



Correspondence

Kounis syndrome should be excluded when physicians treat patients with anaphylaxis



The article, “Epinephrine Use for Anaphylaxis: Too Seldom, Too Late,” by Chooniedass et al¹ was an interesting read. Therefore, we would like to introduce Kounis syndrome, which is defined as the concurrence of acute coronary syndromes with conditions associated with mast cell and platelet activation and involving interrelated and interacting inflammatory cells in the setting of allergic or hypersensitivity and anaphylactic or anaphylactoid insults.² Akoz et al³ reported that the annual incidence of Kounis syndrome at the emergency department among all admissions and patients with allergy was 19.4 per 100,000 (27 of 138,911) and 3.4% (27 of 793), respectively. At Numazu City Hospital (Shizuoka, Japan), the annual incidence of Kounis syndrome at the emergency department from 2012 to 2017 in patients with anaphylaxis was 2% (2 of 100). One of these patients survived, but the other died.⁴ At Shizuoka Hospital, Juntendo University, the annual incidence of Kounis syndrome at the emergency department from 2013 to 2017 in patients with anaphylaxis was 2.2% (3 of 138). All 3 patients survived, but 1 had anoxic encephalopathy induced by cardiac arrest.⁵ These 2 cases of cardiac arrest at Numazu City Hospital and Shizuoka Hospital had been induced by drugs. Acute coronary syndromes, secondary to allergic reactions, are associated with significant morbidity and mortality in sensitized individuals.² In addition, the therapeutic management of Kounis syndrome is a challenging procedure because it requires the treatment of cardiac and allergic symptoms simultaneously.² Accordingly, Kounis syndrome should be immediately excluded when physicians treat patients with anaphylaxis by examining the electrocardiographic findings and measuring troponin levels.

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