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Overlooked complications of allergic reactions: allergic angina and allergic myocardial infarction

Alerjik reaksiyonların gözden kaçan komplikasyonları: Alerjik angina ve alerjik miyokard infarktüsü

Allergic reactions to certain drugs like penicillins (1), cephalosporins (2), ranging from urticaria to anaphylactic or anaphylactoid reaction, are increasingly encountered in the daily clinical practice. Recent increasing number of reported cases about the latter minds us that concurrence of acute coronary syndromes with those allergic reactions could be more in number than it was supposed. The drugs, reported to be accounted for allergic reactions and used widely in daily clinical application, are antibiotics, analgesics, antineoplastics, contrast media, corticosteroids, intravenous anesthetics, non-steroidal antiinflammatory drugs, skin disinfectants, thrombolytics, and others (3, 4).

Allergic angina and allergic myocardial infarction, referred as "Kounis Syndrome", have gained acceptance as a new cause of coronary artery spasm. Two variants of this syndrome were primarily described according to the findings of coronary angiography. Type I variant defines the patient having normal coronary angiography whereas type II requires a quiescent pre-existing atheromatous disease (5). In type I variant acute allergic reaction may progress either to vasospastic angina or acute myocardial infarction (eg. ST elevated or non-ST elevated myocardial infarction). This may reflect an endothelial dysfunction or microvascular angina. In type II variant spasm of coronary artery may result in atheromatous plaque disruption and thus manifests as an acute myocardial infarction.

In this letter, we aimed to remind allergic angina and allergic myocardial infarction by presenting a young patient suffered acute anterior-inferior ST elevated myocardial infarction following intravenously penicillin administration. The patient was a 21 years old male. He presented to the emergency service with loss of consciousness, clammy and cold skin, respiratory distress with bronchospasm and with all signs of cardiogenic shock. The electrocardiogram obtained following the initial interventions to provide airway, breathing and circulation was revealing hyperacute T wave on V2-V6 and ST segment elevation on derivations II, III and aVF. While interrogating the risk factors of premature coronary artery disease, we learned a penicillin drug was administered intravenously just before the clinical setting has initiated. We immediately transport the patient to the angiography laboratory to perform a primary percutaneous coronary angioplasty to the infarct related artery. Coronary arteries were completely normal on the angiography. Patient was transported to the intensive care unit on the support of inotropic medications. We planned the medical management in the intensive care unit with low molecular weight heparin (enoxaparin 80 mg/0.8 ml 2x1 SC), corticosteroid (methylprednisolone 80 mg 2x1 IV), mast cell stabilizer (ketotifen 2 mg tb, 1x1 PO), histamine (H2) antagonist (famotidine 20 mg tb 2x1 PO). ST segment elevation was regressed in a few hours despite the rise of cardiac markers minimally (eg cardiac troponin, CK-MB) as diagnostic criteria of myocardial infarction.

Aforementioned complications and allergic myocardial angina are not uncommon clinical conditions in daily practice because of high likelihood of developing allergic reaction to a wide range of drugs administered intravenously. It will certainly be lifesaving to the sufferer if those complications be minded, evaluated and intervened earlier.

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Incomplete Kawasaki disease: a pediatric diagnostic conflict

İnkomplet Kawasaki hastalığı: Pediatrik tanısal zorluk

Dear Editor,

Kawasaki disease (KD) can be difficult to diagnose; there is no diagnostic laboratory test and there is a 25% chance of serious cardiovascular damage if the treatment is not administered at an early stage. No difficulty exists in diagnosis in the patients with full criteria, but some patients who don't fulfill the criteria have been diagnosed as having "incomplete" Kawasaki disease (IKD). It should be considered in all children with unexplained fever for >5 days associated with 2 or 3 of the principal clinical features of KD. (1, 2).

Two cases of IKD are presented in this letter.

Case 1. A one-year-old boy with a history of 6-day fever and rash and reddening of lips for 2 days was admitted to the hospital. He was