

A Case of Voriconazole-Induced Pseudoporphyria



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Pseudoporphyria is a photodistributed bullous disorder with clinical and histologic features similar to those of porphyria cutanea tarda (PCT), but without accompanying biochemical porphyrin abnormalities.¹ The characteristic clinical findings

include skin fragility, bullae, and scarring within a light-exposed distribution. It has been associated with medications, ultraviolet A radiation, excessive sun exposure, and chronic renal failure/dialysis.¹ Voriconazole is a second-generation azole antifungal

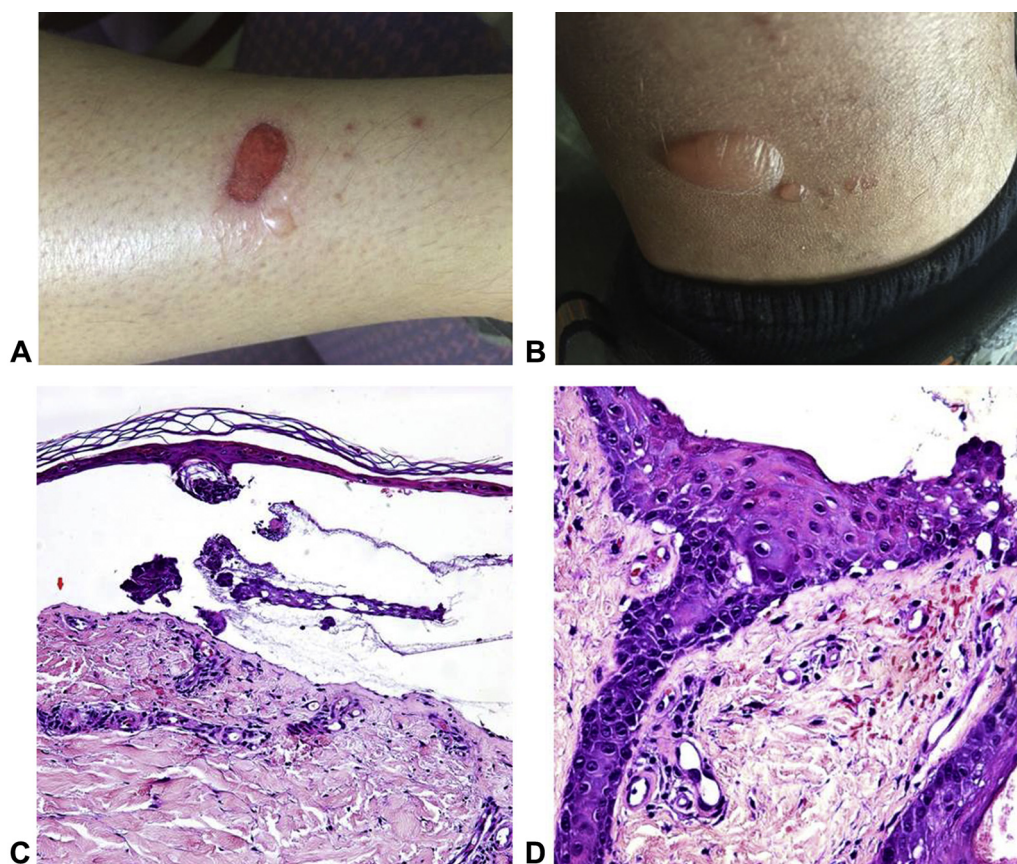


FIGURE 1. Hypochromic lesions in different stages of healing (A). Blister on the right ankle (B). Cutaneous biopsy showing a noninflammatory subepidermal vesicle with festooning (C) and hyaline sheaths (D).

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No funding was received for this work.

Conflicts of interest: The authors declare that they have no relevant conflicts of interest.

Received for publication August 12, 2018; revised August 17, 2018; accepted for publication August 19, 2018.

Available online September 25, 2018.

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J Allergy Clin Immunol Pract 2019;7:653-4.
2213-2198

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<https://doi.org/10.1016/j.jaip.2018.08.018>

agent that shows an enhanced activity against a wide variety of fungi, which has been reported to cause photosensitivity.² We present a case of voriconazole-induced pseudoporphyria.

A 35-year-old man with a past medical history of human immunodeficiency virus, esophageal reflux, obesity, and anxiety presented with a 3-month history of recurrent episodes of blisters. These were trauma-induced blisters (5-25 mm in size) on sun-exposed areas; some blisters developed sloughing off the skin on his upper extremities and progressed to his lower extremities within months without mucosal involvement. His symptoms began within 8 weeks of starting voriconazole for a noninvasive aspergillosis sinus infection. Voriconazole was switched to itraconazole without improvement of symptoms. Other medications, which were continued, included dolutegravir, tenofovir, emtricitabine, esomeprazole, sertraline, and zolpidem. Physical examination showed hypochromic lesions in different stages of healing (Figure 1, A) and a blister on his ankle (Figure 1, B). Laboratory workup included blood and urine porphyrins within normal limits. Skin biopsy revealed noninflammatory subepidermal vesicles with festooning (Figure 1, C), hyaline sheaths (Figure 1, D), and ribbon-like staining of vessel walls on immunofluorescence, which confirmed the diagnosis of drug-induced pseudoporphyria. He was instructed to use sun-protective measure, avoid further exposure to triazole antifungal medications, and use equally efficacious alternatives. His blisters resolved within weeks. Patch testing, challenge, and other

lab workup were declined by the patient. To date, the patient has tolerated isavuconazonium sulfate with no further adverse reactions.

Drug-induced pseudoporphyria is a bullous photodermatosis with the clinical and histologic features of PCT but does not have abnormalities in porphyrin metabolism.² It usually presents with vesicles, bullae, skin fragility, milia, and scarring that occur on sun-exposed skin. Nonsteroidal anti-inflammatory drugs are the most common cause, followed by diuretics, retinoids, and antibiotics.¹ Although the mechanism by which drugs induce pseudoporphyria is not well understood, there is a separation at the subepidermal level that leads to the formation of blisters.²

To our knowledge, pseudoporphyria induced by voriconazole has only been reported 5 times to date per literature review. The photosensitive eruption appears months after starting therapy.² Evaluation should include patch testing to all azoles with a rechallenge to the suspected agent if possible. Routine histologic examination, direct and indirect immunofluorescence, and laboratory evaluation including blood, urine, and fecal porphyrins enable exclusion of other diagnoses. Treatment requires discontinuation of suspected agents and sun protection.¹

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