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ALLERGIC REACTION TO GLIBENCLAMIDE IN A POLYMEDICATED DIABETIC PATIENT

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ABSTRACT
A 76-year-old male patient with maculopapular lesions in the abdominopelvic region, of sudden presentation, with a previous diagnosis of diabetes, arterial hypertension, and hypercholesterolemia under treatment with polypharmacy. Initial diagnosis caused by an alimentary allergic reaction is established. Subsequently, it is evaluated in conjunction with the pharmacy service, concluding that the clinical picture corresponds to an allergic reaction due to drug therapy for diabetes control, which is why the intervention is carried out to suspend previous medication and design the treatment equivalence.

KEYWORDS: Diabetes, Glibenclamide, Adverse Reaction.

PRESENTATION OF THE CASE

A 76-year-old male patient, who came to the clinic for presenting edema limited to macular lesions with a predominantly papular pattern, of 3 days of evolution with variegated morphology, of variable size circumscribed to the abdominopelvic region, pruritic with sudden onset. On physical examination, maculopapular lesions with an erythematous background were found, with no evidence of added infection. The patient was oriented in his three spheres, cardiopulmonary without compromise. Upon questioning, he mentions having eaten shrimp in the days prior to the problem. As a personal pathological history, he refers to having presented an allergic reaction to the drugs allopurinol and carbamazepine 4 years ago. He also comments on being a diabetic with 25 years of evolution, treated with glibenclamide, 1 5 mg tablet every 12 hours and metformin, 1 500 mg tablet every 8 hours,[1] as well as hypertensive with the same state of evolution under treatment with captopril, 1 50 mg tablet every 12 hours.[2] He comments presenting symptoms of mild hypercholesterolemia with 6 months of evolution, treated with 1 bezafibrate 200 mg tablet every 24 hours.[3]

Table 1. Initial situation state.

Sex: Men. Age: 76 years BMI: 27.7 (172 cm, 82 Kg) Allergy (+)						
Health problems (HP)						
Start medication	HP	Concern	Control	Active principle	Prescribed regimen	Consumption
25 years	Diabetes Mellitus	Normal	Yes	Glibenclamide 5 mg.	1-0-1	1-0-1
				Metformina500 mg.	1-1-1	1-1-1
25 years	AH*	Normal	Yes	Captopril 50 mg.	1-0-1	1-0-1

6 months	Hypercholesterolemia	Normal	Yes	Bezafibrato 200 mg.	0-0-1	0-0-1
Several days	Allergic reaction	Normal	No	Loratadine 10 mg.	0-0-1	0-0-1
				**Dexamethasone 8 mg (dosis única)	1-0-0	1-0-0
Several days	Self Medication	Little bit	No	Prednisone	0-0-0	0-0-1
* Arterial Hypertension (AH) ** Dosis utilizada en servicio de urgencias.						

EVOLUTION OF THE CASE

Diagnosis of allergic reaction to food is established and treatment is proceeded with Loratadine, 1 tablet of 10 mg every 24 hours for 8 days.

After finishing oral treatment with antihistamines, the patient continued with pruritic symptoms with extension to the back and lower extremities, which is why he went to the emergency department at a public health institution. Where therapy with systemic steroids (dexamethasone 8 mg)[4] was started, observing remission of symptoms, establishing a diagnosis of allergic reaction of undetermined origin, he was discharged with oral antihistamine treatment consisting of Loratadine, 1 oral tablet every 24 hrs for 7 days.[5]

After 7 days of treatment with antihistamine therapy, the patient continued to have an allergic condition with a slight decrease in symptoms, for which reason he was referred to the dermatology service to perform a skin biopsy, which did not yield any relevant data.

FIRST INTERVENTION

In conjunction with the pharmaceutical service, a reassessment and questioning of the patient is carried out, referring to self-medication with 5 mg oral prednisone, with intake of 1 tablet every 24 hours, until the moment of the anamnesis. Steroid withdrawal is carried out gradually in order to avoid withdrawal symptoms that contribute to complicate the observation and evolution of the patient.

SECOND INTERVENTION

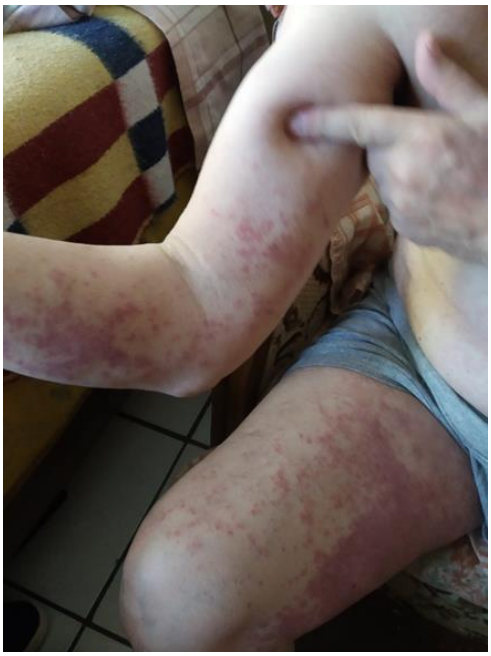
A protocol is started in search of a causal relationship, ruling out possible external allergens. As well as the application of the orange tree algorithm for therapeutics used for chronic degenerative diseases. A score of 6 was obtained, which suggested that glibenclamide was probably responsible for the allergic reaction presented, since the patient mentioned an exacerbation of the allergic condition after taking this medication. A change from glibenclamide to dapagliflozin at a rate of 1 10 mg tablet in the morning[6] was proposed, together with modification of eating habits.

CLINICAL EVOLUTION

The patient continues in subsequent reassessments without presenting initial symptoms and remission of the symptoms.

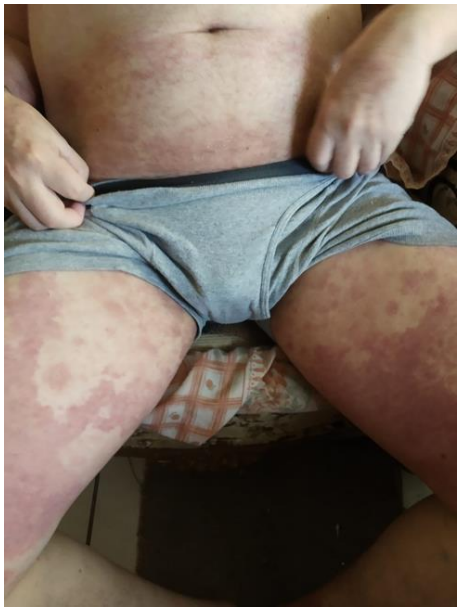
CONCLUSIONS

Adverse reactions to drugs by themselves represent a challenge for all health personnel, even for the patient himself, due to the deep-rooted popular belief that drugs serve to cure, and that they do not cause or could cause a pathological state per se. However, these can be a problem in polymedicated patients with chronic degenerative diseases of long evolution and therapeutic, also complicating the diagnosis and therefore the therapeutic design due to self-medication. For this reason, it is very important to raise awareness and train the entire health team to be attentive to any evidence that could suggest or guide the causal relationship of a picture of this nature, as well as communication and pharmacotherapeutic follow-up by the pharmacist in Close communication with the treating physician.



Source: Own authorship.

Fig. 1: Patient with maculopapular lesions in the upper limbs.



Source: Own authorship.

Fig 2. Patient with maculopapular lesions in the abdominopelvic region.

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