CASE REPORT
OLGU SUNUMU

Allergic reaction due to the use of infliximab
İnfliksimab kullanımına bağlı gelişen alerjik reaksiyon

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SUMMARY

In our case report, we aimed to describe a patient who was diagnosed with ankylosing spondylitis and developed anaphylactoid reaction after receiving infliximab treatment for the second time (100 mg). A 21-year-old female patient presented to the emergency department (ED) with an allergic reaction after intravenous infliximab administration. It was learned that he received the treatment for the second time (100 mg). It was observed that the general condition of the patient was moderate-poor, Glasgow Coma Scale (GCS) 15, swelling of the tongue and lips and difficulty in breathing. We were informed that he had ankylosing spondylitis and familial Mediterranean fever in his history and that he was using prednol. In laboratory examinations, White Blood Cell (WBC) was 31,26 KµL. The patient was monitored in the ED. Adrenaline, prednol and avil treatment was given. About 2 hours later, the patient's clinical and vital signs improved. After 12 hours of emergency follow-up, he was discharged with recommendations. Infiximab, which is preferred in autoimmune diseases, should be applied carefully in terms of allergic reactions and close follow-up should be planned, even if no side effects are observed in the first application.

Keywords: Allergy, ankylosing spondylitis, infliximab

ÖZET

Olgu sunumumuzda ankilozan spondilit tanısı ile infliximab tedavisinin 2. dozunu aldıktan sonra anafilaktik reaksiyon gelişen hastayı anlatmayı amaçladık. 21 yaşında kadın hasta intravenöz infliksimab alımı sonrası alerjik reaksiyon ile acil servise (AS) başvurdu. Tedaviyi ikinci dozunu aldığı öğrenildi (100 mg). Genel durum orta-kötü, Glaskow Koma Skalası (GKS) 15 olan hastanın dilde ve dudakta şişmesi olduğu ve nefes almakta zorlandığı gözlendi. Özgeçmişinde ankilozan spondilit ve ailevi akdeniz ateşi olduğu ve prednol kullandığı tarafımıza bildirildi. Labaratuvar tetkiklerinde beyaz küre sayısı (WBC) 31,26 KµL idi. Hasta AS'te monitorize edildi. Adrenalin, prednol ve avil tedavisi verildi. Yaklaşık 2 saat sonra hastanın kliniği ve vital bulguları düzeldi. 12 saat acil servis takibinin ardından önerilerle taburcu edildi. Otoimmun hastalıklarda tercih edilen infiksimab, ilk uygulamada yan etki görülmese bile alerjik reaksiyonlar açısından dikkatli uygulanmalı ve yakın takibi planlanmalıdır.

Anahtar kelimeler: Alerji, ankilozan spondilit, infiliksimab

INTRODUCTION

Ankylosing spondylitis is a chronic autoimmune disease that affects the peripheral and axial skeletal system (1,2). Infliximab is a monoclonal antibody that acts anti-TNF by affecting TNF-α (tumor necrosis factor) and is used in ankylosing spondylitis resistant to nonsteroidal anti-inflammatory drugs (2,3). It is also used in many diseases such as psoriasis, crohn, and Behçet disease (1). In our case report, we aimed to describe a patient who was diagnosed with ankylosing spondylitis and developed anaphylactoid reaction after receiving infliximab treatment for the second time.

CASE REPORT

A 21-year-old female patient presented to the emergency department (ED) with an allergic reaction after intravenous infliximab administration. It was learned that he received the treatment for the second time. It was observed that the general condition of the patient was moderate-poor, GCS:15, swelling of the tongue and lips and difficulty in breathing. We were informed that he had ankylosing spondylitis and familial Mediterranean fever in his history and that he was using prednol (methyl prednisolone, 16 mg tb, for 3 months). Blood pressure (BP): 140/80, pulse: 100/minute, saturation: 93%, respiratory rate: 35/minute. In laboratory examinations, WBC: 31,26 KµL, neutrophil 28,58 KµL, hemoglobin: 10,7 g/dl, hematocrit 32,8%, platelet 405 KµL, C- Reactive Protein (CRP) 22 mg/L, and liver and kidney function tests were normal. The patient was monitored in the ED. Adrenaline 0,1 mg intramuscular (im), methyl prednisolone 60 mg intravenous (iv) and pheniramine hydrogen maleate 50 mg iv treatment was given. About 2 hours later, the patient's clinical and vital signs improved. After 12 hours of emergency follow-up, he was discharged with recommendations.

DISCUSSION

Infliximab is preferred in many autoimmune diseases as well as in ankylosing spondylitis. It has been shown that the remission rate will be around 50%-60% when used in combination with naproxen (4,5). Another study explained the remission rate with infliximab treatment as 22%-23% in patients with ankylosing spondylitis (6). In a study by Moreno et al, 36 patients who were in continuous remission after the discontinuation of infliximab treatment developed relapse in the first year (7). In a study conducted in psoriasis patients, it was observed that infliximab brought the disease under control in a shorter time, although it was not statistically significant (8). There may be effects depending on its use and discontinuation. The development of ventricular arrhythmia due to discontinuation of Infliximab in patients with ankylosing spondylitis (2) and pulmonary tuberculosis due to the use of infliximab in Behçet's disease is also among the reports (9). In our patient, no side effects related to the first use were observed, and an allergic reaction developed in the hospital environment.

The fact that it affects the immune system and is a TNF-α agonist suggested that infliximab may also cause allergic reactions. In a study by Matucci et al, they observed a skin test positivity rate of 30% and showed that severe allergic reactions may occur during the first application of infliximab (10). In a study of Crohn's patients, approximately 6% of 165 patients developed an infusion reaction; 1% of these were considered as serious infusion reactions (11,12).

In our patient, symptoms started 15 minutes after infliximab infusion, and since she was in a hospital setting, she was treated effectively and on time.

CONCLUSION

Infiximab, which is preferred in autoimmune diseases, should be applied carefully in terms of allergic reactions and close follow-up should be planned, even if no side effects are observed in the first application.

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