

Table 1. Patch tests results

Allergens	%	D2	D4
Mycostatin® suspension as is (100.000 U/ml)		++	+++
Nystatin	30% aqueous (aq)	++	+++
Amphotericin B	1% aqueous (aq)	++	+++
Fluconazole	10% aqueous (aq)	—	—
Erythromycin	10% aqueous (aq)	—	—
Clarithromycin	10% aqueous (aq)	—	—
Azithromycin	10% aqueous (aq)	—	—

Despite its widespread use, the antimycotic nystatin rarely causes allergic reactions. We report on a case of generalized dermatitis because of oral administration of nystatin.

Case Report

A 65-year-old woman, with no history of atopy or eczema, presented to our hospital's emergency room with a pruriginous generalized maculopapular rash involving the face, trunk, arms, and thighs. No pustules were observed. She had no fever or other systemic symptoms. The physical exploration was normal. Eosinophil levels were normal. The rash appeared 1 D after she had started treatment with oral nystatin (Mycostatin® oral suspension 500 000 IU q.i.d.) (mouth rinse followed by swallowing) for oropharyngeal candidiasis. Nystatin was stopped, and she was given fluconazole instead for 2 D and was treated with oral antihistamines and corticosteroids. The lesions persisted during 4 weeks in spite of the treatment.

Patch tests were performed 3 months later with antimycotic agents (nystatin, fluconazole, and amphotericin B). The patient's results are shown in Table 1. 10 controls (5 atopic and 5 non-atopic) were negative.

Prick tests with antimycotic drugs were negative to fluconazole. A single-blind, placebo-controlled oral challenge was negative to fluconazole (up to 200 mg).

Patch tests performed with macrolide antibiotics (erythromycin, clarithromycin, and azithromycin) and with the antihistamines and corticosteroids prescribed for the rash were negative.

Discussion

Nystatin is an antimycotic polyene macrolide used for candidiasis infection. Adverse reactions to nystatin

are exceptional as nystatin is poorly absorbed through the skin and the intestinal tract (1).

Since Wasilewski in 1970 described the first case of contact dermatitis because of topical nystatin (2), only a few cases of contact nystatin allergy have been reported (3).

Nevertheless, a few cases, with a dermatitis appearing within more than 1 D, with a generalized maculopapular or acute pustular exanthematic pattern, a positive oral rechallenge and positive patch tests, suggest a delayed type hypersensitivity to nystatin (4–8).

In our case, the results of clinical presentation and patch tests suggest a delayed type hypersensitivity to oral nystatin.

Of special interest in our case is the severe and prolonged dermatitis caused by this antifungal and the poor treatment response to antihistamines and corticosteroids that carried us to rule out allergic sensitization to other factors and drugs: fluconazole, antihistamines, and corticosteroids.

We found a positive patch test to another polyene macrolide of similar chemical structure, amphotericin B, suggesting cross-sensitization (8). Patch testing with macrolide antibiotics was negative as well as with the imidazole antimycotic, fluconazole.

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Delayed hypersensitivity to oral nystatin

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Felicitas Villas Martínez¹, M^a Pilar Muñoz Pamplona¹, Esther Compes García¹ and Ángel Garde Urzaiz²

¹Allergy Unit, and ²Dermatology Unit, Hospital Obispo Polanco, Teruel 44002, Spain

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- Address:
Felicitas Villas Martínez
Allergy Unit
Hospital Obispo Polanco
Avenida Ruiz Jarabo s/n
44002 Teruel
Spain
Tel: +34 978 621150
Fax: +34 978 621310
e-mail: ayaguel@hotmail.com