Abstract

Case Diagnosis: 46 year old female with flagyl induced neuropathy

Case Description: This is a 46 year old female patient has presented with neuropathy in her lower extremities for 8 years with failure of other therapy. The patient was prescribed with flagyl which led to peripheral neuropathy. This patient has experienced burning and shooting pain in her lower extremities. When the patient presented to the pain service she was noted to be a 10/10 on the visual analog scale (VAS).

Discussion:

Case Description: This is a 46 year old female patient has had peripheral neuropathy in her lower extremities for 8 years with failure of other therapy. The patient was prescribed with flagyl which led to peripheral neuropathy. This patient has experienced burning and shooting pain in her lower extremities. When the patient presented to the pain service she was noted to be a 10/10 on the visual analog scale (VAS).

Background: The neuropathy has been described to be length dependent polyneuropathy due to stocking gait due to skin denervation after metronidazole-induced neurotoxicity. This can occur with high dose long-term usage of metronidazole. The cumulative neurotoxic dose ranges from 13.2 grams to 228 grams. Duration of therapy after symptoms develop ranges from 11 days to 6 months. One case report showed a 3 day latency between starting metronidazole and developing symptoms.9

Methods: The patient was placed on a 21 day comprehensive interdisciplinary pain management program which included physical therapy, psychology, biofeedback, and pain education. The patient was taught how to use various pain management techniques including neuromobilization, breathing, guided imagery. An objective tool used for pain program patients is the Marianjoy Pain Functional Assessment.

Results:

Patient's pain behavior assessment improved from 7.5 to 3.5.

Patient's pain level dropped from 8 to 5 on the visual analogue scale.

Patient improved lifting above waist to eye level by 5 lbs.

Patient also learned techniques including neuromobilization, breathing, desensitization.

Patient learned “flare up drills” to manage the autonomic dysfunction. She was also offered biofeedback.

Initially, she was found to have autonomic dysfunction to stress response in that her pain level would increase by 10/10, she became pale, nauseous, and had body temperature differences in the lower verses upper extremities. Eventually the patient learned how to manage this response with the combination of Butrans and tools used in the pain program to take control of her pain.

Conclusion:

This patient had vascular dysregulation early on in the program creating one area that made therapy difficult. Fortunately, the team was able to manage the autonomic dysregulation. She was also offered biofeedback.

Patient also received techniques including neuromobilization, breathing, guided imagery.

Before initiating the pain program, the patient had been prescribed Norco 10/325mg bid but would run out two weeks early. She would also report waking up at night with pain and requiring Norco to fall asleep. After being placed in the pain program, she would take Butrans qid and would run out two weeks early. Patient also learned how to use techniques such as breathing, neuromobilization to help manage her pain.

References:


