Generalized Bullous Fixed Drug Eruption Masquerading as Stevens-Johnson Syndrome

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Abstract

Generalized bullous fixed drug eruption (GBFDE) is a rare variant of fixed drug eruption (FDE).

This is a case of a male patient who was referred to the dermatology service due to multiple bullae. Careful history taking, with supportive histopathologic evidence, can clinch the diagnosis versus SJS/TEN.

Keywords: Generalized Bullous Fixed Drug Eruption

Introduction

Fixed drug eruption (FDE) is a type IVc immune reaction which manifests as solitary or multiple erythematous to violaceous round sharply demarcated macules, patches or plaques with a dusky red center. It characteristically has same-site recurrence with re-exposure to specific drugs [1, 2]. GBFDE is a rare variant of FDE which occurs in patients who have previously had FDE. It presents with extensive involvement of the skin and mucosa, a similar clinical picture with SJS and TEN.

Case Report

We present the case of a 21-year-old male patient who presented at the Emergency Room (ER) for multiple bullae with mucosal involvement and initially assessed with SJS.

On examination, there was tender generalized erythema with multiple large dusky red patches and well defined tense bullae and vesicles with serous contents over the lips, trunk, upper and lower extremities. There were large tender erosions over the scrotum. Ocular and inner oral mucosa were normal.

Biopsy taken revealed an interface dermatitis with subepidermal split, mixed cell infiltrate and numerous melanophages in the dermis. Bullous FDE was favored. DIF was a negative study.

Resolution of lesions and cessation of new bullae formation soon followed after being given intravenous Hydrocortisone 100mg every 8 hours for 5 days, along with Clindamycin 600mg. Wound care, fluid and nutrition management, and other supportive measures were also given. Patient was left with dusky-brown residual hyperpigmentation.

Discussion

GBFDE is rare and often confused with SJS and TEN. Careful review of history would reveal that GBFDE develops abruptly within several hours after intake of offending medication. Recurrence on the same site of affected skin upon re-exposure to the drug is a hallmark of the disease [6].

Histopathologically, compared to SJS and TEN, there is increased eosinophilic inflammation, fewer necrotic keratinocytes, and more melanosome-laden macrophages [3].

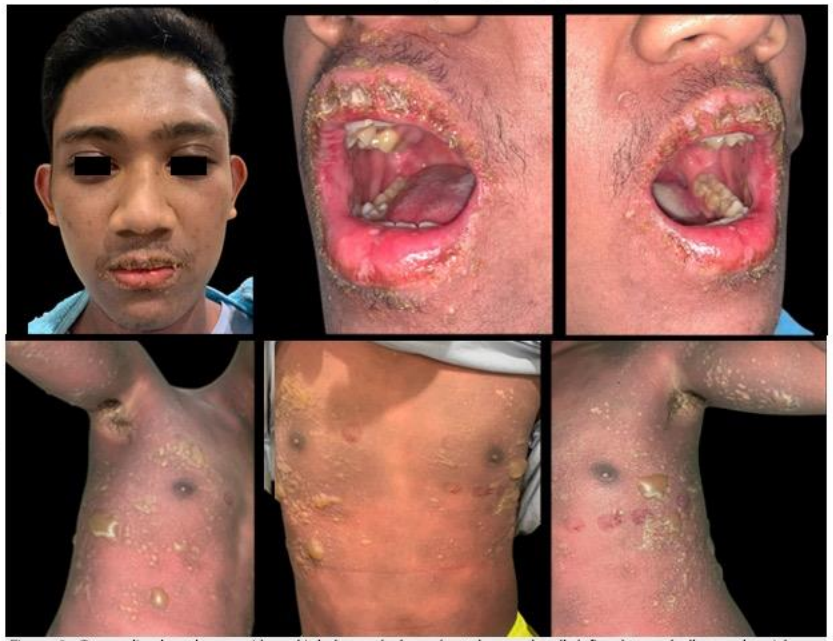

Figure 1 Generalized erythema with multiple large dusky red patches and well defined tense bullae and vesicles with serous contents on the lips, trunk, upper and lower extremities.

In our patient, the temporal correlation with paracetamol, previous history of multiple bouts in the ER where he presented with erythematous patches with a dusky red center, resolution with cessation of paracetamol use, and residual hyperpigmentation led us to consider a diagnosis of generalized bullous FDE due to paracetamol. The histopathological findings were also consistent with this diagnosis.

Conclusion

This case documents that paracetamol may cause GBFDE. It can easily be misdiagnosed with the other bullous dermatosis, erythema multiforme- major and other adverse drug reactions like SJS or TEN.

Careful history taking, with supportive histopathologic evidence, can clinch the diagnosis.

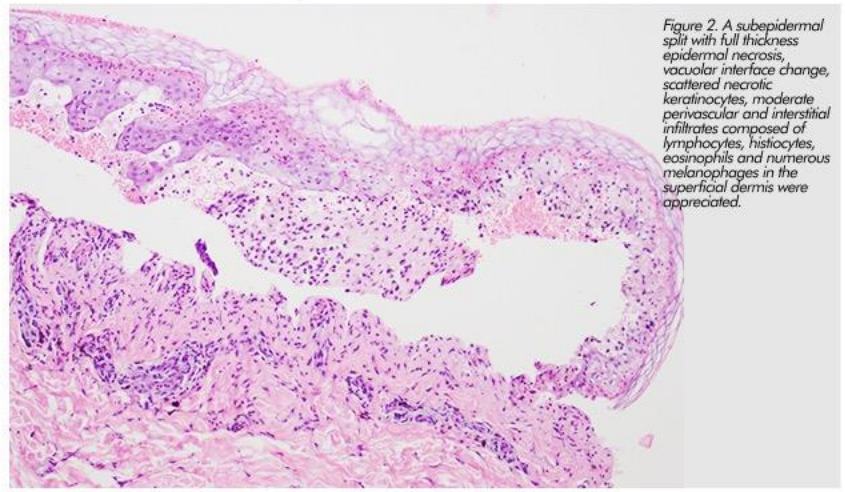

Figure 2. A subepidermal split with full thickness epidermal necrosis, vacuolar interface change, scattered necrotic keratinocytes, moderate perivascular and interstitial infiltrates composed of lymphocytes, histiocytes, eosinophils and numerous melanophages in the superficial dermis were appreciated.

The authors have no conflict of interest. Contact information: seescandor@up.edu.ph

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