

IMAGES IN EMERGENCY MEDICINE.....

Amiodarone induced thrombophlebitis

Thrombophlebitis of peripheral vein is a well recognised complication of intravenous amiodarone use in high doses (300–1200 mg) or prolonged infusion. This case demonstrates that even smaller doses of amiodarone can cause significant thrombophlebitis, if given in a small vein.

A 79-year-old man presented to his local emergency department with haemodynamically stable ventricular tachycardia. Amiodarone, 150 mg, was given via a 20-gauge cannula into a small vein on the dorsum of his left hand. Figure 1, a photograph of the hand, was taken 72 h after his original admission and shows severe amiodarone induced thrombophlebitis. Although thrombophlebitis is a well recognised complication of intravenous amiodarone, this is usually caused by high doses (300–1200 mg) or prolonged administration in a peripheral vein. A meta-analysis of 18 randomised controlled trials studying intravenous amiodarone to convert atrial fibrillation reported a rate of 8% of phlebitis among the 550 patients who received amiodarone.¹

This case clearly demonstrates that even small doses of amiodarone can cause significant thrombophlebitis, if given in a small vein. In cases where peripheral administration is necessary a large bore cannula in the largest vein available should be used.



Figure 1 Severe amiodarone induced thrombophlebitis.

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External iliac artery aneurysm and ureteric obstruction in a solitary kidney

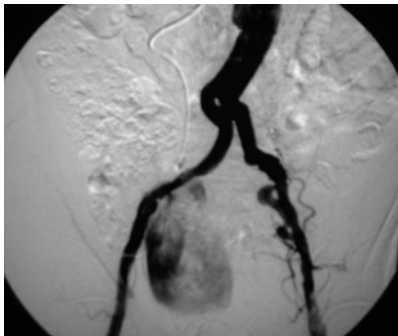


Figure 1 Angiography demonstrating a large external iliac artery aneurysm which was the cause of the ureteric obstruction.

Ureteric obstruction is amongst the commonest urological emergencies with the most frequent cause being renal stone disease. The emergency physician should, however, have a high index of suspicion to help in identifying other causes of ureteric obstruction.

A 64 year old male presented with acute-on-chronic renal failure, having previously had a left nephroureterectomy for renal cell carcinoma. Ultrasonography showed evidence of moderate hydronephrosis of the solitary right kidney. An emergency nephrostomy was performed and a nephrostogram showed a laterally displaced obstructed ureter. An unenhanced computed tomography scan revealed the obstructing lesion to be a large (8.7×8.5 cm) right external iliac artery aneurysm that was also demonstrated on angiography (fig 1). This was treated by endovascular stenting.

External iliac artery aneurysms causing ureteric obstruction in a solitary kidney are rare with only four reported cases.¹ Early diagnosis requires a high index of suspicion and subsequent radiological imaging. Emergency treatment includes nephrostomy and urinary drainage.

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