Fixed Drug Eruption due to Chlormezanone

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Verbov [1] has reported in this journal a case of fixed drug eruption (FDE) due to a paracetamol-chlormezanone combination preparation and described how attempts to provoke the rash on separate testing with the constituents of the drug was unsuccessful, while provocation testing with the proprietary combination preparation (Lobak®) reproduced the rash. This author suggested that some unknown chemical interaction occurring in the manufacture of the combined preparation might be responsible for inducing FDE. The following case confirms that successful provocation of FDE is possible with both the combined preparation and with chlormezanone alone.

A 47-year-old woman was seen, in March 1987, 2 days after the onset of an itchy, burning eruption confined to the dorsal and ventral aspects of several fingers of both hands and to the palm surfaces. The lesions of the palms were erythematous brown-red plaques, while violet-brown bullae were seen on the fingers. The patient gave a history of a similar rash involving the same locations 6 months previously. Further questioning established that she had used the preparation Lobak and had taken 1 tablet on each occasion, several hours prior to the onset of the eruptions. Apart from pernicious anemia diagnosed in 1966, and for which she had received intramuscular vitamin B₁₂ injections, there was no history of other drug use. Histologic findings from a lesional skin biopsy were consistent with a diagnosis of FDE.

Two weeks later, when the rash had resolved, provocation testing with paracetamol 500 mg failed to induce the eruption. Provocation with the proprietary paracetamol-chlormezanone drug, 1 week later, resulted, however, in a recurrence of the rash with a similar distribution and location. Following resolution of the eruption, she was tested 2 weeks later with chlormezanone 200 mg. A burning sensation occurred in the sites of the previous eruption, followed 6-7 h later by the rash which involved the previous sites and, in addition, appeared in several new locations on both hands. A lesional skin biopsy supported the clinical diagnosis of a FDE. The present case confirms that successful provocation of FDE is possible with both the combined preparation and with chlormezanone alone, and does not support the above-mentioned contention of Verbov [1]. However, a refractory period has been reported in some FDE patients, following each provocation, when the offending drug will fail to reproduce the FDE reaction [2]. This phenomenon has occurred in FDE due to phenolphthalein, antipyrine and arspenamine [3]. Finally, successful provocation testing may be dose-dependent [4] with individual variations in patient response. Negative drug provocation tests may be therefore of equivocal significance [5] and should not always exclude the diagnosis of a drug-induced eruption.

References

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