**An Undeclared Medications: The Hidden Enemies**

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**Abstract**

Every case is unique and needs to be dealt with as such. Internal Medicine specialists must cultivate the habit of being extremely inquisitive and inherently suspicious to be able to arrive at the correct diagnosis. Here we present a case that suggested a particular disorder but went to be something totally different altogether. This underlines just how important eliciting history is.

**Introduction**

Every case is unique and needs to be dealt with as such. Internal Medicine specialists must cultivate the habit of being extremely inquisitive and inherently suspicious so as to be able to arrive at the correct diagnosis. Here we present a case that suggested a particular disorder but went to be something totally different altogether. This underlines just how important eliciting drug history is and that traditional or ayurveda medications are not as benign as they are thought to be [1-2].

**Case presentation**

A 39-year-old female was admitted to Apollo Hospital with severe abdominal pain with 3-4 episodes of vomiting and very poor oral intake. The pain had been present for many days but had acutely worsened in the last few hours. It was localized predominantly in para-umbilical areas and did not subside with PPIs, antispasmodics, etc. On detailed
questioning, she reported severe body aches, joint pains, fatigue, and weakness for many months, but denied NSAID/analgesics abuse. There was no other significant medical history.

Clinical evaluation
She was clearly distressed because of the pain. The vitals were normal. Epigastric and para umbilical tenderness+, Pallor++, Mild dehydration+. There was mild pain/discomfort on passive movements of knees/shoulders with areas of tenderness present diffusely all over the body.

Clinical diagnosis
Fibromyalgia, anaemia, and gastritis though seemed out of proportion to the clinical scenario.

Investigations
CBC revealed anemia (normocytic/normochromic) (Table 1). The rest of the tests were all normal. In view of severe retching with abdominal pain and stools for occult blood being positive, Oesophagastroduodenoscopy (OGD) was done, which revealed pan gastritis without *H. pylori* (Figure 1).

![Contrast-enhanced computerized tomography of the abdomen and pelvis](https://erwejournal.com/)

**Figure 1:** Contrast-enhanced computerized tomography of the abdomen and pelvis

Treatment
In view of the pan gastritis on scopy, Pantoprazole infusion was given along with antispasmodics, levosulperide, IV B-complex, Vit D, and IV fluids.
Table 1: Evaluation of laboratory parameters

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemoglobin</td>
<td>10.6</td>
</tr>
<tr>
<td>WBC platelet</td>
<td>275000</td>
</tr>
<tr>
<td>Creatinine</td>
<td>0.93</td>
</tr>
<tr>
<td>Sodium</td>
<td>136</td>
</tr>
<tr>
<td>Potassium</td>
<td>4.5</td>
</tr>
<tr>
<td>SGOT/SGPT</td>
<td>33, 30</td>
</tr>
<tr>
<td>Serum amylase</td>
<td>54</td>
</tr>
<tr>
<td>Serum lipase</td>
<td>104</td>
</tr>
<tr>
<td>TSH</td>
<td>6.78</td>
</tr>
<tr>
<td>Serum iron/TIBC</td>
<td>103, 207</td>
</tr>
<tr>
<td>Anti-CCP antibody</td>
<td>Negative</td>
</tr>
<tr>
<td>RA factor</td>
<td>Negative</td>
</tr>
<tr>
<td>Urine for porphoria</td>
<td>Negative</td>
</tr>
</tbody>
</table>

Thinking out of the box

Something wasn’t quite fitting the picture right from the beginning. Hence, detailed history was taken again and again. Finally, in the third session, it occurred to her that she had indeed taken some Ayurvedic medications for her vague and persistent body aches. She had been assured by her ayurvedic vaidya that these were traditional time-tested medications with NO possible side effects. Putting her abdominal pain + anemia + h/o ayurvedic drugs together, we had thought of lead toxicity [3] and had sent serum lead levels on the first day itself. The results took three days to come in. Meanwhile, the above approach has been initiated. The lead levels were found to be extremely high, clinching the diagnosis. Unfortunately, the tablets/powder that she’d been consuming weren’t available for chemical analysis.

Final diagnosis

Lead toxicity following ingestion of ayurvedic products causes abdominal distress and anemia.

Course of events

She had been taking these products for a long time hence recovery was expected to be slow. After being explained the etiology and favorable prognosis, she felt relaxed and reassured. We considered chelating agents, but by then she had already started signs of recovery on mere discontinuation of offending agents. Hence, we chose to wait and watch. She had started eating comfortably by then and was free of abdominal pain. She was discharged and told to follow up on an OPD basis.
She has been put on a pregabalin + amitriptyline combination for her fibromyalgia and has been doing very well and is totally asymptomatic, OFF analgesics. Her Hb has risen nicely from 10.6 to 12.7 (June 2023) (Table 2). Her serum lead levels have been falling consistently and gradually approaching normalcy - albeit a bit sluggishly, but surely.

### Table 2: Serum lead levels

<table>
<thead>
<tr>
<th>Date</th>
<th>Lead levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.10.22</td>
<td>59.5</td>
</tr>
<tr>
<td>12.11.22</td>
<td>67</td>
</tr>
<tr>
<td>18.12.22</td>
<td>53.83</td>
</tr>
<tr>
<td>9.3.23</td>
<td>29.66</td>
</tr>
<tr>
<td>7.6.23</td>
<td>13.57</td>
</tr>
</tbody>
</table>

**Discussion**

Unfortunately, the diagnosis of heavy metal poisoning is not thought of as much as it should, especially in the background of the consumption of alternative medicine. Symptoms of lead toxicity can be extremely vague and nonspecific, and a high index of suspicion must be maintained. Abdominal colic, constipation, fatigue, headache, irritability, etc. are common manifestations [4]. Motor peripheral neuropathy is seen less frequently. Lead is stored in the blood (2%) and in bone and dentine (95%) [5]. Hence, Lead levels may remain elevated for YEARS even after cessation. This is also probably why her lead levels rose and then fell subsequently [6].

Treatment includes prevention of further exposure, decontamination, and chelation. Iron and calcium intake retards further absorption of lead. Vitamin C aids the excretion of lead from the kidneys [7-10].

Our patient was quite comfortable, and her lead levels were not more than 80 hence, not considered for chelation with DMSA (Succimer) /D-penicillamine/ EDTA. Besides, the availability of succimer in India is always a problem.

**Conclusion**

There is no substitute for an accurate and detailed history. Most hidden enemies are uncovered by patient history and clinical acumen rather than machines/software. Traditional/ayurvedic medications are not as harmless as generally perceived by lay people. There are indeed no free lunches in life. If one wants effects, side effects must be accepted. Chelating agents may be used later (if need be), especially when there is definite clinical improvement.
Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his/her consent for his/her images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Conflict of Interest: Nil

Financial Disclosure: None

References