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A Case of Paroxetine-Induced Lower Gastrointestinal Bleeding: A Multifaceted Approach to Healing

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Abstract

Selective Serotonin Reuptake Inhibitors (SSRIs) are a mainstay treatment for panic disorder, however a potential link to Lower Gastrointestinal Bleeding (LGIB), particularly with Paroxetine, is unknown. We present a rare case of LGIB possibly caused by Paroxetine in a 35-year-old female with panic disorder. LGIB resolved after SSRI cessation, implying a possible causative relationship. We conducted a thorough clinical evaluation, including medical history, medication review, and endoscopic investigations. The patient complained of hematochezia, dizziness, and shortness of breath, which coincided with the start of Paroxetine for panic disorder. A colonoscopy indicated non-specific colitis, while an upper GI endoscopy revealed no abnormalities. LGIB resolved within a week of discontinuing Paroxetine, with no recurrence during following follow-up. This example adds to the little evidence pointing to a possible link between Paroxetine and LGIB in panic disorder. More research is required to understand the underlying mechanisms and confirm causality. While initially mysterious, this case eventually revealed the complicated connection between mental health, medicine, and physical manifestations. It emphasized the significance of alertness in monitoring potential side effects, the efficacy of alternative therapies such as CBT, and the importance of patient awareness in managing complex medical problems.

Introduction

Panic disorder, which is defined by recurring and unexpected panic attacks, has a considerable negative influence on quality of life [1]. Selective Serotonin Reuptake Inhibitors (SSRIs) have become standard treatment, providing significant alleviation [2]. However, a potential adverse effect, an increased risk of Gastrointestinal (GI) bleeding [3], puts a shadow on their success. While upper GI bleeding with SSRIs has received a lot of attention, Lower GI Bleeding (LGIB) is still relatively unknown, especially in the setting of panic disorder and specific SSRIs like Paroxetine. This case study digs into this uncharted terrain, giving light on the probable link between Paroxetine and LGIB in a panic disorder patient.

Recent research reveals that SSRIs cause a small but concerning increase in GI bleeding. Research indicated that SSRI users had 3.6 times higher than expected increased risk of serious bleeding, especially GI bleeding [4]. Furthermore, research found a dose-dependent increase in the risk of upper GI hemorrhage, emphasizing the importance of careful dosing and monitoring [5].

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Despite this known association, LGIB as a specific side effect of SSRIs has received little attention. Two case studies showed LGIB while using SSRIs, implying a possible link beyond upper GI bleeding [6]. However, due to a dearth of data and controlled trials, clear results are elusive. Panic disorder can manifest with GI symptoms, further complicating matters. In such circumstances, disentangling the contribution of SSRIs from the underlying mental health issue becomes critical.

This case report attempts to add to existing knowledge by providing a rare incidence of LGIB likely related with Paroxetine in a panic disorder patient. We intend to shed light on this under-explored area and inform future research in this subject by rigorously studying the clinical presentation, medication history, and risk factors.

Case presentation

A 37-year-old housewife with panic disorder who had been stable on Paroxetine for 4 months presented with a sudden and frightening incident of lower gastrointestinal bleeding. This horrifying occurrence was highlighted by fresh blood and big clots, in stark contrast to her prior improvement. Her panic attacks had disappeared prior to this incident, replaced by peaceful days and restful nights.

Investigations at the emergency department found a reduction in hemoglobin, indicating internal bleeding. Nonetheless, regular testing such as coagulation profiles and platelet counts remained within normal limits. The baffling lack of an obvious perpetrator heightened the worry.

An active bleeding ulcer around 10 cm from the anal margin was ultimately detected by a combined digital rectal examination and rigid proctoscopy. Rapid action was taken. Blood transfusions were given, and the gastrointestinal team rushed to get her ready for sigmoidoscopy and maybe colonoscopy. However, the initial technique produced only limited results. Clotted blood concealed the colon, making a definitive diagnosis impossible. With hemoglobin levels dropping even further, the medical team decided to perform a second look colonoscopy and an abdominal CT scan. This time, the second look colonoscopy revealed the true problem - a big, deep rectal ulcer.

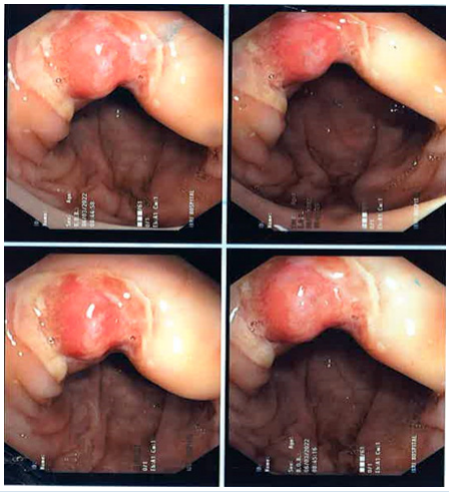

Figure A: Combined Digital Rectal Examination (DRE) with rigid proctoscopy revealed a source of active bleeding about 10 cm from anal verge during SSRIs administration.

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But the story wasn't only about the physical condition. When the clinical pharmacist noticed the unusual bleeding, he suspected that Paroxetine was a problem. This prompted an important decision: To cease the medicine and implement alternate management measures.

Cognitive Behavioral Therapy (CBT) stepped in, replacing drug reliance with an emphasis on self-management skills. The patient's mood improved throughout the course of three appointments. Energy levels increased, tranquility returned, and, most crucially, she became conscious of her former reliance on drugs. Not only had the rectal bleeding ceased at the end of the month, but the patient's hemoglobin levels had returned to normal. A third sigmoidoscopy confirmed that the ulcer had healed completely.

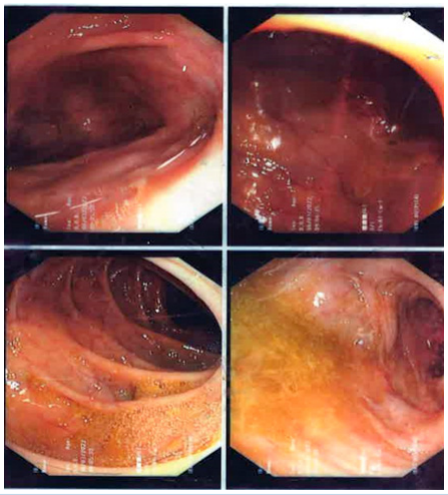

Figure B: Combined Digital Rectal Examination (DRE) with rigid proctoscopy revealed a source of active bleeding about 10 cm from anal verge when SSRIs administration was terminated.

Discussion

This case study emphasizes the possibility of atypical side effects related with Paroxetine treatment, even in seemingly stable patients. While upper gastrointestinal bleeding is more typically associated with SSRIs [7], our case highlights the likelihood of Lower Gastrointestinal (LGIB) problems as well.

The absence of recognizable coagulopathies or pre-existing gastrointestinal pathology adds weight to the drug-induced etiology concept. This is consistent with previous research indicating a relationship between SSRI usage and platelet serotonin depletion, which is required for platelet aggregation and hemostasis [8].

The quick withdrawal of Paroxetine and the implementation of alternate management techniques, including CBT, were critical in attaining symptom resolution as well as psychological empowerment. This is consistent with suggestions to prioritize non-pharmacological therapies in cases of mild to moderate anxiety [9].

However, more study is needed to determine the exact mechanisms behind SSRI-associated LGIB and to identify risk factors for such events. Larger cohort studies and meta-analyses could shed light on the prevalence and specific manifestations of this possible negative influence.

Furthermore, in circumstances where SSRIs are deemed required, investigating alternate serotonergic drugs with fewer gastrointestinal bleeding risks may be advantageous. Escitalopram, citalopram, and fluoxetine are potential alternatives be-

cause they have been shown to reduce the risk of upper gastrointestinal problems [10].

Conclusion

To conclude, this instance emphasizes the necessity of being on the lookout for unusual side effects related with Paroxetine, notably LGIB. Prompt recognition and withdrawal of the medicine, together with other therapeutic approaches, can result in good physical and psychological consequences. More research is needed to better understand the underlying mechanisms and risk factors related with this uncommon but potentially life-threatening condition.

Authors' Contribution: Bushra Hamed Al Jassasi managed the case in collaboration with Mohammed Abdullah Al Shuhoumi. Bushra Hamed Al Jassasi collected the data and drafted the manuscript. Mohammed Abdullah Al Shuhoumi revised and edited the manuscript. All authors approved the final version of the manuscript. Minimal part of the work was presented in an international conference (MDSC https://mdsc.website/) and part of the abstract was published as conference proceedings [11].

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