Multiple drugs

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Lack of efficacy and acute renal injury: case report

A 32-year-old man exhibited lack of efficacy during treatment with dexamethasone, oxygen, unspecified analgesics, enoxaparin-sodium, clindamycin, ceftriaxone, azithromycin and vancomycin. Further, he developed acute renal injury during treatment with vancomycin for multiple resistant *Staphylococcus aureus* infection [*not all routes stated; dosages and time to reaction onset not stated*].

The man presented in December 2020 with brown spider (Loxosceles sp.) bite and was diagnosed with loxoscelism. He started receiving dexamethasone, enoxaparin-sodium [enoxaparin], unspecified analgesics, clindamycin, ceftriaxone and azithromycin. Necrosis was noted and debridement was performed after the region of wound necrosis was demarcated with a reduced risk of spreading the effect of the venom. After stabilising the clinical situation, he was referred to a plastic surgeon. On day 6 of hospital stay, multiple resistant *Staphylococcus aureus* was identified in a sputum collection. Therefore, his antibiotic therapy was switched to vancomycin and clindamycin. For the first 15 days of hospital stay, he presented with mild dyspnoea and remained on oxygen support with a nasal catheter at low flow. On day 15 of hospital stay, laboratory tests revealed signs of systemic loxoscelism, exhibiting lack of efficacy with dexamethasone, oxygen, unspecified analgesics, enoxaparin-sodium, clindamycin, ceftriaxone, azithromycin and vancomycin. Increased urea and creatinine levels were also noted, which were indicative of renal alteration.

he man's vancomycin therapy was discontinued on day 26 due to persistent acute renal injury evident with renal alteration, which was associatedwith the systemic use of vancomycin or Brown spider venom intoxication. He was treated with chlorhexidine, collagenase and helianthus [sunflower oil]. On day 25, the labial condition showed clinical improvement with reduction in oedema and remission of the ulcerated and necrotic portions. Subsequently, he developed vomiting, nausea and loss of appetite, which did not improve with medication. On day 28, he experienced an episode of subtle oxygen desaturation and tachypnoea, requiring 6L of oxygen in a mask, and tested positive for SARS-CoV-2. He was immediately transferred to the COVID ICU and required orotracheal intubation due to intense tachypnoea and respiratory distress associated with desaturation. On day 37, improvement in the mouth changes was noticed with remission of the necrotic and ulcerated parts, and plastic surgical reconstruction was recommended. Further, his systemic condition worsened with acute renal failure, sepsis in the lung, soft tissue and bloodstream by multiple resistant *Staphylococcus aureus*, respiratory distress and ventilator-associated pneumonia by positive Burkholderia in orotracheal aspirates. His condition continued to worsen. On day 53, worsening kidney conditions was evident with increased urea and creatinine levels even after three dialysis attempts in the previous days. CRP levels remained high, indicative of a severe infection. Ventilatory parameters were at maximum level. He continued to show a drop in saturation and haemodynamic instability, necessitating a progressive increase in a double-dose unspecified vasoactive therapy. At day 53, he experienced cardio-respiratory arrest and despite receiving rescue measures, he died.

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