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HYPERTENSIVE CRISIS ASSOCIATED WITH VENLAFAXINE

To the Editor:

Venlafaxine (Effexor; Wyeth Pharmaceuticals, Philadelphia, Pennslyvania), a novel nontricyclic serotonin and norepinephrine reuptake inhibitor, is a widely used treatment for depression and generalized anxiety disorder (1). Side effects of venlafaxine include headache, somnolence, gastrointestinal problems, and mild blood pressure elevation (2). We describe a 37-year-old woman who developed hypertensive crisis associated with venlafaxine.

For 6 weeks, the patient had been taking quetiapine and disulfiram for anxiety, depression, and alcohol abuse, and her blood pressure had been normal on previous clinic visits. Twelve days before admission, her psychiatrist prescribed venlafaxine and risperidone to control worsening anxiety. After 9 days, the patient developed blurry vision and her psychiatrist discontinued risperidone. However, the symptoms persisted and she was referred to an ophthalmologist. In clinic, her blood pressure was 220/140 mm Hg and cotton wool spots were identified in both eyes, prompting admission to the hospital. The patient also reported right arm and leg numbness and headache. Her blood pressure was 224/148 mm Hg and her heart rate was 102 beats per minute. She had no cushingoid features, and her neurological examination was normal. All outpatient medications were withheld. Eight hours after starting infusions of labetolol and nitroprusside, her blood pressure was 150/80 mm Hg and her symptoms had improved. Upon stopping the infusions, her blood pressure remained controlled on oral metoprolol.

Laboratory results showed that her electrolyte, cardiac enzyme, and thyroid-stimulating hormone levels were normal, as were results of urinalysis, electrocardiogram, alcohol level, and toxicology screen. Magnetic resonance imaging demonstrated abnormal T2 prolongation involving both cerebellar hemispheres, the midbrain, medulla, and medial thalamus consistent with hypertensive encephalopathy. Urine catecholamine levels, including 5-hydroxyindole acetic acid, vanillylmandelic acid, and metanephrine, were normal, and a renal ultrasound demonstrated no renal artery stenosis. The patient was discharged home on day 3.

Of this patient's medications, only venlafaxine causes hypertension, although the incidence is low and the effect on blood pressure is mild (2). Among 2817 patients enrolled in randomized trials of venlafaxine, diastolic blood pressure elevations developed in 4.8%, but the mean increase was only 1.02 mm Hg (3). In this meta-analysis, which included patients with pre-existing hypertension, none developed hypertensive crisis (3). The blood pressure effects of venlafaxine are highly dose dependent, occurring more frequently at doses above 300 mg/day (3), and are presumably attributable to noradrenergic potentiation (4).

Interestingly, in our case the patient was on a low dose of venlafaxine (75 mg/day), had no previous history of hypertension, and had an unrevealing extensive evaluation for secondary causes of hypertension. Furthermore, the rapid normalization of blood pressure after discontinuing venlafaxine is consistent with the short half-life of this medication (5 hours) (2). Disulfiram, which interferes with venlafaxine metabolism by inhibiting the CYP3A4 enzyme (2), may have increased toxicity from venlafaxine. Although disulfiram may provoke hypertension independent of venlafaxine through its interaction with ethanol (5,6), we found no evidence to support an acetaldehyde reaction in this patient. Physicians should be aware of the potentially dangerous blood pressure effects of venlafaxine, which may occur at lower doses when inhibitors of the CYP3A4 enzyme system are administered concomitantly.

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RHABDOMYOLYSIS AND HEMOLYSIS AFTER USE OF *COUTAREA LATIFLORA*

To the Editor:

Herbal remedies are extensively employed, although knowledge about their real therapeutic properties is limited. Adverse reactions to such products can occur (1–3), and a stricter regulation of their use is clearly needed (2,4). We report a patient who presented with rhabdomyolysis and hemolysis after ingestion of *Coutarea latiflora* (Copalchi) (Soria Natural, Garray, Soria, Spain), an apparently innocuous plant with presumed antidiabetic properties.

Two days after starting treatment with *C. latiflora*, a 58-year-old man had vomiting, dark urine, and jaundice. Four years earlier, the patient had shown a similar clinical picture after taking the same product. He had been diagnosed with type 1 diabetes 30 years before. On admission, his temperature was 37.3°C and he had jaundice, but otherwise physical examination was normal. Blood analysis showed the following values: total bilirubin, 6.4 mg/dL; direct bilirubin, 0.4 mg/dL; hemoglobin, 9.3 g/dL; mean corpuscular volume 103 μm^3; creatine kinase, 1409 U/L; lactate dehydrogenase, 1075 U/L; alanine aminotransferase, 47 U/L; reticulocyte count, 3.1%; and undetectable haptoglobin. Urine analysis revealed a hemoglobin level of 2.5 g/dL. Results of direct Coombs test, antinuclear antibody screening, and microbiologic studies were negative. Electrocardiogram, chest radiographs, and abdominal ultrasound examination were normal. The patient recovered uneventfully in 7 days.

In a review of the literature (Medline, 1966 to 2003), we found no references to the efficacy or side effects of *C. latiflora*, although there are reports that other herbs also can produce adverse effects (5,6). However, our case strongly suggests that ingesting the plant can provoke rhabdomyolysis and hemolysis. These reports emphasize the need for regulation of the use of herbal remedies based on demonstrated efficacy and safety.

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AN UNUSUAL AXILLARY MASS

To the Editor:

The epidermal adnexa includes hair follicles, sebaceous glands, and sweat glands. Most disorders of these structures are infectious or hormonal in origin and include tinea, furunculosis, acne vulgaris, or hidradenitis suppurativa. Neoplastic transformation, however, does occasionally develop from these adnexal components.

We describe the case of a 54-year-old man who had widely metastatic apocrine gland carcinoma originating from the axilla. The patient presented with a 2-year history of a slowly enlarging right axillary mass. Because the mass was slow growing and painless, the patient did not seek medical attention. As it enlarged and became more friable, a moderate amount of serosanguinous drainage necessitated daily wrapping of the mass with tissue paper. Approximately 1 year before admission, the patient began experiencing a persistent, dry, nonproductive cough.

On examination, the patient was afebrile and had mild temporal wasting. A large 8 × 6-cm right-sided pedunculated axillary mass was noted, as well as a 4 × 3–cm firm, nontender axillary lymph node (Figure 1). Lung examination revealed decreased air movement in the bases and scant crackles throughout. The remainder of the examination was normal. Laboratory studies were within normal limits. Chest radiograph demonstrated multiple nodular densities within both lungs (Figure 2). Wedge biopsy of the axillary mass showed moderately differentiated apocrine gland carcinoma.

Tumors of the epidermal adnexa differentiate along one of four cell lines: follicular, sebaceous, apocrine, or eccrine (1). Follicular cells are nonglandular and are responsible for forming hair. The other three cell types are glandular, each with their own unique method of secretion. Whereas normal eccrine sweat glands cells utilize merocrine secretion or standard exocytosis and sebaceous glands cells utilize holocrine secretion with expulsion of