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Kounis syndrome: A review article on epidemiology, diagnostic findings, management and complications of allergic acute coronary syndrome: Mastocytosis and post-mortem diagnosis



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We have read with great interesting the review on Kounis syndrome causality, epidemiology, clinical presentations, diagnostic findings and complications [1]. The authors correctly reported that type I, II, III variants encountered in clinical practice at 72.6%, 22.3%, and 5.1% respectively but they have not been referred to two crucial points that have been emphasized in recent reports.

1. Kounis syndrome has been already reported in a series of 10 patients with different mast cell-related disorders, who presented with unusual symptomatology [2]. Systemic mastocytosis is characterized by accumulation of clonal mast cells in bone marrow, skin and/or the gastrointestinal tract. Mast cell activation syndromes or indolent mastocytosis are diagnosed in patients with unexplained or recurrent anaphylaxis without skin lesions who do not fulfill the criteria for systemic mastocytosis. Such patients with elevated baseline tryptase (>11.4 ng/ml) are particular prone to have more severe, mostly cardiovascular and Kounis syndrome, symptoms to hymenoptera stings and should be always scrutinized for mast cell diseases [3]. We suggest that mast cell disorders, like atopy, should be regarded as

conditions that can be dangerous in patients subjected in coronary interventions [4].

2. Coronary artery histology is essential for diagnosing fatal Kounis syndrome because of: there are increased number of mast cells in coronary intima, media and adventitia, there are stores of amines deriving from culprit inflammatory cells infiltrating the coronary layers and induce coronary spasm and death and finally patients dying from stent thrombosis due to Kounis syndrome, have coronary tunica adventitia infiltrated by scattered mast cells [5].

Conflicts of interest

The authors report no relationships that could be construed as a conflict of interest.

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