

Amiodarone-induced angioedema

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Key words: amiodarone; angioedema.

● AMIODARONE, a class II antiarrhythmic, is an iodinated benzofuran derivative capable of blocking both α - and β -adrenoceptors. Its iodine content can lead to abnormalities of thyroid-function tests without thyroid dysfunction (1). One of the most serious adverse reactions

is pulmonary damage in which the chest roentgenogram shows a diffuse

Challenge-positive and symptom-free upon withdrawal.

reticular pattern and infiltrates (2).

Amiodarone may cause a bluish pigmentation in the skin, and photosensitivity is common

(possibly due to phototoxicity), but allergic skin reactions are rare (3, 4).

The patient was a 70-year-old woman with a history of facial angioedema. One year before her first visit to our department, she developed episodic facial swelling. This was treated with daily steroids, resulting in clinical improvement. However, facial angioedema reappeared after discontinuation of the steroids, and therefore she received daily steroids for a year. She was admitted to a hospital near her home and was studied in the internal medicine department. At the time of admission, a diagnosis of iatrogenic Cushing's syndrome was made because the echography of the suprarenal glands was normal, ACTH was suppressed, and the patient had a cushingoid appearance but was in no distress. The chest radiograph was normal and laboratory study (including complement evaluation) was negative. As

the patient's condition did not improve, she was referred to our allergy unit for study. A complete clinical history was taken, and she was carefully questioned about past history and recent symptoms. Symptoms of angioedema were unrelated to food ingestion, activity, location, or stress. She had no clinical history of nasal polyps, chronic rhinitis, sinusitis, or asthma. At the time of admission to the hospital, she was taking oral corticosteroids and amiodarone 200 mg/day. This last drug had been started 8 years before for cardiac rhythm abnormalities and had never been discontinued. Physical examination, ECG, and chest radiograph were normal.

Laboratory evaluation was normal (blood analysis and serum chemistries, stool examination for parasites, IgE, immune complexes, autoantibodies, complement evaluation, thyroid tests (T3 and T4), SHIIA, and urinalysis). Skin prick tests with common inhalants (mites, pollens, molds, and danders) and food were negative.

Facial angioedema may be caused by a wide variety of conditions (immunologic disease, endocrine disease, autoimmune and inflammatory disease, and infections). In our patient, the medical history, physical findings, and laboratory tests allowed us to exclude most of these disorders easily.

In view of the patient's previous history, the diagnosis of amiodarone-induced angioedema was entertained. Amiodarone was discontinued, and the symptoms disappeared with the reduction of steroids, which were finally discontinued. In order to confirm that amiodarone was the cause of the patient's reaction, a skin prick test with amiodarone (50 mg/ml concentration) was performed and the result was negative. Furthermore, the patient underwent a double-blind oral challenge with amiodarone. Within 30 min of receiving the dose (200 mg), she began to experience facial flush and facial angioedema. This result was considered positive.

Because repeated ECGs were normal, amiodarone was withdrawn permanently. The patient was well 1 year later at follow-up.

We confirm the relationship between development of angioedema and chronic amiodarone administration. To our knowledge, this paper is the first report of facial angioedema related to amiodarone use. Nevertheless, we could not explain the precise mechanism of this reaction. The negative result in the prick test suggests that the primary mechanism is not IgE-mediated. The pathogenetic mechanism could be metabolic rather than immunologic, because body tissues may act as a large reservoir of this drug under chronic administration, and several of the adverse effects of amiodarone are attributable to deposition of phospholipids in the tissues (2, 5). This could explain other reported cases of dermal side-effects.

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Is alternative medicine acceptable in allergology?

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Key words: acupuncture; alternative medicine; complementary medicine; herbalism; homeopathy.

● THE term “complementary medicine” (CM), or “alternative medicine”, is usually applied to a group of diagnostic and therapeutic approaches different from conventional allopathic medicine; they include acupuncture, homeopathy, herbalism, chiropractic, chromotherapy, ayurveda, and many others. CM is becoming more and more popular: recent surveys show that about one-half the general population (1) and one-third of allergic patients (2) use unconventional remedies. There is also an increasing interest in these treatments

Yes, once regulated and registered.

among physicians: in the USA, about 50% of physicians prescribe or recommend complementary therapies, which are generally perceived as effective treatments (3). British, French, and Dutch doctors frequently use homeopathy; acupuncture is extensively used in Germany for treating pain, and herbal products are widely prescribed by general practitioners as well (4). Nevertheless, systematic data about the attitude of specialists toward CM are still lacking. Therefore, we performed a specific survey among specialists in order to investigate this topic.

During an allergology meeting, 120 specialists involved in treating allergy were asked to complete a simple questionnaire

covering the following items: 1) demographic data, 2) previous use of or intention to use CM, 3) general opinion of the role of CM and its indications, 4) opinion of the scientific basis, 5) attitude of patients toward CM.

Ninety-three colleagues (70 men, 23 women, mean age 42.3 years, range 27–69 years) completed the questionnaire. Their specialties were subdivided as follows: 39% allergists, 26% pulmonologists, 22% pediatricians, 10% dermatologists, and 3% general practitioners. Ninety-one percent of the physicians felt that the use of CM is an emerging and important problem in everyday practice, and only 18% of them judged the attention devoted to CM by official scientific societies to be adequate.

Only 9% of specialists had previously taken specific CM courses, but 30% of them declared their intention to take courses in acupuncture, homeopathy, or herbalism. Interestingly, most specialists (60%) accepted the possible role of CM within conventional medicine, mainly in association with traditional drugs. CM was judged to be particularly suitable for psychiatric disorders (28%), musculoskeletal problems (16%), and allergic and respiratory diseases (15%). Acupuncture was judged to be the most experimentally supported therapy by specialists (48%), as compared to homeopathy (15%), herbal medicine (12%), and chiropractic (9%). However, 69% of specialists did not believe that the safety of CM in general has been unequivocally demonstrated. The general perception of specialists (56%) was that patients use CM mainly because they are dissatisfied with conventional medicine (i.e., unfavorable outcomes with conventional drugs and lack of patient-to-physician relationship). Only 14% of the specialists interviewed wished to ban CM, while the majority of them (86%) agreed that CMs should be officially recognized and registered by governmental regulatory bodies in order to ensure a high

professional standard in this kind of medicine. Finally, it is curious to note that only 8% of the respondents had previously recommended unconventional remedies to one or more relatives.

The results of this simple survey show that there is a general interest in CM, and that the attitude of specialists toward CM is generally favorable. In fact, most of the respondents felt that CM could have a role in the treatment of medical disorders, and that CMs should be registered and regulated. In conclusion, it seems that CM will probably become more and more important, at least in the area of allergic disorders.

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