

Convalescent-anti-SARS-CoV-2-plasma/enoxaparin-sodium/methylprednisolone

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Various toxicities and off label use: case report

A 57-year-old man developed melaena during treatment with enoxaparin-sodium as a prophylactic, and gastritis with oesophagitis during off label treatment methylprednisolone for Coronavirus disease 2019 (COVID-19). Additionally, he received off label treatment with convalescent-anti-SARS-CoV-2-plasma for COVID-19 with no associated ADR. [not all routes and dosage not stated].

The man had a history of diabetes. He presented to the emergency department with dyspnoea for 1 week. Based on further investigation he was diagnosed with COVID-19 and was intubated. He received off label treatment with IV methylprednisolone 40mg every 8h and fluid resuscitation and pressor. For gastrointestinal prophylaxis, he had been treated with SC enoxaparin-sodium [enoxaparin] dosed per GFR. Additionally, he had been receiving treatment with various medication concomitantly. To maintain the oxygen saturations, he received a fraction of inspired oxygen (FiO₂). Gradual improvement was noted in his condition. Therefore, his pressors were discontinued. On day 7 of hospitalisation, he received convalescent-anti-SARS-CoV-2-plasma [convalescent plasma] therapy. Despite it, moderated diffuse ground-glass opacities and diffuse peribronchial thickening bilaterally was observed. Hence, for 10 days, he received unspecified broad-spectrum antibiotics. Later, the dose of methylprednisolone was weaned off on the day 9 of hospitalisation, and successful extubation was done. On day 18 of hospitalisation, he was discharged to a skilled nursing facility (SNF) due to significant deconditioning of prolonged hospitalisation. Subsequently, he developed melaena approximately after 1 month of discharge due to enoxaparin-sodium, and he was re-admitted. Upon further investigation gastritis and oesophagitis was noted due to prolonged use of methylprednisolone. Further, oesophagogastroduodenoscopy findings showed wide-based ulcers in the distal oesophagus without active bleeding. In the histology, acute oesophageal was observed and in the necrotic areas, *Candida* species were noted. Therefore, he was treated with IV pantoprazole and a unit of packed red cells. Later, IV pantoprazole replaced with oral pantoprazole and fluconazole. His tolerance toward the diet was good without any pain. Subsequently, he developed urinary retention which was cured by Foley catheterisation. On the day 9 of hospitalisation, he was discharged to the SNF. After 3 weeks, he had a urinary tract infection, diarrhoea, *Clostridium difficile* and bilateral lower extremity deep vein thrombosis, due to which he was re-admitted. Later, due to severe protein-calorie malnutrition, it was decided to perform a percutaneous endoscopic gastrostomy tube for enteral nutrition. Thereafter, significant improvement was noted in oesophageal ulceration. During a recent visit, he was found to be positive for COVID-19. Later, he was discharged after significant improvement.

Mustafa NF, et al. Acute oesophageal necrosis in a patient with recent SARS-CoV-2. *BMJ Case Reports* 14: No. 8, 16 Aug 2021. Available from: URL: <http://doi.org/10.1136/bcr-2021-244164>

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