Genital fixed drug eruption induced by miconazole with positive provocation test

Kastalli Sarrah, El Aïdli Sihem, Lakhoua Ghozlane, Daghfous Riadh
-Service de recueil et d'analyse des effets indésirables
-Centre National de Pharmacovigilance Tunis - Tunisie -Université de Tunis El Manar

Miconazole is a topical imidazole antifungal agent. It is generally well tolerated. Local irritation and contact dermatitis may occur [1]. FDE has been reported with imidazolic drugs, mainly antifungal agent such as ketoconazole and anti-parasitic agent such us metronidazole, but not with miconazole [2,3].
We report one case of genital FDE due to miconazole confirmed by an oral challenge test.

Case report

A 55-year-old man with a history of arthralgia treated occasionally for many years with indometacin and paracetamol. He had no history of atopy or drug hypersensitivity. In January 2009, he received miconazole oral gel and sulpiride for buccal mycosis with gastrointestinal disorders. Few days after drugs intake, he noticed one erythematous patch in the scrotum accompanied by a burning sensation and pruritus.
Two weeks later, all medications were stopped. The lesion darkened within a few days, turning violet-red in colour, and then gradually resolved following a residual hyperpigmentation.
In April 2009, he took by self-medication miconazole oral gel. Six hours later, he noticed pruritus over the same area, which became erythematous, and a development of a new red patch located in the penis. Dermatologic examination showed two erythematous oval patches, 1 cm to 2 cm in diameter, localized in the scrotum and the penis. A skin biopsy from the affected area of the scrotum was taken. The histology showed a basal cell vacuolization, dermal melanophages, and a superficial perivascular lymphocytic infiltrate, consistent with FDE. The macules faded within few days leaving a residual hyperpigmentation. Four weeks later, after written informed consent had been obtained, the patient underwent oral challenge test with one measuring spoon of miconazole oral gel. Erythematous patches reappeared at the same location as previously reported, 45 minutes after the test dose intake, with a burning sensation and pruritus.

Conclusion

Fixed drug eruption (FDE) is characterized by recurrent well-defined lesions appearing in the same location each time the drug responsible is taken. Lesions may occur on any site on the skin and mucosa.
An objective causality assessment of our case with the Naranjo Score suggested that miconazole oral gel was the “highly probable” cause for this adverse event described with a score of 9, in front of: temporal association of the onset of FDE with miconazole use, resolution after drug withdrawal leaving a residual hyperpigmentation, relapse at the same site after drug reintroduction and positive oral challenge test [4]. this test is the gold standard for diagnosis, as well as clinical and histological findings.
To date, rechallenge is the most reliable method of identifying causative drugs. The causative drug should be avoided to prevent recurrence. The most common drugs associated with FDE are sulphonamide drugs, tetracycline and nonsteroidal anti-inflammatory drugs. Imidazolic drugs, antifungal or anti-parasitic, are uncommon cause.
FDE has been rarely reported with imidazolic drugs such as ketoconazole and metronidazole [2,3].
Miconazole is used topically in management of superficial candidiasis and fungal skin infections. Adverse effects reported, after its topical use, are local irritation, burning, sensitivity reactions and contact dermatitis [1].
To our knowledge, this is the first case of FDE induced by miconazole. To conclude, miconazole should be added in the list of imidazolic drugs causing FDE.

References

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Le lymphome primitif du sein.

Ouafki Imane, Sghiri Tanae, Lkhoyaali Siham, Mrabti Hind, Errihani Hassan,
Service d’oncologie médicale Institut National d’Oncologie (C.H.U Ibn Sina de Rabat-Maroc).

Le lymphome non hodgkinien (LNH) primitif du sein est une entité rare qui représente entre 0.38% et 0.7% de tous les LNH ,1.7% à 2.2% des localisations extra ganglionnaires et seulement 0.04% à 0.5% des néoplasies mammaires [1].Plus de 80% des LNH primitifs du sein sont de type diffus à grandes cellules B, CD20+ [2].Il survient chez la femme d’âge médian entre 40 et 67 ans. Cliniquement, il se présente par une masse mammaire augmentant progressivement de volume, n’ayant pas de caractéristiques spécifiques à la mammographie. Une biopsie adéquate avec un examen anatomopathologique et une étude immunohistochimique sont la clef du diagnostic. Sa prise en charge est encore un sujet de controverse. Dans la plupart des études, une association chirurgie, chimiothérapie par CHOP et radiothérapie reste le schéma thérapeutique de choix. La survie globale à 10 ans est estimée à 76% [2]. Nous mettons l’accent à travers ce cas, sur l’intérêt d’une prise en charge multidisciplinaire des lymphomes primitifs du sein, dans l’optique d’améliorer leur pronostic.

Observation

Il s’agit d’une femme de 48 ans, célibataire, traitée pour tuberculose pulmonaire en 1984 avec rechute traitée en 1994. Le début de sa symptomatologie remonte au mois de Septembre 2010, par