Persistent Bilateral Abdominal Pain as an Atypical Presentation of Statin-Associated Muscle Symptoms

Maanas Chiplunkar DO[1], Joseph Kastrenakes DO[1], Ruben Dovlatyan DO[1], Richard Lau MD[1], Neal Rakesh MD[2]

[1] Department of Physical Medicine & Rehabilitation, NYU Langone Health / Rusk Institute, New York, NY [2] Department of Anesthesiology & Critical Care Medicine, Memorial Sloan Kettering Cancer Center, New York, NY

Introduction

- Statin-associated muscle symptoms (SAMS) typically appear as bilateral proximal myalgia, stiffness, cramping, or weakness.
- Atypical presentations require exclusion of other causes of pain before attributing symptoms to statins.[1-4]
- We describe persistent bilateral abdominal pain that improved after statin withdrawal, alongside reproducible SAMS.

Case Description

74-year-old man: CAD; Crohn's disease s/p fistulectomy and small bowel resection; ureteral cancer s/p left nephrectomy; colon cancer with liver metastasis s/p left colectomy; chronic postoperative RLQ pain.
Hospitalized: adenovirus infection with rhabdomyolysis, AKI, and NSTEMI requiring PCI. Atorvastatin changed to rosuvastatin.

KEY TAKEAWAY
Consider SAMS in unexplained truncal or abdominal wall pain, especially after statin initiation or change.

Clinical Course

1. Hospitalization: atorvastatin switched to rosuvastatin.
2. After discharge: diffuse shoulder, arm, and leg pain. Rosuvastatin stopped, atorvastatin resumed.
3. Thighs improved, but persistent bilateral abdominal pain developed, extending toward the posterior thorax.
4. Pain medicine: TAP blocks, pregabalin, duloxetine, and steroid taper gave minimal or no benefit.
5. Atorvastatin stopped and regimen modified with cardiology: pain improved; neuropathics stopped without recurrence.
6. Atorvastatin rechallenge: diffuse muscle symptoms within 3 days, improved after stopping.

Work-up and Management

GI evaluation: CT abdomen/pelvis and colonoscopy showed no active Crohn's, recurrent malignancy, or other intra-abdominal cause.
Exam: worse pain and tenderness with abdominal wall palpation; equivocal Carnett's sign.
Treatment: bilateral US-guided TAP blocks gave no relief; pregabalin, duloxetine, and oral steroid taper had minimal or uncertain benefit.

Discussion

- Multiple competing causes of abdominal pain were present.
- No GI cause, limited response to neuropathics and fascial plane blocks, improvement after withdrawal, and rapid recurrence on rechallenge support a statin association.[1-4]

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