

Autoimmune haemolytic anaemia associated with use of omeprazole

Sir,

Omeprazole is a widely used drug. It is mainly used for the treatment of gastro-oesophageal reflux disease, peptic ulcer disease and Zollinger–Ellison syndrome. It is tolerated well with few side effects mainly limited to the gastrointestinal tract. However, over the years, serious haematological adverse reactions including haemolytic anaemia, leucopenia and thrombocytopenia have been reported.

The authors report here a further case of autoimmune haemolytic anaemia associated with the use of omeprazole.

A 72-year-old woman who was prescribed omeprazole for gastroesophageal reflux developed an allergic reaction within 2 days, which manifested initially as a generalized rash and marked eosi-

nophilia. This was followed by a fall in her haemoglobin level to 5.6 g/dl without any obvious bleeding. Investigations pointed to drug-related intravascular haemolysis as the cause. She made an uneventful recovery after omitting omeprazole and treatment with steroids.

In most cases of drug-induced haemolysis, provided the bone marrow function is uncompromised, withdrawal of the offending drug will lead to recovery without blood transfusion. In this case, the severity of anaemia and rapid fall in haemoglobin necessitated blood transfusion and simultaneous steroids.

The direct antiglobulin test and reticulocyte count are useful investigations in a patient presenting with anaemia and jaundice without obvious bleeding. The rash and eosinophilia in this patient closely followed initiation of omeprazole, suggesting an adverse drug reaction.

This case serves as a reminder to consider drug reactions as a cause of haemo-

lytic anaemia and highlights omeprazole as one possible cause. It also emphasizes the importance of the National Institute for Clinical Excellence (2004) guidelines which recommend the use of antacids or alginates as drugs of first choice in mild gastro-oesophageal reflux disease.

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National Institute for Clinical Excellence (2004)
Dyspepsia: management of dyspepsia in adults in primary care. Clinical Guideline 17. National Institute for Clinical Excellence, London

Always check the labels

Sir,

While working on a busy gastroenterology ward we admitted a 70-year-old man, whom had been previously fit and well, with a 12-hour history of coffee-ground vomiting and melaena. His past medical history included longstanding epilepsy. His medications on admission were sodium valproate 300 mg twice a day and lamotrigine 200 mg twice a day.

He had an endoscopy later that day which showed a bleeding ulcer, which was injected with adrenaline. He had no further symptoms or signs of gastrointestinal bleeding.

Five days after admission the patient began to complain of blurred vision, a headache and tremor. Over the next 2 days his mobility deteriorated and signs of nystagmus, truncal ataxia, incoordination and past pointing developed. He was unable to feed himself or mobilize. An urgent magnetic resonance imaging scan was organized which was normal. The patient continued to deteriorate and became markedly confused.

Eight days after his symptoms began the ward pharmacist noted that the lamotrigine in the patient's drug locker was labelled Mrs X rather than Mr X. His wife also

happened to suffer from epilepsy. The drug was withdrawn and over the next week the patient's symptoms completely resolved, he regained his lucidity and returned home with his wife.

This patient was started on a high dose of lamotrigine by error. Both the prescribing doctor and the ward pharmacist had checked the medication brought in by the patient and prescribed it accordingly. They had, however, failed to spot that the label on the medication gave his wife's name rather than his.

In addition to considering whether patients' symptoms may arise from medication side effects, it is also important to check that patients' own medications have been correctly and appropriately prescribed. Many things are supposed to be shared in marriage, but medications are not one of them.

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