Propofol

S

Propofol infusion syndrome: 3 case reports

In a study, 3 patients (2 women and 1 man) aged 45–69 years were described, who developed propofol infusion syndrome (PRIS) during treatment with propofol for sedation [*dosages and duration of treatments to reactions onset not stated*].

Case 1: A 45‐year‐old woman was admitted to the emergency ICU with renal failure and severe ARDS, 9 days after the onset of COVID‐19 symptoms. At the time of ICU admission, she had been receiving off label treatment with lopinavir and hydroxychloroquine for COVID-19. On admission, off label tocilizumab was added to the regimen. Given the elevated inflammatory markers, she was started on propofol infusion for sedation along with haemodialysis. However, laboratory tests revealed metabolic acidosis, rhabdomyolysis and elevated creatine phosphokinase. Based on these findings, a diagnosis of PRIS was confirmed. She developed elevated levels of amylase and lipase, which were consistent with acute pancreatitis. Therefore, her propofol infusion was stopped. Within 72h of propofol discontinuation, a significant improvement of the serum triglyceride levels, inflammatory biomarkers and acute pancreatitis biomarkers were noted.

Case 2: A 51‐year‐old man was admitted to the emergency ICU with acute renal failure and severe ARDS, 12 days after the onset of COVID‐19 symptoms. At the time of ICU admission, he had been receiving off label treatment with lopinavir and hydroxychloroquine for COVID-19. On admission, off label tocilizumab was added to the regimen. Given the elevated inflammatory markers, he was started on propofol infusion for sedation along with haemodialysis. However, laboratory tests revealed metabolic acidosis, cardiac arrhythmia, rhabdomyolysis and elevated creatine phosphokinase. Based on these findings, a diagnosis of PRIS was confirmed. He also developed elevated levels of amylase and lipase, which were consistent with acute pancreatitis. Therefore, his propofol infusion was stopped. Within 72h of propofol discontinuation, a significant improvement of the serum triglyceride levels, inflammatory biomarkers and acute pancreatitis biomarkers were noted.

Case 3: A 69‐year‐old woman was admitted to the emergency ICU with renal failure and severe ARDS 9 days after the onset of COVID‐19 symptoms. At the time of ICU admission, she had been receiving off label treatment with lopinavir and hydroxychloroquine for COVID-19. On admission, off label tocilizumab was added to the regimen. Given the elevated inflammatory markers, she started receiving propofol infusion for sedation and underwent haemodialysis. However, laboratory tests revealed metabolic acidosis, cardiac arrhythmia, rhabdomyolysis and elevated creatine phosphokinase. Based on these findings, a diagnosis of PRIS was confirmed. She also developed elevated levels of amylase and lipase, which were consistent with acute pancreatitis. Therefore, her propofol infusion was stopped. Within 72h of propofol discontinuation, a significant improvement of the serum triglyceride levels, inflammatory biomarkers and acute pancreatitis biomarkers were noted.

Sharma B. Does use of propofol aggravate the inflammatory markers and cause propofol infusion syndrome (PRIS) in intubated cases of severe COVID-19 infections?. Journal of Medical Virology : 1-4, 9 Nov 2020. Available from: URL: http://doi.org/10.1002/jmv.26657

803519235