hypotensive in ED, high AG metabolic acidosis with elevated lactic acid (3.3) and leukocytosis (17,200) was present, Urine was positive for cocaine and alcohol, and she yielded to the use of both approximately 12 hours back. On physical examination, the abdomen was tender with rebound positive but no guarding. Maximum tenderness was appreciated in the left pelvic region. There were elevated amylase and lipase levels (496) and based on her clinical history of recurrent attacks of alcoholic pancreatitis in the past, she was managed for acute pancreatitis. CT abdomen came back negative for any serious intra-abdominal process. Abdominal pain persisted, a fluid-filled structure in the right iliac fossa was found on US abdomen consistent with fluid-filled cecum. The patient was hydrated with normal saline. She was still tachycardic and continued to experience a lot of pain. The patient was started on ciprofloxacin and metrogyl, but due to persistent bandemia and unresolved abdominal pain, it was changed to vancomycin and piperacillin-tazobactam and fresh blood cultures and urine cultures were ordered along with CAT scan abdomen with contrast. CAT scan showed the possibility of colitis ischemic vs infectious. Colonoscopy showed moderately severe ischemic colitis in the proximal half of the colon and mild diverticulosis without inflammation and mild fixation by adhesions without obstruction. Urine cultures came back positive for ESBL E.Coli. Antibiotic treatment was continued and the pain gradually subsided. She was discharged on a course of oral antibiotics and after properly verbalizing the perils of cocaine use and its life threatening consequences.

CONCLUSION

Although cardiovascular complications of cocaine use are quite common, gastrointestinal complications are rare. Some of them are ulcerations, retroperitoneal fibrosis, visceral infarction, intestinal ischemia, and gastrointestinal tract perforation.

There have been a few cases of cocaine-associated colonic ischemia that have been reported in the past.

People with cocaine users tend to develop ischemic colitis faster than the non-cocaine counterparts. Bowel surgery is also five times more frequent and dies six times more from colitis related complications than in people who are not cocaine users.