ABSTRACT

Sudden symmetric cutaneous eruption in any patient who is taking medications is consistent with drug reaction. The most frequent adverse events in patients receiving drug therapy is cutaneous drug reactions. They occur within hours of administration of the offending agent. Aspirin is commonly used to prevent coronary and cerebral thrombosis as well as for body aches and pain and freely available over the counter. Hence the importance of identifying fixed drug eruption as its adverse effect remains very vital. We are reporting case of 24 year male who presented with drug eruption after ingestion of NSAID a provisional diagnosis of salicylates induced fixed drug eruption was made, the patient was managed with optimal response.

KEY WORDS: Drug eruption, Salicylates, Adverse Drug Reaction, Der medication.

INTRODUCTION

Antibiotics (trimethoprim-sulfamethoxazole, tetracycline, penicillin, and erythromycin), followed by nonsteroidal anti-inflammatory drugs (NSAIDs; diclofenac sodium, aspirin, naproxen, and ibuprofen he are most common drugs causing fixed drug eruption. Skin lesions recur at the same anatomic sites upon repeated exposures to an offending agent. fixed drug eruption presents mainly as sharply marginated, round or oval itchy plaques of erythema and edema becoming dusky violaceous or brown, and sometimes vesicular or bullous. Bourns in1889 described first case; five years later, Brocq termed it as “eruption erythematopigmentee fixe”. The most common sites are the genitalia in males and the extremities in females and recur within half hour of administration. 

CASE REPORT

Our patient 24 years old male, who was admitted with a 2 days history of headache, developed patches of dark bluish and black areas on the skin of whole body especially on the face, trunk and arms. He also noticed few small bullae on the face and some parts of skin of body with itching and burning sensation. There was no history of fever, dyspnoea or bronchospasm. He had similar type of eruption last year after taking two tablets of aspirin. On clinical examination patient was lying comfortably,--vital haring with patches of dark bluish discoloration of whole body. There were multiple macules of varying sizes on the face, eyelids and around the mouth, neck, chest, arms, abdomen, back, penis and scrotum with small bulla present on the skin of right fore-arm. The diagnosis of fixed drug eruptions due to aspirin was made. Blood complete picture, serum urea, serum electrolytes, urine and stool examination and chest radiograph were normal. Throat swab for culture and sensitivity revealed normal throat commensals growth. He was advised oral and local steroids, oral anti-allergy and local calamine to which he responded optimally within two weeks.

DISCUSSION

Dermatitis medicamentosa or drug eruptions are the cutaneous reaction produced by the internal administration of a drug eruptions are the cutaneous reaction produced by the internal administration of a drug. Fixed drug eruptions follow the use of many drugs including aspirin, salicylate, quinine, iodides and phenolphthalein. Based on their clinical features and the distribution of the lesions, several types have been described. The reappearance of the lesions over the previously affected sites on re-challenge with the offending drug is considered to be a diagnostic hallmark. Acute lesions develop 30 min to eight hours after re-administration of the
incriminating drug and usually the interval between intake of the drug to appearance of lesions is shorter with each episode. Multifocal fixed drug eruption is sometimes confused with Stevens Jhonson syndrome/Toxic epidermal necrolysis. In a retrospective study in Taiwan it was seen that patients with multifocal fixed drug eruption were older than Stevens Jhonson syndrome/Toxic epidermal necrolysis patients. They were less likely to have constitutional symptoms and mucosal involvement. In histopathology, presence of eosinophils, neutrophils, or melanophages in the superficial and deep infiltrates favours multifocal fixed drug eruption over Stevens Jhonson syndrome/Toxic epidermal necrolysis. The absence of fire flag sign and higher eosinophil scores further differentiate fixed drug eruption from Stevens Jhonson syndrome/Toxic epidermal necrolysis.

**CONCLUSION**

Avoiding of offending drug is the most useful treatment.

**COMPETING INTERESTS**

There are no competing interests to declare.
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