Drug rash due to levamisole

Sir,

Levamisole, a commonly used anti-helminthic, has been found to have microfilaricidal, immunostimulant and immunomodulator activities. Its side effects include nausea and vomiting, metallic taste, diarrhea, malaise, insomnia, sensory stimulation, hyperallergic state, dizziness, headache, blurred vision, fatigue and fever. Prolonged use of this drug may cause agranulocytosis, cutaneous necrosis, vasculitis, ataxia, purpura involving the ear, thrombocytopenia and psychosis. Hypersensitivity due to levamisole is rare. Recently, we reported a case of fever due to levamisole. Here we report a patient of vitiligo who developed repeated episodes of fever along with itching and redness of the palms, soles and legs on intake of levamisole. On rechallenge with levamisole he developed the same symptoms within 5 hours.

A 33-year-old man presented with progressive depigmentation of the skin over the abdomen, back, lower limbs and arm since the past 6 months. The patches appeared initially on the abdomen followed by the back and were progressive. He was diagnosed as a case of vitiligo and started on oral betamethasone (5 mg) and levamisole (150 mg) tablets, once daily on two consecutive days every week. After three months, topical fluocinolone acetonide (0.01%) cream was added to the existing therapy. After 8 months, on one occasion, 12 hours following intake of the oral drugs, he developed fever (102°F) with chills and rigor, followed by itching and redness of the skin over the palms, soles and both legs. Sore throat or burning micturition was not associated. He stopped the drugs and sought advice of a local physician. With treatment he became asymptomatic within 8 days. He restarted betamethasone and levamisole after 1 month and developed similar symptoms within 4-5 hours of intake of the drugs. This episode also needed medical help for 5-6 days. He stopped taking the oral medications and continued with the application of the topical steroid.

To confirm the diagnosis of fever and drug rash due to levamisole, rechallenge was done with oral levamisole (150 mg) under medical supervision with the patient’s consent. After 5 hours, he developed fever (102°F) followed by itching, redness and swelling of the lips, palms and soles. The patient was advised oral betamethasone 5 mg 12-hourly and his lesions resolved completely within 24 hours.

Repeated episodes of fever along with redness and itching of palms and soles within 4-12 hours of intake of levamisole points towards the association of the reaction with this drug. Reappearance of similar symptoms during rechallenge with the drug further confirms this association. A similar case was reported by Secher et al.

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REFERENCES
Scleroderma and dermographism in a case of carcinoma ovary

Sir,

Cutaneous paraneoplastic syndromes are rare manifestations of epithelial ovarian cancer. Dermatomyositis,[1] acanthosis nigricans, systemic lupus erythematosus (SLE), and scleroderma have been well described. A syndrome of palmar fasciitis and polyarthritis associated with endometroid carcinoma of the ovary, termed “reflex sympathetic dystrophy” is also known.[2]

A 43-year-old previously healthy lady having two children presented with generalized pruritus and urticaria of six months duration. This was associated with disfiguring hyperpigmentation involving the face, anterior abdominal wall, and the popliteal regions. She also started experiencing difficulty in clenching the fist due to marked skin thickening. She had noticed a mass in the lower abdomen one month prior to the presentation. She underwent a staging laparotomy with a suboptimal debulking of the ovarian mass elsewhere, and was subsequently referred to our center.

She denied a history of recurrent aphthous ulcers, Raynaud’s phenomenon, or proximal myopathy. There was no past or family history of autoimmune disorders, atopy and physical urticaria. She received antihistaminics for pruritus. However the pressure urticaria persisted.

Examination revealed a well-nourished lady having a left scalene node 1 cm in size and an inguinal node of 3 cm. She had sclerodactyly. Thick sclerosed skin was noted in the popliteal fossa, lower abdomen, thighs, and dorsal aspect of the hands. Symmetrical brownish black hyperpigmented irregular patches were evident over the elbows, shoulders, ankles, upper trunk, and popliteal regions [Figure 1]. There was prominent dermographism [Figure 2]. There were no telangiectasias. The rest of the examination was unremarkable.

Investigations revealed a normal hemogram and biochemical profile, including serum LDH and CPK. The