Serum sickness like reaction with minocycline

Sir,

Minocycline is a semi-synthetic derivative of tetracycline. It is being increasingly used in the treatment of acne vulgaris as it is more effective than the conventional tetracycline and drug resistance is less likely. Unfortunately, its side effects, albeit rare, are not trivial and include drug induced lupus, autoimmune hepatitis, hypersensitivity syndromes, p-ANCA positive cutaneous polyarteritis nodosa and serum sickness like reaction (SSLR). Minocycline induced SSLR was first reported in 1990. We have previously reported SSLR with minocycline and now report another case.

A 19-year-old female presented with gross swelling of the face, significant aggravation of her existing acne, a mild cough and a little difficulty in breathing since 2 days. She also had pain in the smaller joints of the hands as well as some larger joints. All these complaints began 48 hours after starting minocycline (50 mg twice daily) which had been prescribed for her nodulocystic acne. The patient could not remember having taken minocycline earlier or developing any reaction to it.

On examination, she had fever (101°F) and was seriously ill. She had generalized tender lymphadenopathy. Her face was markedly edematous. Routine examination of the blood and urine was within normal limits.

Minocycline was immediately stopped and a systemic steroid started along with oral erythromycin. Her condition rapidly improved within the next 3 days and resolved nearly completely within 10 days. She had amenorrhea for the following 2 months.
Serum sickness classically refers to a systemic immunological reaction caused by injected serum and occurs due to deposition of an antigen-antibody-complement complex. It occurs when an antigen (i.e. serum) persists in the circulation for a long duration stimulating IgG or IgM antibody synthesis. These antibodies, along with complement, form complexes which are deposited in various organs. The manifestations develop according to the organ involved. Since heterologous serum is rarely used, such a systemic reaction due to serum is rare. Other causes like drugs are now more commonly implicated and the resultant reaction is called a serum sickness like reaction. Minocycline can cause such a reaction rarely\(^2\(^3\). 

Our patient had all the features of serum sickness like reaction, namely angioedema, lymphadenopathy, arthralgia and fever. It is interesting to note that like most previous reports our patient was also female. Although there may be hematological alterations like hypocomplementemia or signs of renal impairment, their absence does not exclude this diagnosis and a combination of clinical signs is sufficient for the diagnosis of SSLR. Such a reaction should be recognized at the earliest and the drug should be stopped. We hope this report helps to increase awareness about this rare adverse effect of minocycline, which is being used increasingly commonly for the treatment of acne in India.

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REFERENCES


Nimesulide induced bullous fixed drug eruption of the labial mucosa

Sir,

A fixed drug eruption (FDE) is a distinct drug induced reaction pattern that characteristically recurs at the same skin or mucosal site. We report a case of bullous FDE confined to the labial mucosa following intake of nimesulide, a commonly used nonsteroidal anti-inflammatory drug in India.

A 23-year-old man presented with multiple oral blisters of one day’s duration associated with marked burning and soreness. He had developed the lesions within 5 to 6 hours of taking a single tablet of nimesulide (which he had taken by himself). He had also been taking roxithromycin for three days which had been prescribed for his sore throat by an otolaryngologist. In the past he had taken multiple courses of roxithromycin for his recurrent sore throat without any complaints, but this was the first time that he had taken nimesulide.

The patient was afebrile and there were no other associated systemic complaints. Examination revealed multiple, tense bullae filled with clear fluid, varying in size from 0.5-1.5 cm, distributed over the upper labial mucosa with slight surrounding erythema (Figure 1). The rest of the oral mucosa and other mucosal sites were free of lesions.

A biopsy from the bullae was taken. Histopathological

Figure 1: Bullous FDE lesions involving the labial mucosa