

Acute Toe Ischemia in a Patient Receiving Ergotamine

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Abstract

We report a case of ischemia of the big toe secondary to taking ergotamine.

42 year-old women, non-smoker, with no medical history. The patient presented paresthesias and severe pain and of the left big toe. She admitted taking ergotamine tartrate to treat a new episode of headache as she had done previously during 2 years. The patient was diagnosed with arterial ischemia in relation with ergotism.

Cardiovascular manifestations of drug ergotism must be sought.

Keywords: Acute Toe Ischemia; Ergotamine

Introduction

Ergotism, in its major form, leads to a diffuse arterial spasm causing disabling limp claudication and disappearance of all distal pulses and sometimes proximal pulses. Venous spasm can be associated with arterial spasm, with diffuse cyanosis predominating at the extremities, and subcutaneous veins that are difficult, if not impossible, to puncture.

In its minor form, ergotism combines permanent acrorrhigosis and distal erythritis.

We report a case of ischemia of the big toe secondary to taking ergotamine.

Observation

We present a 42 year-old women non-smoker, with no medical history. The patient attended the emergency due to severe pain and paresthesias of the left big toe. On examination, the patient presented a necrotic maculopapular lesions located in the left big toe (Figure 1 and 2). all pulses are present. The blood tests were without abnormalities. A vascular Doppler was normal.

Figure 1

An acute ischemia of the left big toe was retained.

After a new anamnesis, the patient admitted taking ergotamine tartrate to treat a new episode of headache as she had done previously during 2 years. The patient was diagnosed with arterial ischemia in relation with ergotism.

Figure 2

The evolution was favorable thanks to the vasodilator treatment and to the discontinuation of the treatment with ergot derivatives (Figure 3).

Figure 3

Discussion

Ergotamine is an alpha-adrenergic agonist used in the treatment of migraine crisis. It causes peripheral vasoconstriction of the vessels in the smooth muscle. It is mainly metabolized through cytochrome P450 3A (CYP 3A) [1]. Generally, 10% of patients presented an adverse effect such as vomiting, nausea, abdominal pain, only 0,01% developed ergotism characterized by a vasomotor syndrome with peripheral arteria [2]. The first particularity of our

case is that the vasomotor syndrome was affecting just one toe and not the extremities. Some cases of clinical ergotism in HIV-infected patients has been published since 1997 [3-5].

In our case, no medical history is known for our patient specially HIV infection neither other diseases.

Drug ergotism can be triggered or promoted by a drug combination, in particular with antibiotics such as (macrolides: erythromycin) and other hepatic enzyme inhibitor drugs (cimetidine, ranitidine, clofibrate and phenylbutazone). This factor was absent in our patient.

Conclusion

Cardiovascular manifestations of drug ergotism are reported. This observation recalls the potential gravity of ergotism, the diagnosis of which must be raised face to any severe arterial ischemia and drug intoxication must be sought.

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