

Enoxaparin sodium**S****Lack of efficacy: case report**

A 67-year-old man exhibited lack of effectiveness during thromboprophylaxis with enoxaparin sodium.

The man, who had a history of multivessel coronary disease, peripheral arterial disease, diabetes mellitus type 2, hypertension, dyslipidaemia and alcohol dependence, presented to emergency department with viral prodromal symptoms, abdominal cramping and diarrhoea for 5 days on 17 April 2020. His other medications included aspirin, hydrochlorothiazide, lisinopril, amlodipine, metformin, ezetimibe and insulin; however, had not received any medications for 3 weeks due to SARS-CoV-2 restrictions for travel or exposure to sick contacts. On arrival, his vitals signs were noted. Physical examination was unremarkable except for lymphopenia and acute kidney injury. Chest radiograph was consistent with pneumonia, and he started receiving off-label azithromycin, ceftriaxone and hydroxychloroquine along with enoxaparin sodium [enoxaparin; *route and dosage not stated*] for thromboprophylaxis. A nasopharyngeal swab test was performed. His glucose-6-phosphate dehydrogenase levels were noted to be decreased and hydroxychloroquine was discontinued. He remained febrile with increasing oxygen requirements by a high-flow nasal cannula. Repeat chest radiography (CXR) showed multilobar progression suggesting a complete COVID-19 inflammatory panel workup, which revealed elevated interleukin-6 levels confirming a diagnosis of COVID-19 pneumonia. He started receiving off-label lopinavir/ ritonavir and tocilizumab. His fever and tachycardia improved. However on day 7, he experienced hyperactive delirium features including disorientation with incomprehensible speech and rambling, attempt to remove his gown along with concurrent right-sided facial droop with lower and upper extremity flaccidity consistent with stroke.

The man was ineligible for tissue plasminogen activator therapy due to his worsening condition. He received treatment with clopidogrel, aspirin and atorvastatin. He was transferred to a nearby tertiary centre for neurointervention. After the transfer, he developed worsening respiratory failure and required intubation followed by transfer to the intensive care unit. Following extensive imaging studies, SARS CoV-2 induced large vessel occlusions (LVO) including the left internal carotid artery (LICA) and proximal right vertebral artery (RVA) were noted, which had resulted in the massive stroke; additionally, a deep vein thrombosis was also noted. His clinical trajectory worsened with worsening agitation levels, higher ventilator requirements, and multiorgan failure. A request was initiated for extracorporeal membrane oxygenation, however due to poor prognosis, his family decided to transition him to hospice care, where he died on 6 May 2020 [*immediate cause of death not stated*].

Deliwala SS, et al. Acute confusional state as a prognostic sign of COVID-19 large-vessel occlusion (LVO). *BMJ Case Reports* 14: No. 2, 23 Feb 2021. Available from: URL: <http://doi.org/10.1136/bcr-2020-240536>

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