A Case of Midazolam Anaphylaxis

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Introduction: We report a case of midazolam related anaphylactic shock which was experienced during esophagastroduodenoscopy at a regular check-up. Case report: A 53-year woman was scheduled EGD for her routine check-up. She had no previous medication, except she visited the emergency medical center for allergic urticaria, 1 year ago. Before anesthesia, Her vital sign is within normal limit. Next, 5 mg midazolam was given intravenously. Within 4 minutes after drug injection, Blood pressure and peripheral pulse could not be checked, Sinus tachycardia was observed in ECG (Fig. 1). The patient then received 0.2 mg flumazenil, cardiopulmonary resuscitation were used and Norepinephrine 8 μg/min and epinephrine 1 mg were given intravenously. Cardiac massage was done for 6 minutes. After injection, Blood pressure increased to 90/60 mmHg, and the patient moved. The patient developed a rash all over the body. Dexamethasone 5 mg and anti-histamine agent 3 mg were injected. There were no abnormal findings in echocardiography and chest computed tomography in chemical tests, there were no abnormal findings except tryptase level was 14.8 ug/L (normal range 1.9-13.5 ug/L) at the event. Discussion: Serum tryptase level measurements can be an indicator of anaphylaxis, which can be a marker of systemic mast cell activation by elevated serum tryptase. According to a study, tryptase test showed a sensitivity of 64%, a specificity of 89.3%, a positive predictive value of 92.6%, and a negative predictive value of 54.3%.

Acute Lead Poisoning After Herbal Medication

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Background: We are exposed to a lot of metals. Lead, although in little amount, exists in the environment. But, lead usage is increasing more along with the industrial revolution. These days, we are concerned about lead poisoning of dietary supplements as well as occupational exposure. Lead poisoning has many symptoms such as anemia, neurologic symptom, and gastro-intestinal disturbances. Case report: A 61-year-old male patient came to the hospital with the complaint of whole abdominal pain. He was treated with herbal medicine for facial palsy for two weeks. At the initial physical examination, there was a remarkable pale conjunctiva. Hemoglobin level was 7.6 g/dl, Reticulocyte count was 7.9%. Total bilirubin level was 2.0 mg/dl. AST/ALT was 153/231 IU/L. In peripheral blood smear, normocytic hypochromic anemia was noted. We had a lot of tests such as computed tomography, endoscopy, colonoscopy to find diseases related with anemia and vague abdominal pain. However, the results were unremarkable. Because we couldn’t get an accurate diagnosis, we considered the patient’s past medication. Although lead poisoning rarely has anemia and abdominal pain due to herb medication, we decided to conduct blood test to check for the presence of lead. It was 56.96 mcg/dl (normal range; <20 mcg/dl). Analysis of the herbal medicines that the patient had been taking showed that one of four herbal medicines was 25,229 ppm (normal range; <5 ppm). We could diagnose acute lead poisoning. The patient did not be treated by chelation therapy because it is a conservative treatment on a case-by-case basis if the level of lead in the blood is 60-80 mcg/dl. The patient’s symptom was improved with conservative management. Three weeks later, after the patient was discharged from the hospital, we identified that hemoglobin level increased to 11.1 g/dl, AST/ALT was 42/19 IU/L. Conclusion: It is important to detect lead intoxication because of its deposit to bones and soft tissues for a long time. If we did not think about lead poisoning, the patient would be treated for irritable bowel syndrome. We have to know the patient’s history about unexplained abdominal pain and think about environmental poisoning.