

Meeting Point

This new section shall publish the works presented at the scientific meetings organised by Autonomic or Regional Allergy and Clinical Immunology Societies. In this issue works are published which were presented at the XX Scientific Meeting of the Castille and León Association of Allergy and Clinical Immunology, held at León (Spain) in May 1998. Works presented at that meeting which have already been published either in other sections in this same Journal or in other Journals are just indicated here.

Latex sensitization in slate workers: description of a new risk group

C. Díaz Donado

Alergol Immunol Clin 1999; 14: 92-98.

Occupational asthma by *Anisakis simplex*

A. Armentia, M. Lombardero, A. Callejo, J. M. Martín Santos, F. J. Martín Gil, J. Vega, M. L. Arranz and C. Martínez

J Allergy Clin Immunol 1998; 102: 831-934.

Stevens-Johnson syndrome due to a new antiepileptic drug: lamotrigine

J. L. Estrada Rodríguez, F. Gozalo Requés, M. Conde López^a and A. García González^a

Allergy and ^aNeurophysiology Services, Hospital de León, León, Spain

Lamotrigine was first introduced as an adjuvant antiepileptic drug for adult patients with partial complex seizures which could not be adequately controlled with the usual medication or in whom the adverse side effects of such medications were

not acceptable. Lamotrigine was later demonstrated to be useful in generalised seizures, atypical absences, myoclonic absences and the Lennox-Gastaut syndrome. The drug can be given in association with aromatic antiepileptic drugs with no modification of its pharmacokinetics. However, valproic acid reduces the clearance of lamotrigine and more than doubles its half-life; the lamotrigine dose must consequently be reduced when they are given simultaneously.

Experience with lamotrigine encompasses several multicentre studies including a total of 700 patients with partial seizures, in which it has demonstrated its efficacy. The more frequently reported side effects are vertigo, headache, instability and diplopia, usually of mild to moderate intensity and which in most cases have been resolved without the need to interrupt lamotrigine therapy.

The most frequent side effect is skin rash, occurring in 3-10% of the patients and which may occur in up to 20% when valproate is associated. Several cases have been recently reported of severe skin reactions induced by lamotrigine, such as the Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis and hypersensitivity syndrome.

We here report a new case of SJS in association with lamotrigine.

CASE REPORT

The patient was a 40-year-old woman with a diagnosis of complex partial seizures since the age of 18 years. When she was 30 years old she started treatment with carbamazepine which had to be suspended because of fever, leukopenia ($2.4 \cdot 10^9$ cells/l) and thrombocytopenia. Treatment was the-

reupon instituted with valproate at a dose of 1000 mg/12 hours. This caused thrombocytopenia ($45 \cdot 10^9$ cells/l), which improved (to $90 \cdot 10^9$ cells/l) upon reducing the dose to 700 mg/12 hours. Three months before consultation the patients seizures worsened; gabapentine was at that time added to the treatment with good tolerance, and then lamotrigine at progressively increasing doses. Three weeks after beginning therapy with lamotrigine (50 mg/day) the patient developed skin and systemic symptoms: cervical lymphadenopathies as the presenting symptom, followed by fever (38°C), chills. Malaise and prostration 24 hours later and, 72 hours later, by facial skin rash and sensation of pharyngeal foreign body, with worsening of the fever to 40°C . The patient was seen at an outpatient emergency clinic, where blood analyses were performed, disclosing leukopenia ($2.8 \cdot 10^9$ cells/l) and thrombocytopenia ($45 \cdot 10^9$ cells/l). The lamotrigine therapy was suspended on the next day, but the patient began complaining of photophobia and swallowing difficulties, and conjunctival secretion and a localised exanthema on the proximal areas of the limbs, back and face was observed which was not compatible with the classical pattern (target or herpes-iris lesions). In the following hours vesicular lesions appeared on the lips and mouth; a diagnosis of SJS caused by lamotrigine was established, and the patient was admitted into hospital. The gabapentine therapy was also withdrawn and systemic corticosteroids were started. After a few hours with this treatment the fever decreased (30°C) and the general situation improved. On the sixth day after the beginning of the reaction the fever had fully disappeared and the exanthema had improved. In the following days the patient again tolerated solid foods, the oral vesicles disappeared, and she was discharged on the ninth day.

DISCUSSION

The Stevens-Johnson syndrome is a potentially life-threatening phenomenon which is often associated to infectious causes (herpesvirus, mycoplasmas) or to adverse drug reactions. In the latter case, atypical skin lesions (different from the herpes-iris) are the most usual ones. The responsible drug has been usually introduced between one and three weeks before the reaction appears. For this

reason, and because of the dramatic improvement after the withdrawal of lamotrigine, it was concluded that this was probably the responsible drug, as valproate was still being given and gabapentine had been started three months previously.

According to the data available, four cases of SJS due to lamotrigine have been published. It is known that aromatic antiepileptic drugs (phenobarbital, carbamazepine and phenytoin) are the cause of SJS in one out of every 10,000 treatments. The new antiepileptic drugs, such as gabapentine, clobazam or lamotrigine had been thought to be safe. After presenting this fifth case of lamotrigine-induced Stevens-Johnson syndrome, we believe this new drug should be the target of increased attention as the possible cause of severe cutaneous adverse events.

REFERENCES

1. Gou KL, Ross SR, Chisp P. Lamotrigine. A review of its pharmaceutical properties and clinical efficacy in epilepsy. *Drugs* 1993; 46: 152-176.
2. Chattergoon DS, McGuigan MA, Koren G, Hwang P, Ito S. Multiorgan dysfunction and disseminated intravascular coagulation in children receiving lamotrigine and valproic acid. *Neurology* 1997; 49: 1442-1444.
3. Dooley J, Camfield P, Gordon K, Camfield E, Wirrell Z, Smith E. Lamotrigine-induced rash in children. *Neurology* 1996; 46: 240-242.
4. Sachs B, Ronnau AC, von Schmiedeberg S. Lamotrigine-induced Stevens-Johnson syndrome: demonstration of specific lymphocyte reactivity in vitro. *Dermatology* 1997; 195 (1): 60-64.

Allergy to barnacle (*Pollicipes cornucopiae*)

J. D. Méndez Alcalde, A. Sánchez Alonso and B. Bartolomé Zavala^a

Allergy Section, "Río Carrión" Hospital, Palencia;
^aLaboratorio Aplicaciones Ifidesa-Arístegui, Bilbao, Spain

We report two cases of patients sensitised to barnacle (*Pollicipes cornucopiae*).