Anaphylactoid reaction to hydroxycoBALamin with tolerance of cyanocobalamin

Sir,

A patient with an anaphylactoid reaction to hydroxycoBALamin but good tolerance of cyanocobalamin is described, which empha-
sizes the usefulness of challenge tests in cases of allergic or pseudoallergic reactions.

A 33-year-old woman with a history of Crohn’s disease developed subacute combined degeneration of the spinal cord due to vitamin B12 deficiency. Replacement therapy with hydroxycoBALamin was established at a dose of 10 mg intramuscularly every month with no problems for more than a year. In the second year, the patient was given cyanocobalamin parenterally, and this was followed by improved urticaria and angioedema with involvement of the upper airway. Prick and intradermal tests performed with 5 mg/ml and 100 μg/ml of hydroxycoBALamin, respectively, were negative. Under in-hospital observation the patient was given 2500 μg of hydroxycoBALamin by the intramuscular route. 20 min later, she experienced pruritus on her palms, shortly followed by generalised urticaria, prominent edema and palpebral oedema, hoarseness and chest tightness. The patient was treated with epinephrine, methylprednisolone and chlorphen-
iramine with total recovery in 2 hours. A challenge test with benzyl alcohol, added as preservative, was carried out with no reac-
tion. On the basis that the neurologic manifestations would progress without adequate replacement therapy, a desensitiza-
tion protocol was developed. Increasing doses of hydroxycoBALamin, beginning with 0.05 μg, were administered every 15 min by the intramuscular route. Ten minutes after the injection of 125 μg of hydroxycoBALamin, even the same allergic reaction appeared. Premedica-
tion with antihistamines did not provide reli-
ably effective protection from the hydroxycoBALamin-induced reaction in the patient. However, intramuscular challenge tests with cyanocobalamin up to 10 mg, per-
formed on three different occasions, were fol-
lowed by no reactions at all. Thus, the patient receives 10 mg of cyanocobalamin monthly without problems.

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2 James J, Warren RP. Sensitivity to cyanocobala-


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Salvage angioplasty following failed thrombolysis

Sir,

Dr May and Jennings are correct to point out the dilemmas facing physicians responsi-
ible for the further management of patients with acute myocardial infarction and appar-
ent failure to respond to thrombolytic therapy. The lack of evidence supporting any par-
cular management strategy is surprising given that up to 50% of patients fail to respond to thrombolytic therapy in the first few hours and that persistent ST segment elevation following acute myocardial infarction (AMI) is clearly associated with poor outcome. Purcell et al demonstrated a mortality of 18.2% in unselected patients with AMI and <50% resolution of ST segment elevation in the worst lead 60 minutes after the initiation of thrombolytic therapy. A subset of the INJECT trial revealed a mortality of 17.5% in patients with <50% resolution of the summed ST segment elevation in leads reflecting the infarct zone. Even though it is frequently stated that such electrocardiographic (ECG) features are not 100% sensitive or specific for persistent arte-
rificial occlusion, the presence of such features must alert us to a patient who is at high risk of further adverse events. Salvage angioplasty has only been examined in one prospectively con-
ducted randomised study against conserva-
tive therapy.6 Despite a statistically significant reduction in the incidence of death or severe heart failure, this strategy has not been widely adopted or examined in the context of angioplasty era. This is surprising, given that this study probably underestimated the benefit of salvage angioplasty for a number of reasons. Firstly, high-risk patients, including those with a previous myocardial infarction who are perhaps more likely to benefit from attempts to open a second vessel, were excluded. Secondly, patients in this trial were taken on for salvage angioplasty relatively late after the onset of chest pain. Thirdly, intra-aortic balloon counterpulsation was rarely used, but is now known to reduce the risk of arterial occlusion following salvage angioplasty. Fourthly, the trial was performed without the use of platelet inhibitors, such as abciximab (ReoPro). These agents have been shown to be beneficial in high-risk angioplasty without increased risk of haemorrhage. Lastly, and most importantly, this trial was performed in the early 1990s before the modern coronary artery stent era. It is undoubtedly the case that the availability of coronary artery stents allows angioplasty in the context of AMI to be performed with greater success and one would go so far as to say that the results of the trials of immediate angioplasty following thrombo-
lytic therapy, which universally demonstrated unfavourable outcomes with this strategy, have no relevance in the modern stent era. This is an area which commands further study. Our policy of performing salvage angi-
oplasty in the context of <50% ST segment resolution in the worst lead 2 hours after the initiation of thrombolysis, is based on the reported favourable results, especially if the patient presents promptly, receives throm-
bolysis promptly and the 2-hour ECG is scru-
pulously reviewed. Our experience is that this policy can reduce mortality from an expected 17-20% to 5%. Thus, patients with persistent ST elevation following thrombo-
lytic therapy should be considered early for...