Dipyrone/prednisolone/prednisolone sodium succinate

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Acute urticaria and hyperglycaemia: case report

In a retrospective single-case study, an 84-year-old man was described who developed acute urticaria while receiving dipyrone for back pain. Subsequently, he developed hyperglycaemia following treatment with prednisolone and prednisolone sodium succinate for acute urticaria [*routes not stated; not all dosages, duration of treatments to reaction onsets and outcomes stated*].

The man, who had multiple morbidities, was hospitalised due to deteriorating general condition. He reported fatigue and feeling unwell. He complained of general weakness and worsening drowsiness in the last 15 days. He was tired and listless. Prior to that, he had a fever and a dry cough. His fever had been dropping for about 3–4 days prior to admission. He had uncomfortably sore throat and his appetite had decreased. He was dehydrated at the time of admission despite drinking sufficient amounts of fluids. Anamnesis revealed that he had insulin-dependent type 2 diabetes mellitus. His insulin regimen had been adjusted about 5–6 months prior with insulin detemir and insulin glulisine [Apidra]. One week prior to admission, he had consulted a dermatologist for acute urticaria. He had started receiving prednisolone sodium succinate [Solu-Decortin; Natrium; prednisolone-21-succinat] 100mg and dimetinden. The dermatologist had prescribed a cortisone pulse therapy with prednisolone 10mg in the morning for 5 days and cetirizine. One day prior to admission, his blood glucose levels had increased significantly which was attributed to prednisolone and prednisolone sodium succinate. He had hypoglycemia early in the morning and hyperglycemia up to 500–600 mg% during the day. He had noted dyspnoea, even on light exertion, when performing day-to-day activities at home. Upon admission, he also complained about immobilizing knee pain. He had a known chronic pain syndrome with back and joint pain. He had been receiving dipyrone [Novalgin; metamizole] and pregabalin for several years for back pain. He had also been receiving doxepin to calm down and to relieve anxiety. He reported symptoms of an upper respiratory tract infection for about 10 days, which had been treated for 2–3 days with acetylcysteine on an outpatient basis. On the day of admission, he was tested for SARS-CoV-2 RNA on 6 April 2020 which was found to be negative. A second test performed on 7 April 2020 was positive. He started receiving off-label treatment with multivitamin supplements IV calcium chloride/magnesium chloride/malic acid/potassium chloride/sodium acetate/sodium chloride [Sterofundin] and IV ascorbic acid/biotin/cobalamin/colecalciferol/cyanocobalamin/dexpanthenol/flavin mononucleotide/folic acid/niacin/nicotinamide/pantothenic acid/pyridoxine/retinol/riboflavin/thiamine/tocopherol [Cernevit] for COVID-19. He was treated with physiotherapy, daily massage sessions and inhalation therapy with ipratropium bromide and salbutamol. Aconitium was also used. Oxygen therapy was applied due to reduced spontaneous oxygen saturation. Thereafter, his respiratory function stabilized and condition improved.

The man's intensive conventional insulin therapy was optimized with close blood sugar monitoring. Insulin detemir dose was set to 24IU and insulin glulisine was administered with meals at increased doses. He was started on a special dietary regimen. At the time of discharge, his blood sugar levels were found to be at satisfactory range. The acute urticaria was suspected to have caused by dipyrone. Therefore, dipyrone was switched to naproxen. He was also treated with thioctic acid for suspected diabetic polyneuropathy. Thereafter, his pain improved. He was discharged following 8 days of hospitalisation.

Romeyke T, et al. COVID-19 patient with severe comorbidity in multimodal acute care setting with non-invasive medical ventilation: A clinical outcome report. Clinics and Practice 11: 81-91, No. 1, 2021. Available from: URL: http://doi.org/10.3390/clinpract11010013