

# Amphotericin B Induced Anaphylactic Reaction and Electrolyte Imbalance: A Case Report

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## ABSTRACT

Amphotericin B, a polyene antifungal antibiotic derived from a strain of *Streptomyces nodosus*. It acts by binding to sterols in the cell membrane of susceptible fungi, with a resultant change in the permeability of the membrane. Amphotericin B can cause allergic reactions, electrolyte imbalance and severe side effects, such as chest discomfort accompanied by dyspnea, flushing, agitation, tachypnea, tachycardia, hypoxemia, hypotension, or hypertension, are likely to develop following the injection of Amphotericin B. Anaphylaxis, cardiac toxicity and respiratory failure have also been associated to different formulations of Amphotericin B as life-threatening acute events. This case report is on a 57-year-old male patient who was admitted with a condition of left diabetic foot with non-healing medial supra heel ulcer and fungal infection on the site of wound. The patient was given Amphotericin B in emulsion form due to the high priority of fungal infection and the need for antifungal medicine, which led to anaphylactic reaction and electrolyte imbalance, which were treated immediately and the same preparation was continued with a low infusion rate. When infusion is discontinued, antihistamines can assist to alleviate the symptoms. In this case, it is recommended that the patient's condition and clinical parameters should be closely followed after the medicine has been administered.

**Keywords:** *Streptomyces nodosus*, Diabetic foot, Dyspnea, Tachycardia

## 1. INTRODUCTION

Amphotericin B is a polyene macrolide antibiotic produced from *Streptomyces nodosus*, a type of actinomycete. Of the 200 known polyene agents, Amphotericin B is the only one with toxicities that are sufficiently limited to permit intravenous administration [1]. Amphotericin B is one of the oldest and most efficient antimycotic agents, however, its usefulness is limited due to dose-dependent side-effects, notably nephrotoxicity [2]. Newer formulations of Amphotericin B (AmB) complexed with liposomes or lipid emulsions have been developed. AmB in Intralipid (IL) has been shown in preliminary studies to be as effective as conventional AmB formulations while being less toxic, but there are few data on its stability, compatibility, or in vitro antifungal activity [3].

Amphotericin B has broad spectrum and has remained the drug of choice for life-threatening invasive fungal infections [4]. The mechanism of action of the binding of the AmB molecule to the ergosterol in the fungal cell membrane, forming an aggregation that generates a transmembrane channel, enabling cytoplasmic contents to flow out, resulting in cell death [5] and it causes oxidative stress in the cells. Moreover, Amphotericin B modulates the immune system, and this activity has been

related to the protective effect of the molecule, but also to its toxicity in the host [6].

**Antifungal treatment with** Amphotericin B is the gold standard for the most severe mycoses. However, side effects are widespread, with nephrotoxicity being the most dangerous, appearing early in treatment and usually reversible in the majority of individuals. Acute renal failure is the most significant complication of Amphotericin B therapy. Tubular damage is a well-known concern related with the drug[7]. Male gender, greater average daily dose of AmB (35 mg/day), diuretic use, body weight 90 kg, simultaneous use of nephrotoxic medications, and impaired baseline renal function are all risk factors for AmB nephrotoxicity.

**Severe adverse reactions such as Nephrotoxicity, Chest discomfort accompanied by dyspnea, flushing, agitation, tachypnea, tachycardia, hypoxemia, hypotension, or hypertension** likely to occur after the administration of Amphotericin B [8]. Currently, three lipid Liposomal Amphotericin B (AmBisome, NeXstar Pharmaceuticals/Fujisawa, San Dimas, CA), Amphotericin B colloidal dispersion (ABCD, Amphocil, Sequus Pharmaceuticals, Menlo Park, CA), and Amphotericin B lipid complex are commercially available formulations (ABLC, Abelcet, Liposome Company, Princeton, NJ). Although these novel formulations are safer than the parent medicine amphotericin B deoxycholate, they are quite expensive, and data on their enhanced efficacy in treating systemic fungal infections is still lacking [9].

Other reported life-threatening acute reactions associated with the different formulations of Amphotericin B are anaphylaxis, cardiac toxicity, respiratory failure and electrolyte imbalance [10]. The antihistamines can help to relieve the symptoms that occur quickly after the infusion is stopped. In **this case**, anaphylactic reactions and electrolyte imbalance were induced by the drug and which is corrected immediately and resumed with the same preparation with a slow infusion rate. Here report a clinical observation of Amphotericin B induced anaphylactic reaction and electrolyte imbalance.

## 2. CASE PRESENTATION

A 57-year-old male patient was admitted with a condition of sustained accidental burning wood had fallen on his left foot about a month ago and developed a bleb in the area that he had poked with a safety pin, he had been working in a farm, and subsequently developed an infection and was taken to a local hospital. Tab. linezolid and Tab. Clindamycin was given and debridement was performed. On 06/09/2021, the patient was transferred to this hospital with a swelling and blackish discoloration after being treated at another hospital with injections of piperacillin and tazobactam and injection metronidazole. His medical history revealed that he had Type 2 diabetes for the previous 15 years, had diabetic foot care, and had recently been diagnosed with systemic hypertension. On local examination, a 4x3cm non-healing lesion was discovered, and an x-ray of the left foot was performed. On 7<sup>th</sup> September 21, the left foot was debridement once more. On the left medial supra heel region, fungal-like elements were seen on the surface of the wound. **There was no photographic record for this case and the drug Amphotericin B was initiated after debridement.**

**Table No. 1: Serum Potassium Levels:**

	Day 1	Day2	Day 3	Day 4	Day 5
Serum k <sup>+</sup> [3.5-5.1mmol/L]	4.79	3.42	4.29	4.29	4.44

On 07/09/21 (day 1) ,administered 200mg of **Amphotericin B emulsion** in 250ml of 5% dextrose and infused for 3-4 hours (60mg/h).On the next day, drug-induced hypokalemia was discovered, with the patient's serum K<sup>+</sup> level dropping from 4.79mmol to3.42 mmol/L (3.5-5.1mmol/L), which was conservatively controlled with inj.KCL (Potassium chloride) 20mmol and syrup KCL 10ml, TDS. On the 3<sup>rd</sup> day, the serum K<sup>+</sup> level returned to normal, at 4.29 mmol/L, and remained stable.

Despite the fact that his clinical condition did not improve, his non-healing foot persisted, and his condition worsened, left above the knee was amputated on 09/09/21. As surgical prophylaxis inj. Piperacillin with Tazobactam 4.5 g IV was given and empirically continued for 5 more days. On 10/09/21 (4<sup>th</sup> day), the same doses of inj. Amphotericin B was given, infused over 3-5 hours (70mg/hr) and the next day (5<sup>th</sup> day), the same dose was given, but the patient developed anaphylactic reactions, including breathing difficulties, shivering, and a fever spike of 100.8°F, which lasted 30 minutes. Inj.hydrocortisone 100mg IV Stat and inj.Paracetamol 1g, as well as nebulization with Budesonide, has been given and managed conservatively. On the same day, catheterized urine was sent for a fungal stain, but no fungal materials were found, but the drug was continued to reduce the infection. On September 12and 13 (6<sup>th</sup> and 7<sup>th</sup> day) inj. Amphotericin B 200mg mixed with 250ml of 5% dextrose was given infusions over 3-4 hours (50mg/hr) . The patient was stable, and he was checked on every hour.

**Table No. 2:** The laboratory examination revealed abnormalities:

Parameters	Observed value	Normal value
C-reactive protein	27.78 mg/L	Upto5.0mg/L
WBC	15100 cells/mm <sup>3</sup>	4000-10000 cells/mm <sup>3</sup>
Platelets	438000 cells/mm <sup>3</sup>	150000-410000 cells/mm <sup>3</sup>
Eosinophils	7.0%	1-6%
Basophils	0.4%	1-2%
Lymphocytes	16%	20-40%
HCT	21.1%	40-50%
Hb	6.9g/dl	13-17g/dl
Total RBC	2.45mil/mm <sup>3</sup>	4.5-5.50mil/mm <sup>3</sup>
Serum alkaline phosphatase	186.6 U/L	30-120U/L
Serum GGT	158 U/L	11-50U/L
Serum protein	5.50g/dl	6-8g/dl
S.Albumin,	2.66g/dl	3.5-5.0g/dl
Blood urea	46.79 mg/dl	10-40mg/dl
S .creatinine	2.30mg/dl	0.5-1.2mg/d

**In the nephrologist's opinion, the patient was having nonoliguric AKI (Acute Kidney Injury).** The patient got symptomatically better and was discharged with advised to monitor their blood glucose periodically **as the patient was Diabetic.** On the Naranjo's causality assessment scale the adverse event was 4 indicating a possible reaction to Amphotericin B.

### 3. DISCUSSION:

Amphotericin B, antifungal activity is based on its hydrophobic moiety binding to the ergosterol moiety of the fungal cell membrane, causing depolarization of the membrane and influx of protons and monovalent cations by increasing membrane permeability, destroying activity and allowing the cytoplasmic contents to leak out, resulting in cell death [11]. Treatment of fungal infection in diabetic patients may be complicated due to the various disease-related changes to the pharmacokinetics and pharmacodynamics (PK/PD) of a drug [12]. As a result, in individuals who are resistant to long-term antibiotic therapy, fungal pathogens should be investigated. In high-risk people, early identification of fungal infections is crucial for avoiding serious outcomes such as amputation of the foot [13]. As per Julio Collazos *et al.*, [14,15] prolonged treatment with this drug is associated with high rates of toxicity, mainly renal, although an acute toxicity also is manifested, primarily as chills, fever, and nausea during infusion of the drug.

Hyperkalemia, Hypokalemia, Hypocalcemia, Hyperphosphatemia, Hypophosphatemia, hypomagnesemia are some electrolyte imbalances induced by Amphotericin B. In this patient, after the wound debridement on the left ankle region, fungal like elements seen on the surface of wound, even the fungal stain culture report shows no growth, based on clinical experience of the physician, high probability of fungal infection, antifungal medication, inj. Amphotericin B have been started. Later developed hypokalemia induced by inj. Amphotericin B, which then managed conservatively with inj. KCL (Potassium chloride) 20mmol and syrup KCL 10ml, TDS. Apparently the condition was not improving they have done left knee amputation and resumed the antifungal treatment with Amphotericin B without dose alteration. Later, breathing difficulty, shivering, and fever were induced by inj. Amphotericin B emulsion, which lasted for 30 minutes, and oxygen ventilation for breathing was provided immediately, as well as inj. hydrocortisone, inj. paracetamol, and budesonide nebulisation. After lowering the infusion rate, the adverse effects were corrected, patient became comfortable, and afebrile. The same preparation was resumed for 2 more days with the slow infusion rate. This case study demonstrates the importance of meticulously planning patient care prior to, during, and after the injection of Amphotericin B emulsion.

Clinical parameters should be monitored regularly, if any abnormalities have been found should be corrected immediately with appropriate treatment.

### 4. CONCLUSION:

In this scenario, it is suggested that after the drug administration, the patient's state and clinical parameters should be carefully monitored. Deep tissue infections could also be caused by invasive fungal infections. As a result, in individuals who are resistant to long-term antibiotic therapy, fungal pathogens should be investigated.

### CONSENT

The patient's informed consent was obtained before the case facts were published.

### ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author.

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