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## ACEI associated angioedema

### Dear Editor

We were pleased to see the recent article by Andrew et al<sup>1</sup> drawing attention to the important issue of angioedema occurring as a complication of therapy with angiotensin converting enzyme inhibitors (ACEIs) (*AFP* January/February 2012). We understand that the case presentation was intended to provide an example of the potential severity of this condition, with a tragic outcome. However, we were concerned at the lack of any comment regarding the initial management of the patient, which was inappropriate and dangerous. It is stated in the discussion that ACEI associated angioedema is usually unresponsive to antihistamines and corticosteroids. It is usually also (as illustrated by this case) unresponsive to adrenaline. As it is not always certain that a patient who experiences angioedema while on an ACEI is necessarily suffering from ACEI induced angioedema (it might be coincidental allergic or idiopathic angioedema), a cautious trial of these drugs is reasonable. However, there is no instance in which it is appropriate to administer four doses of 0.3 mg intravenous adrenaline to any patient, let alone a patient who is 78 years of age with no immediate threat of respiratory obstruction.

There is often confusion between the diagnosis of isolated angioedema and anaphylaxis. Isolated angioedema (without urticaria, bronchospasm or hypotension) may be idiopathic or allergic in origin. If the airway is threatened by laryngeal or posterior pharyngeal swelling, initial treatment is similar to that for anaphylaxis. Recent guidelines for anaphylaxis management<sup>2</sup> recommend intramuscular adrenaline and, if subsequently necessary, adrenaline infusion, but specifically caution against the use of intravenous adrenaline boluses. If there

is reason to suspect bradykinin mediated angioedema (use of ACEIs, hereditary or acquired C1 inhibitor deficiency), adrenaline should either not be used or not be repeated after initial failure. Emergency airway management is of prime importance and the bradykinin antagonist icatibant (now available in some major hospital emergency departments) should be strongly considered.

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### References

1. Andrew N, Gabb G, Del Fante M. ACEI associated angioedema. *Aust Fam Physician* 2011;40:985–8.
2. Anaphylaxis wallchart. *Australian Prescriber* 2011;34:124.

### Reply

#### Dear Editor

Thank you to Dr Smith and Professor O'Hehir for their interest in our article<sup>1</sup> on ACEI angioedema. We agree that the use of intravenous adrenaline to treat this problem is inappropriate and dangerous. Furthermore, since ACEI angioedema typically occurs in older populations, many patients will have an inherent elevated risk of cardiovascular events.

However, our primary goal in writing the case report was not to discuss the details of acute airway management, but to increase awareness, particularly among primary care physicians, of the potential for angioedema in patients treated with ACEIs. Much of the literature regarding ACEI angioedema is in specialist journals (ie. ENT and immunology) and recognition of the phenomenon in the primary care setting is suboptimal.

The real tragedy in this case was that the significance of the episode of tongue swelling

6 months prior was not appreciated, and that the symptom of 'swollen tongue' on the morning of presentation did not trigger closer observation. The referral with 'macroglossus of uncertain aetiology' suggests that the role of the ACEI had not been recognised.

More broadly, this case raises issues regarding current quality and safety practices in healthcare in Australia. While this event could be regarded as a sentinel event (event in which death or serious harm to a patient has occurred), it does not meet the agreed national list of core sentinel events.<sup>2</sup> For medications this is 'medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs'. This death is not reportable to the coroner, or audited as would a surgical, obstetric or paediatric death. As such, opportunities to reduce the risk of future similar events may be being missed.

The consultation paper for establishing a set of Australian Safety and Quality Goals for Health Care<sup>3</sup> has an emphasis on the prevention of harm, and a priority to reduce harm from medicine. This may be an opportunity to develop further strategies to improve the safe use of medicines, including reducing the risk of infrequent but potentially severe adverse effects that can occur with the correct use of prescribed medications, especially given the increasing use in lower disease risk populations.

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### References

1. Andrew N, Gabb G, Del Fante M. ACEI associated angioedema. *Aust Fam Physician* 2011;40:985–8.
2. The Australian Institute of Health and Welfare. Available at [www.aihw.gov.au/publication-detail/?id=6442468005](http://www.aihw.gov.au/publication-detail/?id=6442468005) [Accessed 25 January 2012].
3. The Australian Commission on Safety and Quality in Health Care. Consultation paper. Available at [www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/ASQGHC](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/ASQGHC) [Accessed 25 January 2012].

## International medical graduates

### Dear Editor

Thank you very much for the excellent article on international medical graduates, 'Patient centred care – are international medical graduates 'expert novices'? by Maria Dahm<sup>1</sup> (*AFP* November 2011). I am an IMG myself, having worked in Australia for over 11 years now. I have just started my general practice training this year and did my registrar presentation on the topic 'What is the patient's agenda'. While I agree with many of the author's comments, I would like to point out certain issues that may be faced by doctors, not only IMGs, who are new to general practice training.

General practice is a business based on service (as opposed to producing goods). Even if a general practice registrar is a salaried employee, as opposed to someone who depends on percentage of billings, he or she is confined to time restrictions demanded by the business model of the practice, most of which are not government funded or charitable organisations. Most registrars get to see a patient within a 15 minute allotment and most patients do not seem to realise that if they have a complex or multiple issues that need to be covered during their appointment they will need to book longer appointments. This poses severe restraints on the doctor who has to make sure that nothing serious gets missed and that the next patients are not waiting hours behind their scheduled appointment time.

It may be ideal to have a 'conversation' with the patient rather than an 'interview', but most of our conversation skills are formed and perfected in the primary school period. International medical graduates are by definition doctors who arrive in Australia after they have at least finished their primary university degree. Learning all the idioms and mannerisms of another culture involves not only learning the language but also having to live and work in that culture for a quite a long time. Doctors who engage in conversations rather than interviews may not necessarily obtain all the relevant information at all times, or they may already have much of

that information at hand, having seen those patients for years beforehand.

In addition, IMGs have to do layers of exams before they can start to practise as fully independent specialists (including as general practitioners). The expectations and time restraints of exams mean that these doctors, even after they are in Australia, have to get used to the 'rapid fire sequence' of questioning, and not be too relaxed to, for example, ask an old lady about her dog that died a year ago or so. I am sure IMGs who have been established as GPs for a long time may have a more similar style of questioning to the locally trained doctors.

I would, however, like to applaud Ms Dahm on the excellent article that is at the very heart of general practice, that is, the style of the consultation.

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### Reference

1. Dahm MR. Patient centred care – are international medical graduates 'expert novices'? *Aust Fam Physician* 2011;40:895–900.

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