may help in the diagnosis if USG is non contributory. The 99m technetium pertechnates scan are also useful to pick up gastric mucosa lined duplication cysts. Excision is the treatment of choice as duplications will continue to be symptomatic unless removed. Isolated GI duplication has an excellent post surgery prognosis[4].Exact cause for large antral gastric ulcer is not known; however a rare physiological alteration similar to retained antral syndrome, a syndrome of uninhibited gastrin secretion and refractory gastric ulcers as seen after surgery for peptic ulcer disease has been contemplated[5]

SRIKANTH KP[1],
THAPA BR[1],
SADHNA B LAL[1],
PREMA MENON[2],
KUSHALJIT SODHI[3],
KIM VAIPHEI[4],
RAO KLN[2]

Correspondence: Prof Thapa BR
Department of Pediatric Gastroenterology[1], Pediatric Surgery[2], Radiology[3], and Histopathology[4],
Post Graduate Institute of Medical Education and Research
Chandigarh-160012, India
Email: brthapa1@yahoo.co.in

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Anaphylactic reaction to omeprazole

Introduction

Proton pump inhibitors (PPI), the most potent inhibitors of gastric acid secretion, have revolutionized the treatment of acid related disorders, including gastroesophageal reflux disease, peptic ulcer disease, and gastropathy induced by nonsteroidal anti-inflammatory drugs (NSAIDs). They are combined with antibiotics to eradicate Helicobacter pylori. Since the introduction of omeprazole, a proton-pump inhibitor (PPI), in 1988, several other PPIs i.e., lansoprazole, rabeprazole, pantoprazole, and esomeprazole have been developed. They are generally well tolerated, with minimal adverse effects, most of which are related to the drug's pharmacokinetic interaction profiles[1]. Although hypersensitivity reactions are rare, several anaphylactic reactions have been reported[2-5].Some reports describe the presence of cross-reactivity between different members of the group, although no definite pattern has emerged[6-9]. We present a case of omeprazole induced anaphylactic reaction which was managed uneventfully.

Case report

A 64-year-old woman received a prescription for omeprazole 20 mg capsules from her general practitioner for peptic symptoms. About 55 minutes after taking the first capsule, she developed malaise, periorbital edema, erythema of the skin, pruritus, nausea, and vomiting. On presentation to our hospital her pulse was feeble and blood pressure was not recordable. After treatment with injection adrenaline (1:1000dilution) 0.5mg subcutaneously, injection hydrocortisone intravenously, injection pheniramine intravenously, injection normal saline infusion, she recovered uneventfully. The acute onset of urticaria, edema, and hypotension and a close temporal association of these clinical signs with the ingestion of the tablet in our patient allow this reaction to be classified as anaphylactic shock, according to the Council for International Organizations of Medical Sciences.[10]

Discussion

Anaphylactic shock is classified as a sudden and substantial decrease of arterial blood pressure in close temporal association with exposure to a drug or other substance, which is not a vasovagal reaction and is not induced by a direct effect of a drug on cardiovascular function or hemodynamic regulation. Alternatively, the term anaphylactic shock may be used if

clinical signs of shock such as hypotension, tachycardia or bradycardia, no heart rate, or loss of consciousness are present, or when one or both of the following groups of symptoms are also present: (1) itching, erythema, urticaria, angioedema and (2) laryngeal edema or spasm or bronchospasm.[10]

Haeney[2] reported on a patient who repeatedly developed angioedema and urticaria two hours after ingestion of omeprazole 20-mg capsules but not after use of enteric-coated granules without the capsule shell (which in Europe consists of gelatin, red iron dioxide, and titanium dioxide), suggesting a causal relationship with the capsule shell and not with omeprazole. The triggering constituent was not identified.

Bowl by and Dickens [3] reported a patient who developed angioedema and urticaria immediately after taking oral omeprazole 20 mg, which was confirmed by rechallenge. Challenge with omeprazole granules without the capsule shell was also positive, which suggests an allergy to the drug and not to the capsule.

Galindo et al.[5] reported on a patient who developed anaphylaxis a few minutes after infusion of omeprazole 40 mg; evidence of cross-reactivity was provided by skin tests to omeprazole and lansoprazole.

The available evidence indicates that the PPIs currently in use can cause anaphylactic reactions. These benzimidazole derivatives are chemically related, observations in a few patients suggest that cross-sensitivity may occur. However, further study is needed to provide more precise information regarding the frequency of anaphylactic reactions during the use of these drugs. Because anaphylaxis is a potentially serious reaction, healthcare professionals need to be aware when prescribing these agents that PPIs can occasionally cause anaphylactic reactions.

Conclusion

This case report suggests that the PPI can cause anaphylactic reactions and that one should be aware of its life threatening adverse reaction while prescribing PPIs.

SANGEY CHHOPHEL LAMTHA[1],
RAM NARESH ALLAM[2],
CAROLINE KARTHAK[1],
KARMA DOMA BHUTIA[3]

Correspondence: Dr. Sangey Chhophel Lamtha
Department of Gastroenterology[1], Medicine[2]
Central Referral Hospital
Sikkim Manipal Institute of Medical Sciences
5th Mile, Tadong and Department of Microbiology[3],
Sir Thutop Namgyal Memorial Hospital
Gangtok, Sikkim – 737101, India
Email: Sangey79@yahoo.com

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Giant villous adenoma of rectum mimicking an infiltrating adeno-carcinoma

Introduction

Giant villous adenoma (GVA) is a rare mass forming lesion of the gastrointestinal tract, which is often difficult to differentiate