En la actualidad se sabe que la penicilina se clasifica en el grupo IV de fármacos que pueden inducir pancreatitis[2] (esto es, únicamente existencia de descripción de algún caso clínico, sin constancia de la reintroducción del fármaco para producir de nuevo la afectación pancreática). Como otros antibióticos que pueden producir pancreatitis, esta asociación se considera probable[1,3], pues el proceso se ha producido tras la aplicación del medicamento y ha desaparecido tras su retirada. Para estimarse como asociación definida, precisaría el criterio de recurrencia tras la reanudación del medicamento (obviamente por consideraciones éticas además de carecer de trascendencia no se reintrodujo el fármaco). En este sentido, se descartó en nuestra paciente convenientemente que el consumo de alcohol y la litiasis biliar estuvieran en relación con la pancreatitis, lo cual establecería la etiología *a priori* una proporción muy elevada de este proceso. Por último, conviene destacar que no se conoce con exactitud la fisiopatología de la pancreatitis inducida por la AC, pero se cree en relación con una reacción inmunológica de hipersensibilidad al fármaco, como en otros casos de inducción de pancreatitis por otros antibióticos[4].

Para finalizar, aunque conociendo la rareza de esta asociación, por otro lado considerada probable en este caso, una vez descartadas las causas más frecuentes de pancreatitis debemos tener en consideración la inducción farmacológica en la etiología de dicho proceso.

Conflicto de intereses

Los autores declaran no tener ningún conflicto de intereses.

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Visceral leishmaniasis as an unusual infectious complication in a patient with Crohn's disease treated with infliximab

Leishmaniasis visceral como una complicación infecciosa inusual en un paciente con enfermedad de Crohn tratados con infliximab

To the Editor,

The pharmacologic management of Crohn's disease (CD) is based on location, extent and severity. Therapeutic options usually include immunosuppressive agents. Opportunistic infections do occur amongst these patients.

We present the case of a caucasic 36 years old male, diagnosed in 1998 with CD (A2L2B1), living in the countryside with his dog. He was in clinical remission under infliximab monotherapy, and blood tests were routinely obtained. In one of those tests, serum creatinine of 4 mg/dl was found. He was admitted to Nephrology department; renal biopsy was performed showing interstitial nephritis. The patient received steroids and achieved some improvement in renal function. During 3 months, the patient had fever in the evening and a worsening renal function, which coincided with decreased corticosteroid dosage. Finally, the patient was admitted again with fever and pancytopenia. Splenomegaly (17 cm) was found in CT-scan and positive serology for Leishmania was obtained. Note that the PCR for Leishmania in renal biopsies was negative, although it was done once the serology was positive, weeks after the sample of renal tissue was taken. The parasite was neither identified in the renal biopsy nor in the bone medulla. The patient received daily treatment with liposomal amphoterin (AmBisome®, 5 mg/kg/day) for five days, and later on weekly for five weeks. Once the treatment was completed, the patient was asymptomatic and showed almost normal renal function. In the subsequent visits, it was found the developed tick. The CD situation was updated during hospitalization and colonoscopy showed mucosal healing; infliximab was withdrawn then. After 6 months, the patient still remains under no immunosuppressive therapy, still in deep remission (a new colonoscopy was recently performed), and serology for Leishmania has become negative.

We report the case of visceral leishmaniasis in an immunocompromised patient with interstitial nephritis, which was resolved with anti-protozoan treatment.[1] Leishmaniasis consists of complex vector-borne diseases caused by more than 20 species of the protozoan genus Leishmania and is transmitted by sand fly vectors. Visceral leishmaniasis (VL) is caused primarily by the 2 related species: *Leishmania donovani* and *Leishmania infantum* (LI). LI infection occurs in the Mediterranean area, and inmunosuppresed adults have

higher risk of clinical disease. The transmission is considered zoonotic, the major reservoir is the domestic dog. Most VL cases are asymptomatic. Symptoms are usually insidious, with slow progression of malaise, fever, weight loss and splenomegaly. Anemia can occur due to bone marrow suppression, hemolysis and splenic sequestration. Mild renal impairment frequently happens, and it is reversible with effective treatment of VL.[2] Definitive diagnosis requires the evidence of the parasite by either a smear or culture in tissue. Histopathologic diagnosis requires visualization of amastigotes. Serum antibodies tests and molecular techniques are being used increasingly for diagnosis of VL in Europe. Liposomal amphotericin B is the preferred choice. Response to treatment is generally assessed clinically.[3]

Patients treated with immunomodulators may be at increased risk for serious or fatal infections. Infliximab, which specifically targets tumor necrosis factor-α, is also associated with adverse events including opportunistic infections.[4] Moreover, it is well known that infliximab use is associated with reactivation of latent tuberculosis and other intracellular pathogens.[5] The risks for serious infections or fatal infectious complications associated with infliximab seems to be similar to that observed with the use of conventional immunomodulators, and patients at higher risk of serious infectious complications seem to be those with more disease severity, older age, and the concomitant use of corticosteroids, narcotic analgesics or two or more immunomodulators.[4,6,7] Our patient presented no risk factors beyond infliximab treatment, although he suffered from a serious infection and his life was put at risk. In spite of not having risk factors, patients receiving immunomodulators need to be under a close vigilance; this is the only tool to detect complications and to prevent serious problems.[7]

In conclusion, because CD is a chronic disease that requires maintenance treatment, physicians must consider the benefit/risk profiles of all therapies. There is a need for more research regarding the long-term safety of biologics. This case highlights the necessity of a close monitoring and comprehensive clinical investigation that should be performed in the presence of fever or any kind of clinical deterioration, in order to rule out unusual causes of complications.

Conflict of interest

The authors declare no conflict of interest.

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