Aspirin

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Isolated visceral angioedema: case report

An 80-year-old woman developed isolated visceral angioedema during treatment with aspirin for lumbago.

The woman presented to an outside institution with vomiting, nausea and acute epigastric pain. She had a medical history of end-stage renal disease due to antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis. Prior to current presentation, she had undergone a kidney transplantation 13 years ago, which had required side-to-side anastomosis and a small bowel resection of 2cm. At the same time, the ongoing immunosuppressive medications included prednisone and tacrolimus. Additionally, she had a history of hypertension with ongoing lisinopril treatment, hysterectomy for localised uterine cancer, and lumbago managed with oral aspirin 325mg twice daily. Over the previous year, she had experienced similar presenting symptoms including vomiting, nausea and abdominal pain, which eventually attributed to small bowel obstruction. The small bowel syndrome was established due to post-surgical adhesions and responded positively to conservative therapy. Upon presentation, a CT scan reported thickening in the transverse colon, and a moderate and diffuse thickening at the distal ileum of the small bowel. A superimposed closed small bowel loop was presumably detected in the left upper quadrant.

The woman was treated with IV hydration and bowel rest, and later discharged when presented asymptomatic. One month later, an MRI showed no wall thickening or dilation of the entire bowel. Following MRI, nausea, abdominal pain, nausea and vomiting recurred 2 weeks later. A CT scan reported dilated and fluid-filled multiple loops of small bowel and a transition point in the anastomotic region of right-lower quadrant. A conservative treatment was provided and her symptoms resolved. She was admitted to the hospital 2 months later with earlier symptoms, and aspirin therapy was stopped. A CT scan reported increased mucosal enhancement and wall thickening of the multiple stretches of dilated ileum/distal jejunum. A new thickening was also detected in the rectosigmoid colon extending from the descending colon up to the mid-transverse colon. A probable bowel obstruction was ruled out due to absence of a transition point. Her condition showed improvement within days with IV hydration and bowel rest. A visceral angioedema secondary to aspirin was suspected [*duration of treatment to reaction onset not stated*]. Her lisinopril was substituted with amlodipine during discharge.

Initially upon hospitalisation, the woman's aspirin dose was withheld, which was resumed during discharge. The similar symptoms recurred one month later and she was admitted to the hospital again. A CT scan reported worsening thickened walls in various sites of colon and small bowel. An elevated CRP level was seen. In the previous month, there was no exposure to an ACE-inhibitor. Thus, visceral angioedema was attributed to aspirin, which was subsequently withdrawn. Within 24 hours, her condition improved and she was discharged. A CT scan was performed 5 weeks later in an asymptomatic condition which indicated remission of the bowel wall thickening. Six months after the discharge, she had a telehealth visit and informed her transplant nephrologist that no symptoms recurred and her bowel condition had significantly improved. Two months later, she died due to pneumonia secondary to COVID-19.

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