

Bullous Fixed Drug Eruption Induced by Paracetamol: Report of a Case

To the Editor:

Fixed drug eruption (FDE) is a cutaneous adverse drug reaction commonly seen in children and adolescents that is frequently misdiagnosed, leading to recurrent eruptions when the offending drug is re-administered.^{1,2} The diagnostic hallmark is its recurrence at previously affected sites. Although the term "fixed drug eruption" was introduced by Brocq in 1894, the phenomenon had been initially described by Brouns 5 years earlier.³ Bullous FDEs are rare and require differentiation from other pediatric blistering diseases.

We describe a 7-year-old boy with bullous FDE due to paracetamol. The episode occurred in the course of a fever treated with paracetamol. Sixty minutes after drug administration, the young patient developed a bullous lesion, 0.8 mm in diameter, located on the left big toe and circumscribed by a circular lilac-colored border, which is generally considered significant of FDE (Fig 1). He had not been subject to other drug intakes in the previous month. Blood cell count, kidney and liver function, serum electrolytes, serum glucose, C-reactive protein, and immunoglobulin levels were all within normal limits. He was treated with a zinc oxide paste for 2 weeks. In a few days, the inflammation subsided and reepithelization progressed, leaving a hyperpigmented residual lesion. No scarring or milia formation ensued.

The morphology of the lesions (with residual post-inflammatory pigmentation and recurrence at identical sites) as well as the history of recent drug ingestion are diagnostic of FDE. Toxic eruptions induced by paracetamol are rare and usually of the fixed type.⁴ Bullous FDE is still more rare,⁵ and when it appears in children, it requires differentiation from other pediatric blistering diseases, including bullous erythema multiforme, linear immunoglobulin-A bullous dermatosis, and bullous pemphigoid.

In the reported case, we did not perform a skin biopsy for histologic examination because the child's parents did not give their consent, likely because of the patient's very



Figure 1. A bullous lesion, circumscribed by a circular lilac-colored border, on the patient's left big toe. The lesion occurred after the patient was administered paracetamol.

young age. On the other hand, the clinical diagnosis was supported by the absence of possible alternative diseases. The characteristic border color, the healing in a few days after discontinuation of the drug, and the absence of a foot trauma history (and then no possible entry sites of infective agents) caused us to propose the diagnosis of bullous FDE as the only possible one. Even if patch testing with the suspected drug is sometimes used for confirmation of FDE, up-to-date rechallenge is the most reliable method of identifying the causative drug. Nevertheless, we thought it would not be ethical in this young patient's case.

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