Case Report: Recurrent Disseminated Intravascular Coagulation Caused by Intermittent Dosing of Rifampin

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Abstract. Daily rifampin therapy is associated with minimal adverse effects, but administration on an intermittent or interrupted basis has been associated with severe immunoallergic reactions such as hemolytic anemia, acute renal failure, and disseminated intravascular coagulation. We describe a patient with Mycobacterium leprae infection who experienced recurrent episodes of disseminated intravascular coagulation after intermittent exposures to rifampin, and review eight previously reported cases of rifampin-associated disseminated intravascular coagulation. In six (75%) cases, previous exposure to rifampin was reported and seven (87.5%) patients were receiving the medication on an intermittent or interrupted basis. Clinical features of rifampin-associated disseminated intravascular coagulation included fever, hypotension, abdominal pain, and vomiting within hours of ingestion. Average time to reaction was 3–6 doses if rifampin was being administered on a monthly schedule. Three (37.5%) of eight reported cases were fatal. A complete history of previous exposure to rifampin is recommended before intermittent therapy with this medication.

CASE REPORT

A 66-year-old woman was hospitalized in July 2009 after acute onset of fever, nausea, and vomiting. Her medical history was significant for lepromatous leprosy diagnosed at age 19, for which she had received multiple courses of therapy that included dapsone, rifampin, clofazimine, and thalidomide. Her leprosy remained quiescent on monotherapy with dapsone from 1986 until November 2008. At that time, she was started on the World Health Organization multidrug treatment regimen for leprosy that included ofloxacin, 300 mg orally/day; dapsone, 100 mg orally/day; and rifampin, 600 mg orally/month to alleviate the need for lifetime monotherapy with dapsone. Minocycline, 50 mg orally/day was substituted for ofloxacin after development of diarrhea. Other medical history included pulmonary tuberculosis diagnosed at age 37 that was treated with multidrug therapy including rifampin, cirrhosis secondary to hepatitis B virus infection for which she was receiving lamivudine, papillary thyroid cancer, bipolar affective disorder, and type II diabetes mellitus.

On July 21, 2009, she ingested her ninth monthly dose of rifampin as part of her intermittent dosing regimen. Within three hours, she experienced sudden onset of fever, nausea, and hematemesis and came to the Emergency Department. On examination, her blood pressure was 81/38 mm of Hg, her heart rate was 130/minute, and her temperature was 39.0°C. She was icteric. There was bleeding from the nares, oral cavity, urinary tract, and venipuncture sites. There was mild tenderness to palpation of the abdomen.

Laboratory investigations obtained within 12 hours of admission were compatible with disseminated intravascular coagulation (DIC): international normalized ratio = 3.33 (reference = 0.8–1.2); prothrombin time = 80 seconds (reference = 26–28 seconds); fibrinogen < 1.5 g/L (reference = 1.5–3.50 g/L), and D-dimers > 4,000 μg/L (reference = < 250 μg/L) and with intravascular hemolysis; hemoglobin = 89 g/L (reference = 120–160 g/L); bilirubin = 6.8 mg/dL (reference = < 1.3 mg/dL), and lactate dehydrogenase = 1,317 U/L (reference = 125–243 U/L). The serum creatinine level was 2.9 mg/dL (reference = 0.6–1.1 μmol/L). Abdominal ultrasound showed trace free fluid adjacent to the gallbladder.

Her hypotension responded to two liters of intravenous normal saline. Pantoprazole was infused, and empiric antimicrobial therapy with piperacillin/tazobactam was initiated for a suspected intra-abdominal focus of infection. She required transfusion of two units of fresh-frozen plasma, 10 units of cryoprecipitate, and 2 units of packed erythrocytes to correct her hematologic abnormalities. Within 24 hours of presentation, she was afebrile, hemodynamically stable, and had laboratory evidence of resolving DIC. Blood cultures obtained on admission were negative. Gastroscopy showed antral gastritis and mild duodenitis without evidence of varices.

Because of the temporal relationship between the ingestion of rifampin and her acute illness, further history was obtained. Three months earlier on April 19, 2009 after her sixth monthly dose of rifampin, she had abrupt onset of nausea and oliguria. Outpatient laboratory investigations showed evidence of acute kidney injury and a decrease in hemoglobin concentration from baseline. Urinalysis showed heme-granular casts. Although a cause was not identified, the laboratory abnormalities resolved without need for therapeutic intervention. One month later on May 17, 2009, after her seventh monthly dose of rifampin, she was hospitalized with fever, abdominal pain, and anuria. Laboratory investigations showed acute and chronic kidney injury and laboratory abnormalities compatible with DIC with intravascular hemolysis. An infectious etiology was not identified. A renal biopsy showed acute tubular necrosis. She recovered after receiving blood product support and temporary hemodialysis. One month later on June 19, 2009, immediately after her eighth monthly dose of rifampin, she was hospitalized with a repeat diagnosis of DIC and anuric renal failure requiring re-initiation of hemodialysis. A precipitant was not identified, and she again recovered. Laboratory abnormalities associated with her four presentations are shown in Figure 1.

Serologic investigations performed within 48 hours of the ninth monthly intermittent dose of rifampin in July 2009 showed that she was blood group B+, erythrocyte antibody screen negative, and direct antiglobulin test negative. However,
testing of her serum against rifampin-treated erythrocytes showed a rifampin-dependent antibody that was not reactive with rifampin metabolites or dapsone.1

DISCUSSION

Rifampin is most commonly used in the treatment of mycobacterial infections in which it is given as part of multidrug therapy. It may be administered on a daily basis or on an intermittent dosing schedule. Adverse effects of rifampin, when administered on a daily basis, include IgE-mediated allergic reactions, rash, minor gastrointestinal upset, hepatotoxicity, and clinically important drug-drug interactions.2 Rifampin is currently recommended as part of the World Health Organization multidrug treatment for Mycobacterium leprae infection, in which it is given on a once per month schedule in combination with dapsone and clofazimine.3 Rifampin administered on an intermittent or interrupted schedule can produce distinct and severe adverse effects known as immunoallergic reactions, rash, minor gastrointestinal upset, hepatotoxicity, and clinically important drug-drug interactions.4

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Rifampin is believed to result from antibody-mediated complement activation, which is triggered by circulating rifampin-erythrocyte complexes, resulting in erythrocyte destruction. Exposure of the circulation to erythrocyte constituents results in activation of the coagulation

![Figure 1. Time plots for trends in laboratory parameters over four episodes of immunoallergic reactions to rifampin in a 66-year-old woman for A, hemoglobin concentration; B, platelet count; C, creatinine; D, prothrombin time; E, international normalized ratio; and F, fibrinogen levels. Black arrows indicate times of ingestion of rifampin.](image-url)
Table 1. Nine cases of disseminated intravascular coagulation associated with rifampin therapy

| Case no./reference | Age, y/sex | Indication for rifampin | Rifampin dosage | Concurrent antimicrobial medications | Time to development of DIC | Outcome
<table>
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<tbody>
<tr>
<td>1/Brasil et al.</td>
<td>10 NA/M</td>
<td>Leprosy</td>
<td>600 mg/month</td>
<td>Clofazimine, dapsone</td>
<td>Third dose</td>
<td>Death</td>
</tr>
<tr>
<td>2/Denis and others</td>
<td>48/F</td>
<td>Pulmonary tuberculosis</td>
<td>600 mg/day</td>
<td>NA</td>
<td>5 months including many treatment interruptions</td>
<td>Recovery</td>
</tr>
<tr>
<td>3/Fujita and others</td>
<td>43/M</td>
<td>Pulmonary tuberculosis</td>
<td>450 mg/day</td>
<td>Isoniazid, streptomycin</td>
<td>7 days</td>
<td>Recovery</td>
</tr>
<tr>
<td>4/Ip and others</td>
<td>29/F</td>
<td>Pulmonary tuberculosis</td>
<td>600 mg, three times a week</td>
<td>NA</td>
<td>First dose</td>
<td>Recovery</td>
</tr>
<tr>
<td>5/Luzzati and others</td>
<td>35/M</td>
<td>Pulmonary tuberculosis</td>
<td>450 mg/day</td>
<td>Isoniazid, pyrazinamide, ethambutol</td>
<td>450 mg/day, three times a week</td>
<td>Recovery</td>
</tr>
<tr>
<td>6/Namisato and Ogawa</td>
<td>64/M</td>
<td>Leprosy</td>
<td>600 mg/month</td>
<td>NA</td>
<td>Third dose</td>
<td>Recovery</td>
</tr>
<tr>
<td>7/Nowicka and others</td>
<td>53/F</td>
<td>Leprosy</td>
<td>450 mg/day</td>
<td>NA</td>
<td>Third dose</td>
<td>Recovery</td>
</tr>
<tr>
<td>8/Souza and others</td>
<td>46/F</td>
<td>Leprosy</td>
<td>600 mg/month</td>
<td>NA</td>
<td>Sixth dose</td>
<td>Recovery</td>
</tr>
<tr>
<td>9/Present report</td>
<td>66/F</td>
<td>Leprosy</td>
<td>600 mg/month</td>
<td>Dapsone, minocycline</td>
<td>Sixth dose</td>
<td>Recovery</td>
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DIC = disseminated intravascular coagulation; NA = not available.

Three (37.5%) patients died. 

We add to the literature the case of a patient with remote exposure to rifampin for the treatment of pulmonary tuberculosis and *M. leprae* infection in whom recurrent episodes of DIC and hemolytic anemia developed as a complication of intermittent rifampin therapy for treatment of leprosy. The patient’s first immunoallergic reaction, resulting in acute renal failure, occurred immediately after ingestion of her sixth dose of rifampin. In the three subsequent presentations with DIC, broad-spectrum antibiotics were prescribed for suspected sepsis. Confirmation of rifampin as the trigger for DIC was made on the third presentation for DIC by identification of rifampin-dependent antibodies in her serum. This patient and others reported in the literature demonstrate that clinical and laboratory features cannot reliably distinguish between cases of rifampin-associated DIC and cases of DIC secondary to other causes.

In the case presented, temporal association of episodes of DIC with rifampin administration, recurrent reactions with repeat drug exposure, the absence of further episodes of DIC after discontinuation of rifampin, and presence of rifampin-dependent antibodies confirm the causal role of rifampin in this patient’s recurrent episodes of DIC. Clinicians must be aware of the presentations of severe immunoallergic reactions to rifampin, which can appear during intermittent therapy, particularly if prior exposure to rifampin has occurred. A detailed drug history is paramount to making this diagnosis. In patients experiencing immunoallergic reactions to rifampin, this medication must be permanently discontinued because these reactions may be fatal. Daily administration of rifampin, as currently recommended in the United States for the multidrug therapy of leprosy, appears to be safer from an immunologic standpoint.

Received September 23, 2011. Accepted for publication November 8, 2011.

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REFERENCES


