A case of Rifampicin induced pseudomembraneous colitis

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ABSTRACT

We report a case pf pseudomembranous colitis that developed in a patient with tuberculous abdominal lymphadenopathy during treatment with rifampicin. The patient had delayed presentation (3 months) after the start of rifampicin. She had one relapse after 2 months that was successfully treated, and she finished her antituberculosis therapy without any further relapses. Awareness of this serious complication of rifampicin therapy should be encountered.

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Pseudomembraneous colitis (PMC) was first described in the 19th century and has subsequently been recognized with increasing frequency as a serious, sometimes lethal gastrointestinal disease. *Clostridium difficile (C.difficile)* was identified as a cause of antibiotic-associated PMC in 1978.[1] Clostridium difficile is a gram-positive spore-bearing anaerobic bacterium that was initially reported to be a component of the normal intestinal flora of newborn infants by Hall and O'Toole.[2] *Clostridium difficile* associated diarrhea is one of the leading causes of nosocomial enteric infections.[3,4] It can affect as many as 10% of patients hospitalized for more than 2 days.[5] The most common predisposing factor for *C.difficile* colitis is the use of antibiotics such as ampicillin, clindamycin, and cephalosporins. It has not been clearly established following aminoglycoside, sulfonamide and antimicrobial agents whose activity is restricted to fungi, mycobacteria, parasites or viruses.[4,6] Rifampicin is a pivotal antimicrobial in the treatment of tuberculosis; a large number of patients are exposed to its potential adverse effects each year. We are reporting a case of PMC following rifampicin treatment with a long latency period; one relapse and the patient was able to finish her course of anti-tuberculosis therapy successfully.

Case Report. A 43-years-old Saudi female came to our medical outpatient department for further evaluation of abdominal pain. The patient was complaining of epigastric pain for 2 years that was diagnosed as irritable bowel syndrome. The pain became more severe over the last 6 months, it is constricting in nature, radiating to the back, aggravated by spicy food, has no relieving factors and associated with loss of appetite and weight (patient does not know how much). There was no history of vomiting or changing bowel habit. She gave history of menorrhagia of 4 months duration for which she was followed by gynecologist. Her systemic review was irrelevant and apart from history of Bilharzias 15 years ago that was treated, no past history of significance was detected. She is a housewife, married with 3 children, and non-smoker. Her family and allergic history were irrelevant. She was not on any regular medications recently. On examination; she was pale but not jaundice. Her neck, chest and cardiovascular

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