Case Report

Pegaspargase Induced Hypertriglyceridemia Resulting in Severe Fatal Pancreatitis

Neil Vyas, Rafael Ching Companioni, Melik Tiba, Hassan Alkhawam, and Aaron Walfish

1Department of Medicine, Icahn School of Medicine at Mount Sinai (Elmhurst), 79-01 Broadway, Queens, NY 11373, USA
2Department of Gastroenterology, Elmhurst Hospital Center, 79-01 Broadway, Queens, NY 11373, USA

Correspondence should be addressed to Neil Vyas; neilvyas09@gmail.com

Received 5 October 2015; Accepted 12 November 2015

Academic Editor: Yoshihiro Moriwaki

Copyright © 2015 Neil Vyas et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Pegaspargase is used to treat acute lymphocytic leukemia (ALL). Pegaspargase definitely has its benefits in treating ALL; however, we cannot lose sight of one of its very rare but potentially deadly complications, acute pancreatitis. Clinicians should monitor triglycerides while the patient is on treatment with Pegaspargase and suspect acute pancreatitis if the patient develops abdominal pain. If pancreatitis occurs, therapy should be stopped immediately and not reinstituted. For patients with hypertriglyceridemia without pancreatitis, discontinuation of therapy should be considered.

1. Case Presentation

The patient was a 24-year-old male with a history of Acute T-Cell Lymphoblastic Leukemia (ALL) on recent chemotherapy including Pegaspargase. He was admitted to hospital for abdominal pain and was found to have acute pancreatitis secondary to hypertriglyceridemia. Physical examination was significant for tachycardia (127 bpm), decreased air entry in the base of the right lung, and generalized abdominal tenderness and distention. Laboratory tests were remarkable for elevated liver enzymes (ALP 360 U/L, AST 310 U/L, GGT 216 U/L, ALT 44 U/L, and LDH 829 U/L), elevated lipase 228 U/L, and hypertriglyceridemia >3,000 mg/dL. Abdominal CT showed acute pancreatitis with necrosis: peripancreatic, intraperitoneal, and extensive retroperitoneal fluid (Figure 1). Subsequently, his severe pancreatitis was associated with acute kidney injury and respiratory failure, which is illustrated by elevated BUN, creatinine, and persistent hypoxia. According to the Atlanta Classification, patient is classified under severe acute pancreatitis. In addition, patient’s BISAP score was 3, which establishes that his risk of death was significantly increasing. Despite appropriate treatment for pancreatitis, according to current guidelines/recommendations, he expired.

2. Discussion

The initial chemotherapeutic agent to treat Acute T-Cell Lymphoblastic Leukemia (ALL) was Asparaginase. This particular drug underwent extensive testing and was targeted for pegylation, thus forming Pegaspargase. The new drug retains its antileukemic effect while allowing less frequent administration. Pegaspargase is currently gaining popularity over Asparaginase therapy due to having fewer incidences of hypersensitivity reactions and its long half-life (367 hours), allowing dosing every 14 days as opposed to Asparaginase, which is dosed daily [1].

Pegaspargase (Onaspar) is a modified version of L-asparaginase conjugated with polyethylene glycol. In leukemic cells, Asparaginase hydrolyzes L-asparagine to ammonia and L-aspartic acid leading to depletion of asparagine. Leukemia cells need exogenous asparagine; thus asparagine depletion in leukemic cells leads to inhibition of protein synthesis and apoptosis. Despite its potential benefits, there are a wide range of side effects. One rare, but potentially deadly complication, is severe pancreatitis.

Acute pancreatitis is characterized by obstruction of the secretory transport system and activation of pancreatic enzymes. These enzymes autodigest the pancreas leading...
to inflammation and can lead to impairment of function and morphology. There are several etiologies of pancreatitis, but the two most common causes especially in western countries are alcohol and gallstones. However, there are less common causes such as hyperlipidemia, or more specifically hypertriglyceridemia. The breakdown of triglycerides into toxic free fatty acids (FFA) by pancreatic lipases is the cause of lipotoxicity and ultimately acute pancreatitis in patients with hypertriglyceridemia [2].

In regard to Pegaspargase, one proposed mechanism of this drug-induced pancreatitis is hypertriglyceridemia. It is suggested that apolipoprotein E polymorphism may influence the development of hyperlipidemia in ALL patients receiving Pegaspargase therapy [3]. One study revealed that apolipoprotein E (apoE) isoform apoE4 (epsilon4) participated in the induction of extreme hypertriglyceridemia, since the frequency of the apoE4/E3 phenotype in the patients with extreme hypertriglyceridemia was higher compared to those in the patients without extreme hypertriglyceridemia and control subjects [4]. Another proposed mechanism is an increase in the apoCIII/apoCII ratio because it functions as an inhibitor and an activator of lipoprotein lipase (LPL), respectively [4]. This ultimately results in an accumulation of triglyceride concentrated lipoproteins in plasma.

Monitoring triglycerides while on Pegaspargase therapy would be appropriate in avoiding pancreatitis. Weekly interval monitoring of triglyceride levels will give closer management for patients and prevent hypertriglyceridemia induced pancreatitis. Triglyceride levels of >200 mg/dL–999 mg/dL would be considered moderate and cessation of Pegaspargase should be considered and clinically correlated [5]. However, triglyceride levels of >1000 mg/dL are considered a risk factor for pancreatitis and are categorized under severe hypertriglyceridemia [5]; thus cessation of Pegaspargase should be instituted. Moreover, when clinical symptoms of pancreatitis such as abdominal pain present, even without hypertriglyceridemia, Pegaspargase therapy should be stopped and not reinstituted. There is a time relationship between administering Pegaspargase and onset of abdominal pain. Multiple studies have revealed the development of abdominal pain within a median of 2 weeks from the onset of Pegaspargase administration [1]. Clinicians should be aware of a higher incidence of pancreatitis with Pegaspargase therapy and with careful history taking; focused abdominal examinations and monitoring triglycerides pancreatitis can be avoided.

Conflict of Interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

References
