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Erythema multiforme from sulfaguanidine

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Case Report

A 25-year-old man presented with slightly elevated erythematous mac ules symmetrically distributed over the buttocks, back, backs of the hands and olecranon area, which had evolved into bullae in 24–48 h. He had no mucosal lesions or any other symptoms. He had taken paracetamol and Angileptol (sulfaguanidine, benzocaine, enoxolone), and had used Anginovac oral spray (dequalinium, enoxolone, hydrocortisone, lidocaine) 12 h previously. He was treated urgently with antihistamine and oral corticosteroid. The eruption resolved favourably in a week, leaving some postinflammatory hyperpigmentation. He had experienced three previous episodes of morphologically different cutaneous lesions (macules, papules, wheals and bullae), all associated with the administration of Angileptol and Anginovac.

Patch tests were applied on a residual cutaneous lesion, with readings at 1, 2 and 3 days (D) with paracetamol, sulfamethoxazole, sulfaguanidine and sulfanilamide (all 10% DMSO), Angileptol (as is), Anginovac spray (as is), benzocaine (5% in petrolatum) and DMSO as control. At D1, sulfaguanidine alone showed an erythematous purple lesion with a clear-cut peripheral limit (Fig. 1), all other drugs being negative at D1–D3. Patch tests with sulfaguanidine were negative in 10 control patients. Single-blind controlled oral challenges with paracetamol, hydrocortisone, lidocaine and Anginovac (therapeutic doses) were negative.

Discussion

Sulfonamides often cause cutaneous eruptions, particularly when systemically administered, like sulfamethoxazole and sulfadiazine (1). A few cases of erythema multiforme (EM) (2, 3) and lupus-like eruptions (4) have been reported from ocular sulfacetamide. Sulfaguanidine is widely used topically to treat oropharyngeal infections, and has low intestinal absorption. The only adverse cutaneous reactions previously reported from sulfaguanidine have been ectodermosis erosiva pluriorificialis (5) and fixed drug eruption (FDE) (6). EM caused by sulfaguanidine has not previously been reported to our knowledge.

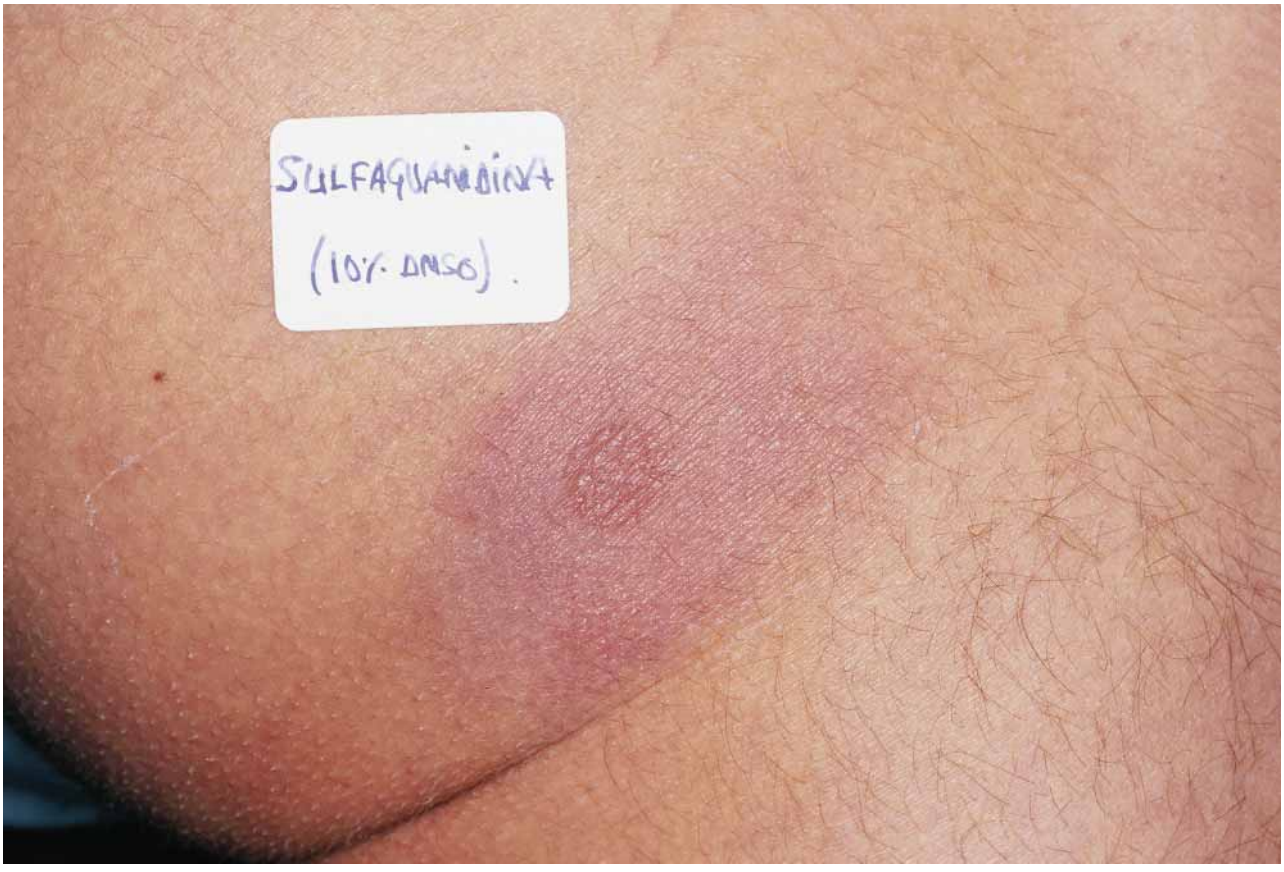

Fig. 1.

Though it has lower sensitivity than oral challenge and may exceptionally elicit generalized reactions (7), reduction of risk to the patient makes patch testing advisable as the initial diagnostic method. False-negative results may be due to (i) too low a patch test concentration, (ii) unsuitable vehicle decreasing penetration of the drug or (iii) inappropriate patch test application area (8).

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