angioedema. A cardiologist was consulted and as her ECGs were normal, amiodarone was withdrawn permanently. The patient is fine even after one year follow-up.

Amiodarone is currently a widely prescribed medicine, being used in ventricular and supraventricular arrhythmias and to maintain sinus rhythm in atrial fibrillation.[3] The pathogenetic mechanism was thought to be metabolic rather than immunologic, because body tissues may act as a large reservoir of this drug under chronic administration, and several of the adverse effects of amiodarone are attributable to the deposition of amiodarone conjugated phospholipids in the tissues.[3,7]

Our observation indicates that a serious complication like angioedema due to this drug may not be as rare as is thought to be. However, it may be under-reported due to the unawareness of such an adverse effect of the drug or simple lack of documentation. It is very important to know and recognize these rare adverse effects of a fairly widely prescribed drug at an early stage to avoid a serious outcome. To the best of our knowledge, this is only the second report in the literature about facial angioedema induced by amiodarone use.

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Sparfloxacin induced blue/black discolouration of all nails: Report of three cases

Sir,

Discolouration of nails is usually seen as an adverse reaction to drugs.[1] Pigmentation can occur either in the nail plate or vascular nail bed. The term chromonychia indicates an abnormality in color of the substance and / or the surface of the nail plate and / or subungual tissues. When the cause is endogenous, discoloration often corresponds to the shape of the lunula. Melanonychia is increased melanogenesis in the nail matrix.

Chloroquine produces blue-black nail bed,[2] silver induces dark blue nail bed (argyria), amodiaquine causes hyperpigmentation, phenolplthalein - dark blue discoloration, and zidovudine (AZT) produces brown-black longitudinal streaks in the nail plate.[3] Hyperpigmentation due to an increase of melanin pigment in nail and nail bed has been noted in children after six weeks’ treatment with doxorubicin.[4] Carbamazepine was reported to have produced yellow discolouration in the nails which cleared within 6 months after stopping therapy.[5] We report blue / black discoloration of nails in 3 patients due to sparfloxacin, which has not been reported so far in the literature to the best of our knowledge.

Case 1

A 16 year old boy presented with recurrent boils on the scalp. He was prescribed sparfloxacin 400 mg as a loading dose, followed by 200 mg daily for 15 days. He
followed up after 15 days with nail discoloration (Figure 1). The nails showed blue-black pigmentation involving the lunulae. Involvement of all 20 nails was noted. Sparfloxacin was stopped and patient was followed-up for 6 months. The discoloration gradually moved distally and disappeared (Figure 2).

Case 2
A 22 year old male had grade III acne. He was started on sparfloxacin 400 mg as loading dose, followed by 200 mg daily once for 15 days with clindamycin cream topically. He came for review after 20 days and complained of bluish discoloration of nails in lunular area of all 20 nails. After stopping the drug the discoloration disappeared gradually moving distally in 6 months duration.

Case 3
A 25 year old male patient, an agriculturist, presented with recurrent Bockhardt’s impetigo on the legs. Sparfloxacin and topical mupirocin were prescribed for 20 days. He came with recurrence after 45 days. We noticed black discoloration of the nails (Figure 3). After omission of the drug, the pigmentation gradually disappeared within 6-8 months.

Sparfloxacin is a newer difluorinated quinolone antimicrobial agent. All fluoroquinolones act by inhibiting bacterial DNA gyrase enzyme, which is required for DNA replication. Sparfloxacin is known to be bactericidal against both Gram positive and Gram negative organisms. It is also known to be effective against *M. tuberculosis, M. Leprae, Mycoplasma, Legionella* and *Chlamydia* species. The commonly known adverse cutaneous reactions of sparfloxacin are photosensitivity, fixed drug reaction, toxic epidermal necrolysis and skin rashes. The other adverse effects are abdominal pain, vomiting, diarrhea, and neurological disturbances like insomnia, confusion, paresthesia, and hallucinations.

Nail pigmentation following sparfloxacin has hitherto not been reported. In our patients the blue-black nail pigmentation appeared two to three weeks following therapy and persisted for a long duration even after stopping the drug. However on follow-up of the patients over a period of 6-8 months, we noted gradual disappearance of the pigmentation. Nail discoloration is a benign condition and disappears with time but may
proves of cosmetic discomfort to the patient.

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Onycholysis: An unusual side effect of roxithromycin

Sir,

Onycholysis is a separation of the distal part of the nail plate from its nail bed and/or lateral supporting structures. One or more nails may be affected. The affected nail plate itself is smooth and firm. The separated portion is usually in the shape of a half moon and appears white due to loss of light reflection from the nail bed. It may get discolored green, black or blue due to subungual accumulation of bacteria, yeast or dirt. In most cases onycholysis is acquired following a number of exogenous or endogenous factors. Many drugs especially antibiotics and chemotherapeutic agents are known to cause onycholysis through known or unknown mechanisms.

We describe here a case of onycholysis following therapy with roxithromycin. To the best of our knowledge this is the first case of this unusual side effect of roxithromycin. A 22-year-old office worker having chronic sinusitis had been taking 150 mg roxithromycin twice daily for eight weeks, although prescribed for two weeks only. He noticed whitening of the distal half of all his finger nails and their progressive separation from the nail beds. He had no pain or tenderness of nails. There was no history of any other drug intake or excessive and undue sun exposure. During this period he had not handled any chemicals or been involved in any occupation known to cause onycholysis.

Systemic drugs can affect nails and the nail changes range from pain, discoloration, shedding or loss of nail plate. Nail changes after drugs can be due to toxicity to the nail matrix, nail bed or hyponychium and to the periungual structures. Most of the antibiotics and drugs like psoralens causing onycholysis do so due to:

On examination his finger nails showed onycholysis (Figure 1). Free ends of all finger nails were white and had debris underneath. There was no proximal inflammatory band or tenderness. Nail folds, skin of hands and other parts showed no abnormality. Toe nails were normal. His systemic examination and routine laboratory investigations showed no abnormality. KOH mounts from the nail clippings and subungual debris showed no fungal element. Roxithromycin was discontinued immediately. The patient was reassured and asked to come for review after 4 weeks, but did not follow up.

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Figure 1: Onycholysis of all finger nails