Case Report

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ACECLOFENAC INDUCED ERYTHEMA MULTIFORME MAJOR: A CASE REPORT

Chandak Rakhi[1],Sonule Sonal[2],Kulkarni Sunita[3],Akhade Sonali[4]
1. Associate Professor
2. Post Graduate
3. Head and Professor
4. Post Graduate
Swargiya Dadasaheb Kalmegh Smurti Dental College &Hospital, Hingna road, Wanadongri, Nagpur, Maharashtra

ABSTRACT:

Erythema multiforme (EM) is an interesting dermatologic disease which has oral manifestations of unknown cause, which is possibly mediated by deposition of immune complex (mostly IgM) in the superficial microvasculature of the skin and oral mucous membrane that usually follows an infection particularly herpes simplex and mycoplasma pneumonia) or drug exposure. EM is clinically characterized by a ‘‘minor’’ form and a ‘‘major’’ form which is more severe which is also known as “Stevens-Johnson syndrome”. This form is usually caused by reactions to medicines, rather than infections. It presents with involvement of one or more mucous membranes with epidermal detachment involving less than 10% of total body surface area. It presents a diagnostic dilemma because the oral cavity has the ability to produce varied manifestations. Here we present a case of fifty year old male reported to our department who developed ulceration all over the mucosa with lesion on hand and genital area after taking medication for toothache.

Key Words: Erythema multiforme, Stevens-Johnson syndrome, aceclofenac, methylprednisolone.

INTRODUCTION:

Erythema multiforme (EM) is an acute inflammatory mucocutaneous disease of the skin and mucous membranes that causes a variety of skin lesions. Erythema multiforme occurs mostly in children and young adults. [1]A major form of EM, SJS is named for Albert Mason Stevens and Frank Chambliss Johnson, American pediatricians in 1922.[2] Women are affected more often than men (2:1) and rare after 50yrs.[3]

Almost any medicine can induce skin reactions, and certain drug classes, such as non-steroidal anti-inflammatory drugs (NSAIDs), antibiotics and antiepileptics, have drug eruption rates approaching 1–5%. [4] Although most drug-related skin eruptions are not serious, some are severe and potentially life-threatening.

CASE DETAIL:

A fifty year old male was absolutely alright 3 days back. After which he suddenly started experiencing toothache in lower left back tooth region at midnight for which he took 1tablet of analgesic (aceclofenac) but pain did not subsided so, again he took 2 more tablets at a time. Next day in the morning he noticed swelling all over the face including lips and

*Corresponding Author Address: Dr. Sonal S. Sonule Email: s.sonule@yahoo.com

also noticed ulcerations all over the mouth. Swelling over the face and ulceration in mouth had increased in severity. So, he again visited to near by pharmaceuticals where he took another medication cetrizine. But he didn't get any relief, rather worsen.

He reported to Department of Oral Medicine & Radiology with the chief complaint of difficulty in drinking, swallowing and ulceration all over the oral cavity since 3 days. On examination large erythematous and desquamated areas were seen on labial mucosa, right & left buccal mucosa, soft and hard palate, with prominent lip involvement. Medical, personal and family history found to be normal. The patient gave h/o similar type of ulceration of oral mucosa before one year after taking aceclofenac medication for toothache subsided within 2 days. General examination suggested icterus and his vital signs were normal. Systemic examination revealed fatigue, lethargy and oligouria with no burning in micturation.

Exfoliative cytology was performed and reported normal epithelial cells in cluster and in groups. So, we advised him to apply 0.1% Triamcinolone acetonide on the lesion for 2 to 3 times and recalled him next day. He returned after 24 hrs with more extensive erythema over the entire oral mucosa with sloughing of superficial epithelium and bleeding spots over vermilion border of upper lip.(Figure.1) A 'single targatoid lesion' was seen on dorsal aspect of left hand between wedge of middle and ring finger about 2 cm in diameter with epithelial desquamation with little itching. (figure.2) Similar targatoid lesion also appeared on the skin of testis about 1.5 cm of diameter in size.(figure.3) Based on the case history and examination he was diagnosed clinically as drug induced erythema multiforme major.

The baseline investigation revealed Haemoglobin level of 13.3g/dl, leukocytes 8000/mm^3 with raised values of neutrophils 74%, lymphocytes 20% and eosinophils 1%, monocytes 5%, RBC count 3.87 million/ mm^3, platelet count 2.55 lac/mm^3, ESR value raised 17 mm at the end of 1 hr. Liver function test showed slight increase in ALT 56 units/l, AST 30 units/l, serum alkaline phosphates 180 IU/L. Serology test were negative. Therefore we added systemic prednisolone 10mg TDS and continued topical steroid. Recalled him next day.

Patient did not get any relief. Crusted lesions were seen on lower lip and lesion on left hand showed epithelial sloughing. So referred him to general physician where he was administered Hydrocortisone 100mg (IV) stat and injection avil 2cc (IM) and continued him on systemic prednisolone 10 mg QID for 5 days, tablet avil TDS for 5 days, and omeprazole BD for 5 days. Patient was recalled after 5 days.

He returned after 5 days, inflammation and erythema were slighty reduce in severity over the right and left buccal mucosa, crusty lesions were present on upper and lower lip, petechie was present at the junction of hard and soft palate.

Lesion on hand showed complete denuded superficial epithelium and bleeding spots were seen at the center of the lesion. Suddenly after 5–10 minutes the lesion on hand started bleeding profusely. Immediate dressing was done. And again patient was reffered to general physician on same days. There he was prescribed with tablet methylprednisolone 8 mg BD for 7 days and was followed by tapper of 8 mg OD for 7 days, Tablet pantaprazole (40mg) BD for 7 days, Betadine gargles, Candid B mouth paint 2 to 3 times a day for 7 days , Syrup- Divol LA T.I.D for 7 days.

Complete resolution of oral and genital lesions with new skin formation evident on after 10 days. (figure.4)

DISCUSSION:

Hallmark of the disease is typical and/or raised atypical target lesions. In EMM oral lesions are multiple, large, shallow, irregular, painful ulcers surrounded by an erythematous margin and covered by whitish plaques of desquamated epithelium occurs. Affected patients may have trismus, dysphonia, dysarthria, and/or dysphagia. Other mucosal surfaces including ocular, nasal, pharyngeal, laryngeal, lower respiratory, and anogenital may be involved.[1]

Drug-associated EM seems to involve CD8+ T-cell attack and expression of tumor necrosis factor alpha in lesional skin in the absence of HSV-DNA.[5] There is no reliable laboratory based mean of definitively diagnosing EM except PCR technique. Systemic reactions, with cutaneous, nasal, and bronchial symptoms, and few cases of allergic and nonallergic anaphylactic reactions [6,7-10], have also been reported.

Many patients can be miss diagnosed therefore casual drugs should be stopped and relevant infection should be treated. Mouthwashes containing local anesthetic and mild antiseptic compounds with liquid diet may help in relieving painful oral symptoms. In severe forms of EM, hospital and supportive care are often important. Corticosteroids are the most commonly used drugs in the management of EM, despite the lack of evidence. EMM should be treated with systemic corticosteroids (prednisolone 0.5–1.0 mg/kg/day tapered over 7–10 days) whereas drug induced EMM should be treated with methylprednisolone.

CONCLUSIONS:

Systemic steroids are the mainstay of treatment. Supportive care, treatment of infections and withdrawal of precipitating agents are equally important. Also, the allergic patients should be advised to refrain same class of drugs in future. Therefore dentist should perceive complete knowledge of hypersensitivity reaction occurring due to drug intake.

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FIGURES:

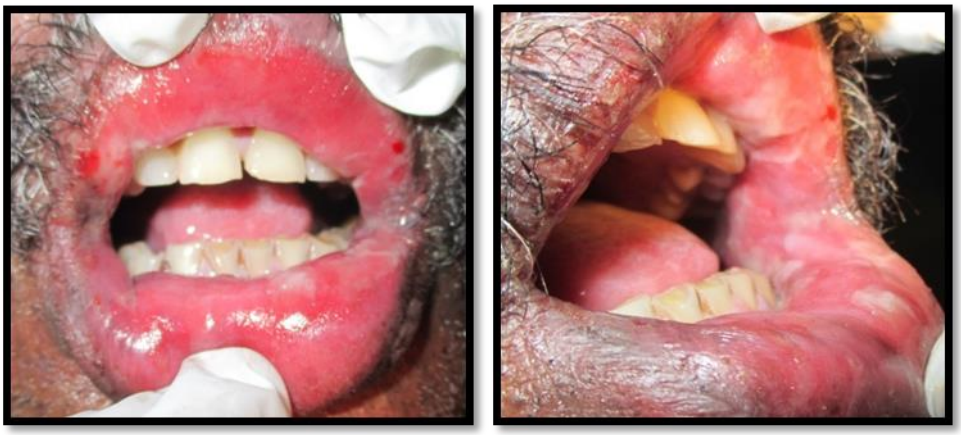

Figure.1Large erythematous and desquamated areas on labial and buccal mucosa with bleeding spot.

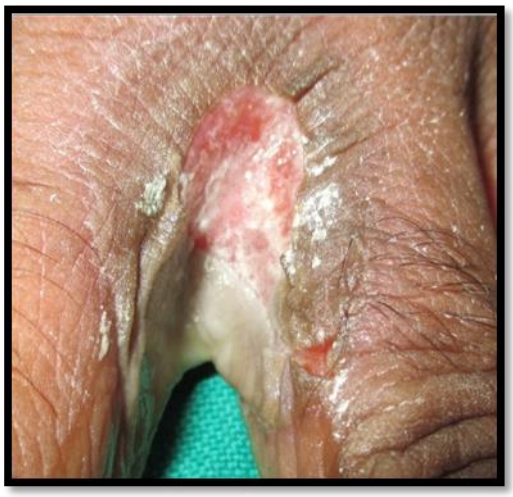

Figure.2‘Targatoid lesion’ on dorsal aspect of left hand between wedge of middle and ring finger about 2 cm in diameter with epithelial desquamation

Figure.3 Targatoid lesion on the skin of testis about 1.5 cm of diameter in size

Figure.4 lesions healed.