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Clinical vignette: Levamisole-tainted cocaine causing leukocytoclastic vasculitis

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Levamisole-Tainted Cocaine Causing Leukocytoclastic Vasculitis

INTRODUCTION:

♦ In 2009, MMWR reported that up to 70% of cocaine seized at US borders is cut with levamisole.⁶

This anti-helminthic agent is primarily used in veterinary medicine, but it has immunomodulating properties and has been used to treat some forms of cancer in humans. Specifically, it was tested in colon cancer² and has some steroid-sparing use in pediatric nephrotic syndrome.

From experience in these populations it is known to cause a reversible neutropenia. The association of cocaine and levamisole with leukocytoclastic vasculitis is recently being reported in the medical literature.³⁻⁵



and endothelial cell is provided in skin biopsy of a cryoglobulinemic patient

USE AS A CUTTING AGENT:

The reason for levamisole's increasing use as a cutting agent is multifactorial and a fascinating interplay of pharmacology and drug distribution and sales.

♦ At the point of sale, use of levamisole does result in larger and heavier rocks, leading to the assumption that a higher quality product is being purchased.

There is some preliminary evidence that levamisole itself may be selected for pharmacologic qualities, rather than just the resultant effect on appearance.

Levamisole may interact with monoamine neurotransmitters in key regions of the brain, specifically with serotonin, norepinephrine, and dopamine.¹⁰ This may be enhancing the cocaine user's subjective high, leading to repeat use.



Dilated venules with abundant small to medium-sized fibrin thrombi

Upper arrow: fibrin thrombus in a dilated venule Lower arrow: extravasation of inflammatory neutrophils Deposition of IgG, IgM, IgA, C3, and fibrinogen present in the vascular walls is diagnostic of vasculitis¹

Do note that this immunofluorescence slide is not of the patient being presented, due to the loss of fluorescence after a couple weeks. However, it is representative of what would be seen accord to the pathology report.

There is a conflict between the histopathology and the direct immunofluorescence, something that has been also noted in prior case reports.8



Neynaber S, Mistry-Burchardi N, et al. Acta Derm Venereol 2008

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CASE REPORT:

♦ A 36-year-old woman presented to Emergency with 2.5 years duration of waxing and waning severe pain related to confluent necrotic lesions involving her lower extremities. Her medical history was significant for crack cocaine use for 12 years, resulting in a recent admission for febrile neutropenia consistent with levamisole toxicity. Last use was the night prior to this presentation, toxicology screen was positive for cocaine.

Physical exam revealed a cachectic, malnourished woman in severe distress with painful non-blanching purpura noted along the helixes of both ears and tip of the nose. Her lower extremities had large, minimally retiform purpuric plaques with surrounding erythema, which later developed hemorrhagic bullae over the subsequent 10-day hospital course.

◆ At admission, her absolute neutrophil count was 2,200, reaching a nadir of 1,000. Inflammatory markers included C-reactive protein elevated at 6.9, erythrocyte sedimentation rate greater than 120.

◆ No evidence of infectious process was found during the hospital course, including viral serologies and bacterial cultures.



Large, minimally retiform purpuric plaques with surrounding erythema over the lower extremities Painful, non-blanching purpura along the helix of the ears and the tip of the nose

◆ ANA was positive (titer, 1:320), as well as P-ANCA positive (titer, 1:2560) with both PR3 and MPO significantly elevated at 441 and 289, respectively. Additional rheumatologic serologies included positive Lupus-like inhibitor, Beta-2 glycoprotein IgM, anti-cardiolipin IgM, and normal IgG levels.

♦ A skin biopsy was obtained and histopathology showed dilated venules with abundant small to medium-sized fibrin thrombi. (panel at Left)

Direct immunofluorescence pattern had deposition of IgG, IgM, IgA, C3, and fibrinogen in venule walls diagnostic of leukocytoclastic vasculitis. (panel at Left)

Treatment with steroids resulted in slow partial resolution of the lesions.

TREATMENT:

• There is no specific treatment for this condition, rather identification of the cause and then removal of the offending agent is the primary issue.

Small role of systemic corticosteroids, but unproven.

DISCUSSION:

Timely identification of this process is key for therapeutic intervention of patient abstinence from all cocaine use.

♦ As levamisole is being found with such frequency in cocaine, manifestations of toxicity with respect to impaired immunity and vasculitis must be made known to practitioners.

This presentation does not tend to respond to immunosuppressants and in fact application of steroids or cytotoxic therapy may worsen the condition when combined with the effects of cocaine and levamisole.

♦ Additionally,

COCAINE-RELATED PSEUDOVASCULITIS

LEVAMISOLE-RELATED VASCULOPATHY



Neynaber S, Mistry-Burchardi N, et al. Acta Derm Venereol 200



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Disclosure:

Some tissue images are not from the case presented as they were not bhrosen@salud.unm.edu available.