

NIH Public Access Author Manuscript

Ann Intern Med. Author manuscript; available in PMC 2012 November 06.

Published in final edited form as: *Ann Intern Med.* 2009 January 6; 150(1): 27–32.

Brief Communication: Radiographic Contrast Infusion and Catecholamine Release in Patients With Pheochromocytoma

Smita K. Baid, MD, Edwin W. Lai, BS, Robert A. Wesley, PhD, Alex Ling, MD, Henri J.L.M. Timmers, MD, PhD, Karen T. Adams, MSN, CRNP, Anna Kozupa, MD, and Karel Pacak, MD, PhD, DSc

Eunice Kennedy Shriver National Institute of Child Health and Human Development and Warren G. Magnuson Clinical Center, National Institutes of Health, Bethesda, Maryland, and Radboud University, Nijmegen Medical Center, Nijmegen, the Netherlands.

Abstract

Background—Contrast-enhanced computed tomography (CT) is useful for localizing pheochromocytoma. However, in patients with suspected pheochromocytoma, CT is often canceled or not performed because of the strong belief that intravenous contrast may induce hypertensive crisis.

Objective—To examine whether intravenous low-osmolar contrast administration during CT induces catecholamine release that increases blood pressure or heart rate.

Design—Prospective study.

Setting—Warren G. Magnuson Clinical Center, National Institutes of Health, Bethesda, Maryland.

Participants—22 patients with pheochromocytoma (15 nonadrenal and 7 adrenal) and 8 unmatched control participants without pheochromocytoma.

Measurements—Plasma catecholamine levels, blood pressure, and heart rate.

- Mr. Lai and Drs. Timmers and Kozupa: National Institutes of Health, 10 Center Drive, Bethesda, MD 20892.
- Dr. Wesley: National Institutes of Health, 9000 Rockville Pike, Bethesda, MD 20892.
- Dr. Ling: National Institutes of Health, 9000 Rockville Pike, Room 1C-351x, Bethesda, MD 20892-1182.

Reproducible Research Statement: *Study protocol:* Précis available at http://pqs.cc.nih.gov/protocol_query/protocol/1442. The complete protocol is available from Dr. Pacak (karel@mail.nih.gov). *Statistical code:* Available from Dr. Wesley (bwesley@mail.nih.gov). *Data set:* Available from Dr. Pacak (karel@mail.nih.gov).

Author Contributions: Conception and design: S.K. Baid, E.W. Lai, A. Ling, K. Pacak.

Analysis and interpretation of the data: S.K. Baid, E.W. Lai, R.A. Wesley, H.J.L.M. Timmers, K. Pacak.

Drafting of the article: S.K. Baid, E.W. Lai, H.J.L.M. Timmers, K. Pacak.

Critical revision of the article for important intellectual content: S.K. Baid, E.W. Lai, R.A. Wesley, A. Ling, H.J.L.M. Timmers, K. Pacak.

Final approval of the article: S.K. Baid, E.W. Lai, R.A. Wesley, K.T. Adams, H.J.L.M. Timmers, K. Pacak.

Provision of study materials or patients: S.K. Baid, A. Kozupa, K. Pacak.

Administrative, technical, or logistic support: E.W. Lai, K.T. Adams, H.J.L.M. Timmers, K. Pacak.

Collection and assembly of data: S.K. Baid, E.W. Lai, H.J.L.M. Timmers, K. Pacak.

Corresponding Author: Karel Pacak, MD, PhD, DSc, Reproductive and Adult Endocrinology Program, Section on Medical Neuroendocrinology, National Institutes of Health, Building 10, CRC, Room 1E-1-3140, 10 Center Drive, MSC-1109, Bethesda, MD 20892-1109; karel@mail.nih.gov.

Current Author Addresses: Drs. Baid and Pacak and Ms. Adams: Eunice Kennedy Shriver National Institute of Child Health and Development, 10 Center Drive, CRC 1E-1-3140, MSC-1109, Bethesda, MD 20892.

Potential Financial Conflicts of Interest: None disclosed.

Statistical expertise: R.A. Wesley.

Obtaining of funding: K. Pacak.

Results—Plasma catecholamine levels within and between groups did not significantly differ before and after intravenous administration of low-osmolar CT contrast. Patients with pheochromocytoma experienced a clinically and statistically significant increase in diastolic blood pressure that was not accompanied by corresponding increases in plasma catecholamine levels. The difference became non–statistically significant after adjustment for use of α - and β -blockers.

Limitation—The study lacked a placebo group, and the sample was relatively small.

Conclusion—Intravenous low-osmolar contrast–enhanced CT can safely be used in patients with pheochromocytoma who are not receiving α - or β -blockers.

Computed tomography (CT) is used to localize pheochromocytoma once it has been biochemically diagnosed. Noncontrast CT has high sensitivity (approximately 90%) in various types of pheochromocytoma, and contrast can increase both the sensitivity and specificity of CT (1).

It is commonly believed that the contrast media used for CT can induce hypertensive crisis in patients with pheochromocytoma. Reports of complications (such as hypertensive crisis) are well described in patients who underwent angiography for diagnosis and localization of pheochromocytoma in the 1960s and 1970s (2). However, these invasive procedures used high-osmolar (ionic) contrast agents, which are associated with more adverse events than low-osmolar (nonionic) contrast agents (3). Low-osmolar contrast agents are now used for most invasive and noninvasive radiologic procedures, including contrast-enhanced CT.

Since 2003, more than 200 patients with pheochromocytoma have been evaluated with contrast CT at the National Institutes of Health, Bethesda, Maryland. In our experience, there have been no reports of hypertensive crisis after injection of intravenous low-osmolar CT contrast in patients with pheochromocytoma, although we did not routinely record vital signs initially. We report the effect of intravenous administration of low-osmolar contrast during CT on plasma catecholamine release, blood pressure, and heart rate in patients with and without pheochromocytoma, to determine whether it induces catecholamine release that increases blood pressure or heart rate.

Methods

The protocol for this study was approved by the institutional review board of the Eunice Kennedy Shriver National Institute of Child Health and Human Development at the National Institutes of Health. All patients provided written informed consent.

Patients

We evaluated plasma catecholamine levels, blood pressure, and heart rate responses in 30 patients who received oral and intravenous low-osmolar contrast (Isovue 300 [Bracco Diagnostics, Princeton, New Jersey; ALTANA Pharma AG, Singen, Germany]), 30 mL at 1.8 to 2.0 mL/h, for whole-body CT at the Warren G. Magnuson Clinical Center, National Institutes of Health. Twenty-two patients had histologically confirmed solitary adrenal or metastatic pheochromocytoma. Eight patients in whom pheochromocytoma had been ruled out served as a control group. The Appendix Figure (available at www.annals.org) provides details on sampling and recruitment.

All patients had blood samples obtained through an indwelling forearm venous cannula at baseline (approximately 1 hour before the start of CT with the patient at rest and the intravenous line placed at least 20 minutes before blood draw); prescan (immediately before the start of CT, with the patient instructed to lie on the CT table for 10 minutes before the blood draw and start of CT); and at 5, 10, 15, and 20 minutes after contrast injection. Heart

rate and blood pressure were measured at all time points. Patients were supine during all measurements. Contrast was administered intravenously between the prescan and 5-minute post– contrast administration time points. Patients who were receiving antihypertensive medications continued to take these medications.

Plasma was analyzed for concentrations of catecholamines, including norepinephrine and epinephrine by high-pressure liquid chromatography, as described elsewhere (4).

Statistical Analysis

We used the 2-sample t test to compare preinjection and postinjection changes in patients with pheochromocytoma and control participants, comparing the change from the average of the 2 preinjection values with the average of the 4 postinjection values. We also used the 2sample t test to compare preinjection and postinjection changes in patients with solitary adrenal pheochromocytoma with those in patients with nonadrenal pheochromocytoma. Paired analyses within groups were done by using paired t tests. We used 2-way analysis of variance to test for differences between the patient groups while adjusting for whether the patients were or were not receiving adrenoreceptor blockade medications. For norepinephrine and epinephrine end points, log values were used because the raw values for these 2 variables were heavily skewed. All P values are 2-sided, and a value less than 0.05 was considered statistically significant. Summary values are presented as means.

Role of the Funding Source

This study was supported by the Eunice Kennedy Shriver National Institute of Child Health and Development, National Institutes of Health. The funding source played a role in the decision to submit the manuscript.

Results

We studied 22 patients with pheochromocytoma (12 women and 10 men; mean age, 46 years [range, 27 to 64 years]) and 8 control participants (4 women and 4 men; mean age, 49 years [range, 35 to 60 years]). The biochemical profile of pheochromocytoma was noradrenergic in 12 patients, adrenergic in 2 patients, mixed noradrenergic and adrenergic in 7 patients, and dopamine-secreting tumor in 1 patient (Table). Values were not available for every variable at each time point (Figure). However, for each variable except epinephrine (28 participants), values were sufficient for all 30 participants to be included in the comparisons of average values obtained before and after contrast administration.

Compared with preinjection values, epinephrine levels were significantly lower after contrast injection in patients with pheochromocytoma (mean change, $-1 \log \text{pmol/L}$ [95% CI, $-3 \text{ to } 0 \log \text{pmol/L}$]; P = 0.041). Norepinephrine values did not statistically significantly differ. Systolic blood pressure (mean change, 10 mm Hg [CI, 3 to 16 mm Hg]; P = 0.005) and diastolic blood pressure (mean change, 5 mm Hg [CI, 2 to 9 mm Hg]; P = 0.005) were significantly higher after contrast in the pheochromocytoma group. There was no statistically significant change in heart rate. In the control group, no statistically or clinically significant differences before and after contrast injection were observed in norepinephrine or epinephrine level, systolic or diastolic blood pressure, or heart rate.

Average preinjection norepinephrine levels were about 3 times higher in patients with pheochromocytoma than in control participants (Figure). However, the average change in norepinephrine levels from before to after contrast injection did not statistically significantly differ between the groups (mean change, 0.0010 log nmol/L [CI, -0.0004 to 0.0024 log nmol/L]; P = 0.148). Average preinjection epinephrine levels were similar in both groups. The between-group difference in average change in epinephrine levels before and after

contrast injection was not significant (mean change, 0 log pmol/L [CI, -3 to 2 log pmol/L]; P = 0.69).

Preinjection systolic and diastolic blood pressures were similar in patients with pheochromocytoma and control participants. The *t* tests did not show a significant effect of contrast administration on systolic blood pressure (P = 0.142) but did show a borderline significant effect on diastolic blood pressure (P = 0.045).

Average preinjection heart rates were higher in control participants than in patients with pheochromocytoma, although not significantly so. The effect of contrast administration on heart rate also did not significantly differ between the groups (P = 0.69, t test).

Nine patients with pheochromocytoma and 2 control participants were taking β -blockers, and 9 patients with pheochromocytoma and 3 control participants were taking α -blockers. Norepinephrine and epinephrine levels, systolic and diastolic blood pressure, and heart rate did not significantly differ before and after contrast administration between patients with pheochromocytoma and control participants after adjustment for use of α - and β -blockers. The between-group differences in diastolic blood pressure became non–statistically significant after adjustment for α -blocker use (P = 0.058) or β -blocker use (P = 0.069).

Changes in norepinephrine and epinephrine levels, systolic and diastolic blood pressure, and heart rate did not statistically significantly differ before and after contrast injection in patients with solitary adrenal pheochromocytoma and those with nonadrenal pheochromocytoma.

Discussion

We found little evidence that oral or intravenous administration of low-osmolar contrast leads to catecholamine release or catecholamine-induced increases in blood pressure or heart rate in patients with pheochromocytoma, findings that support our clinical observations that intravenous low-osmolar CT contrast does not induce hypertensive crisis in pheochromocytoma patients. A few patients had clinically significant increases in systolic and diastolic blood pressure and moderate increases in heart rate; however, these results were incongruent with their respective change in catecholamine levels. Other factors, such as anxiety or nervousness, may have contributed to increases in these values in these patients.

In a study of 10 patients with pheochromocytoma (4 with metastatic disease), Mukherjee and colleagues (5) reported that occasional patients with pheochromocytoma showed unpredictable catecholamine responses to intravenous administration of low-osmolar CT contrast; however, they concluded that catecholamine release and intravenous administration of contrast were unrelated. Our results agree with this conclusion. In addition, our sample included patients with both norepinephrine- and epinephrine-secreting tumors, as well as more patients with metastatic pheochromocytoma, who have greater tumor burden and higher catecholamine levels than those with solitary lesions.

The primary limitations of our study are related to the relatively small sample and lack of a placebo group. Multiple comparisons without correction may have also had some effect, as evidenced by the borderline statistically significant result in the between-group comparison of diastolic blood pressure.

In conclusion, we found that intravenous low-osmolar CT contrast had no appreciable effect on norepinephrine and epinephrine release in patients with various types of pheochromocytoma. We therefore conclude that use of intravenous low-osmolar contrast–

enhanced CT for localization of pheochromocytoma can be considered safe in these patients and that α - or β -adrenergic blockade, which is often given to prevent hypertensive crisis, is not necessary.

Acknowledgments

The authors thank Dr. Graeme Eisenhofer for his contribution in the preparation of this manuscript and the Warren G. Magnuson Clinical Center Department of Diagnostic Radiology staff for supporting the study.

Grant Support: By Eunice Kennedy Shriver National Institute of Child Health and Development, National Institutes of Health.

Appendix Figure. Study flow diagram



CT = computed tomography.

* Initial enrollment period.

[†] Recommended to the authors to include more patients with solitary adrenal pheochromocytoma.

References

- Ilias I, Pacak K. Current approaches and recommended algorithm for the diagnostic localization of pheochromocytoma. J Clin Endocrinol Metab. 2004; 89:479–491. [PMID: 14764749]. [PubMed: 14764749]
- Rossi P, Young IS, Panke WF. Techniques, usefulness, and hazards of arteriography of pheochromocytoma. Review of 99 cases. JAMA. 1968; 205:547–553. [PMID: 5694996]. [PubMed: 5694996]
- Aspelin P, Stacul F, Thomsen HS, Morcos SK, van der Molen AJ. Members of the Contrast Media Safety Committee of the European Society of Urogenital Radiology (ESUR). Effects of iodinated contrast media on blood and endothelium. Eur Radiol. 2006; 16:1041–1049. [PMID: 16395531]. [PubMed: 16395531]

- Eisenhofer G, Goldstein DS, Stull R, Keiser HR, Sunderland T, Murphy DL, et al. Simultaneous liquid-chromatographic determination of 3,4-dihydroxyphenylglycol, catecholamines, and 3,4dihydroxyphenylalanine in plasma, and their responses to inhibition of monoamine oxidase. Clin Chem. 1986; 32:2030–2033. [PMID: 3096593]. [PubMed: 3096593]
- Mukherjee JJ, Peppercorn PD, Reznek RH, Patel V, Kaltsas G, Besser M, et al. Pheochromocytoma: effect of nonionic contrast medium in CT on circulating catecholamine levels. Radiology. 1997; 202:227–231. [PMID: 8988215]. [PubMed: 8988215]

Swatermark-text

\$watermark-text

Baid et al.



Figure.

Average norepinephrine and epinephrine levels, heart rate, and blood pressure in patients with pheochromocytoma compared with control participants before and after intravenous administration of computed tomography contrast.

Arrows indicate the time of low-osmolar contrast injection. Bars represent 95% CIs. Number of patients with available data shown at each time point; there are no obvious outliers within the data.

Baid et al.

Table

Characteristics	
Patient	

Participant	Sex	Type of Pheochromocytoma	Biochemical Profile of Tumor	Use of a. or β-Blocker	Plasma Leve	Norepinephrine 1, <i>log nmol/L</i>
					Mean Precontrast Value	Change*
Pheochromocytoma group						
1	Female	Metastatic	Mixed	Both	0.056	0.0005
2	Male	Metastatic	Mixed	β-Blocker	0.061	-0.0008
ĸ	Male	Metastatic	Mixed	Both	0.057	-0.0027
4	Male	Metastatic	NE	Neither	0.039	0.0004
S	Female	Metastatic	NE	Neither	0.039	-0.0008
9	Female	Mestastatic	NE	Neither	0.043	0.0062
7	Male	Extra-adrenal	DS	Neither	0.031	0.0005
∞	Female	Metastatic	NE	Neither	0.034	0.0010
6	Female	Metastatic	NE	α-Blocker	0.041	-0.0010
10	Male	Metastatic	NE	α-Blocker	0.038	-0.0015
11	Male	Metastatic	Mixed	Both	0.050	-0.0008
12	Female	Metastatic	NE	Neither	0.038	-0.0007
13	Female	Metastatic	NE	Neither	0.036	-0.0013
14	Female	Metastatic	NE	β-Blocker	0.034	-0.0017
15	Female	Metastatic	NE	Both	0.041	0.0012
16	Male	Adrenal	Epi	Neither	0.032	0.0017

Participant	Sex	Type of Pheochromocytoma	Biochemical Profile of	Use of a or B-Blocker	Plasma	Norepinephrine
			Tumor		Leve	el, <i>log nmol/L</i> *
					Mean Precontrast Value	Change [*]
17	Female	Adrenal	Epi	Neither	0.036	0.0014
18	Female	Adrenal	Mixed	Both	0.048	0.0012
19	Male	Adrenal	Mixed	Both	0.039	0.0009
20	Male	Adrenal	NE	Neither	0.035	0.0007
21	Female	Adrenal	Mixed	Both	0.038	-0.0001
22	Male	Adrenal	NE	Neither	0.033	-0.0012
Within-group summary						
Average value (95% CI)					0.041	0.0001 (-0.0007 to 0.0009)
P value for before vs. after contrast administration					0.71	
Control group						
-	Male	NA	NA	Unknown	0.037	-0.0018
2	Female	NA	NA	Neither	0.034	-0.0002
б	Female	NA	NA	Neither	0.033	-0.0009
4	Male	NA	NA	a-Blocker	0.035	0.0016
S	Female	NA	NA	Both	0.039	-0.0022
6	Male	NA	NA	Neither	0.031	-0.0006
7	Female	NA	NA	Neither	0.034	-0.0018
8	Male	NA	NA	Both	0.037	-0.0011
Within-group summary						
Average value (95% CI)					0.035	-0.0009 (-0.0019 to 0.0001)

\$watermark-text

\$watermark-text

\$watermark-text

Participant		Sex	Type of Pheochromocytom	Bioch a Profij Tume	iemical U le of B	Jse of a- or -Blocker		Plasma No Level, <i>l</i> i	repineph og nmol//	rrine L
							Mean Precontra	ast Value C	hange*	
P value for before v contrast administra	's. after ation						0.078			
Between-group sum:	nary									
Average value (95%	CI)							0.0010 (-0.0	004 to 0.	0024)
Pvalue for pheochro vs. control group	mocytoma						0.148			
Plasma Epinephri log pmol/1	ne Level,		Systolic Blood Pressure, <i>mn Hg</i>		Di	astolic Blood ssure, <i>mm H</i>		He	eart Rate, eats/min	
Mean Precontrast Value	Change*	Mean	Precontrast Ct Value	lange*	Mean Prec	ontrast Value	Change*	Mean Precoi Value	ntrast	Change*
25	-2		135	38		<i>11</i>	14	91		0
23	-3		144	37		83	6	56		- 8
22	L-		138	34		84	25	74		4-
14	0		117	28		74	∞	58		4
18	0		132	27		84	4	72		0
17	9-		128	6		79	<u>د</u> -	86		7
18	-2		132	∞		71	12	55		-2
16	9-		122	7		78	-	66		13
12	4-		66	5		62	0	74		ε
15	-1		136	-		78	11	64		-
21	-1		157	-3		86	-3	72		-2
15	<i>+</i> -		114	-3		73	-5	86		3
12	1		115	ŝ		75	- 1	76		0

Baid et al.

\$watermark-text

\$watermark-text

\$watermark-text

Plasma Epinephr log pmol/	ine Level, L	Systolic Blo Pressure, <i>mn</i>	ood n Hg	Diastolic Bl Pressure, <i>mn</i>	ood 1 Hg	Heart Rate beats/min	ť
Mean Precontrast Value	Change*	Mean Precontrast Value	Change*	Mean Precontrast Value	Change*	Mean Precontrast Value	Change*
16	0	161	-10	62	4	62	3
9	2	142	-12	78	-	60	2
24	ε	149	ŝ	42	4	63	9
19	ب ب	136	2	80	ε	73	-4
20	ε	147	L	06	0	79	-4
30	0	133	13	64	22	74	6
15	0	120	2	78	4	63	2
26	0	127	19	72	4	64	2
16		128	∞	81	5	57	6
18	-1 (-3 to 0)	132	10 (3 to 16)	<i>LL</i>	5 (2 to 9)	69	1 (-1 to 3)
0.041		0.005		0.005		0.31	
19	0	148	33	94	-	61	6
11	-	120	2	71	S	57	4
21	ب ب	143	4	84	S	86	ν.
21	0	127	25	73	ε	67	ω
24	4	136	-19	79	-12	82	0
I	÷-	138	S	82	4	71	ι, Έ
17	-2	119	6-	82	L-	80	L-
19	5	139	-4	90	L-	73	-10
19	-1 (-3 to 1)	134	1 (-10 to 11)	82	-1 (-7 to 4)	76	0 (-5 to 6)

Ann Intern Med. Author manuscript; available in PMC 2012 November 06.

Baid et al.

\$watermark-text

\$watermark-text

\$watermark-text

Systolic Blood Diastolic Blood Heart Rate, Pressure, <i>mm Hg beats/min</i>	* Mean Precontrast Change [*] Mean Precontrast Change [*] Mean Precontrast Change [*] Value Value	0.85 0.59 0.93	8.8 (-3.12 to 20.74) 6.5 (0.16 to 12.79) 0.88 (-3.67 to 5.43)	0.142 0.045 0.69	reting; Epi = predominantly epinephrine-secreting; NA = not applicable; NE = predominantly norepinephrine-secretic	lministration values minus the average of 2 pre-contrast administration values.
Systolic Blood Pressure, <i>mm Hg</i>	* Mean Precontrast Change [*] Mean] Value	0.85	8.8 (-3.12 to 20.74)	0.142	ceting; Epi = predominantly epinephrine-secreting;	ministration values minus the average of 2 pre–cor
Plasma Epinephrine Level, <i>log pmol/L</i>	Mean Precontrast Change	0.31	0 (-3 to 2)	0.69	DS = predominantly dopamine-secr *	The average of 4 post–contrast adı +

\$watermark-text

\$watermark-text

\$watermark-text