Stevens–Johnson syndrome following astemizole therapy

Sir,

Astemizole is a long-acting H1-histamine receptor antagonist of the non-sedating type, which is in widespread use for allergic rhinitis.1 We report a case of severe Stevens–Johnson syndrome developing after a short course of this drug, bought as the proprietary preparation Pollon-eze, containing astemizole 10 mg.

A 28-year-old man on a walking holiday in England took astemizole 10 mg daily for hayfever. He had used terfenadine on previous occasions with no ill effects. He took no other medications and had no significant past medical history. The onset of fever, headache and mouth ulceration was followed within 24 h by a generalised rash. He was admitted to hospital five days after the last dose of astemizole with fever, widespread blistering skin lesions and mucosal ulceration; a diagnosis of Stevens–Johnson syndrome was made. Despite high-dose systemic steroid therapy, a erythema multiforme drug eruption syndrome developed, necessitating prolonged mechanical ventilation. He eventually made a full recovery apart from minor comeal ulceration. Antibody titres for Mycoplasma pneumoniae, Herpes simplex and anti-streptolysin O were all negative.

It is often difficult to establish definitively the cause of Stevens–Johnson syndrome; as in this case, the severity of the illness precludes rechallenge with the drug considered responsible.2 Reports to the Committee on Safety of Medicines on suspected adverse cutaneous reactions to astemizole include cases of photosensitivity and urticaria, but to our knowledge no cases of Stevens–Johnson syndrome have been reported as a complication of anti-histamine use.3 Recognised drug causes of erythema multiforme and Stevens–Johnson syndrome are listed in the box.

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Clinical features of Sweet syndrome

- fever, malaise, headache
- arthralgias, myalgias
- asymmetrical arthritis involving both small and large joints
- conjunctivitis
- symptoms of acute pneumonitis and recurrent respiratory symptoms with pulmonary infiltrates
- Dressler’s syndrome with pleuro-pericardial effusions
- abrupt onset, tender violaceous or erythematous plaques/nodules on skin of upper limb, head and neck
- skin ulcerations (rarely involving mucous membranes)
- hepatomegaly, splenomegaly

When associated with malignancies, Sweet syndrome has a more severe clinical manifestation, characterised by a tendency to ulcerate, and involve mucous membranes and extra-cutaneous sites. The secondary form has no sex predilection, but the primary form is more common in women. The commonest haematologic malignancy with which it is associated is acute myeloid leukaemia;1 the association with chronic myeloid leukaemia, although uncommon, does not herald an aggressive transformation of the disease. It may precede, accompany, or follow the malignancy. Oral corticosteroids, potassium iodide, non-steroidal anti-inflammatory agents, dapsone, and colchicine are all used in the treatment of Sweet syndrome.4 Pathogenetically, Sweet syndrome is hypothesised to be a neutrophilic hypersensitivity reaction to a non-specific immunological response in malignancy,5 to as yet recognised antigens present in the skin. A role for cytokines is also being considered.

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Sweet syndrome in chronic myeloid leukaemia.


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