A young man presenting with pleural effusion: presumably due to acute pancreatitis from sodium valproate

MCB Galahitiyawa¹, JDVC Lekamwasam², RMSK Ratnayake³, P Manivannan¹, MRP Weerawansa¹
¹Registrar in Medicine, ²Consultant Physician, ³Senior Registrar in Medicine, Karapitiya Teaching Hospital, Galle.

A 24 year old patient with seizure disorder and mental subnormality since birth, presented with left hypochondrial pain, shortness of breath, cough and left sided pleuritic type chest pain of two weeks duration. He had no fever, but was anorexic during this illness. Patient had been taking phenobarbitone 60 mg bid and phenytoin sodium 100 mg bid for 23 years and sodium valproate 400 mg bid had been added to achieve a better control of seizures 2 months ago. The last convulsion was 2 months ago and there was no history of recent fall or trauma to the chest.

On admission patient was afebrile, dyspnœic, and emaciated. There was a left sided pleural effusion involving the lower and middle zones while the right hypochondrium was mildly tender. Except for ESR of 40 mm, initial investigations including full blood count, blood picture, urinalysis, blood urea, serum creatinine and clotting profile were normal. Sputum was negative for AFB and malignant cells while Mantoux test was negative. Pleural aspiration was uniformly blood stained and the possibility of acute pancreatitis was considered. CT of the abdomen showed enlarged and oedematous pancreas. His serum amylase was found to be high which confirmed the diagnosis of acute pancreatitis. Pleural fluid amylase was also found to be high.

Although rare, acute pancreatitis has been reported with the long term use of sodium valproate [1,2]. The clinical features of acute pancreatitis were subtle in our patient and major attention was paid to the moderately large pleural effusion. Blood stained pleural effusion always raise the possibility of either primary or secondary malignant diseases. However among other well recognised causes of blood stained effusion such as uremia and recent trauma, the possibility of acute pancreatitis should always be considered. When this occurs, one would expect clinical features of acute pancreatitis to be obvious but subtle clinical features made the diagnosis difficult in our patient. One may argue that the incrimination of sodium valproate as the aetiological cause of effusion is not justifiable without reintroducing the drug to see the recurrence of the effusion. This was not done as we considered it to be unethical.

References