

Fixed drug eruption caused by metronidazole

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Case Report

A 31-year-old woman presented with itchy dark eruptions on her body which had appeared over the last year. On examination she showed 6 hyperpigmented, round, 3×4 cm macules on her abdomen and back. The lesions began as itchy and erythematous and gradually became pigmented. She had been taking several drugs for dental infection, including acetylsalicylic acid, metronidazole and spiramycin. A skin biopsy was carried out. On the basis of clinical and histopathological features, a diagnosis of fixed drug eruption was considered.

Patch tests on apparently normal skin with the GEIDC standard series and with the suspected medication were performed with negative results. Subsequently, topical provocation on previously involved skin was done, with positive results for Rhodogil®

(metronidazole and spiramycin). One month later, topical provocation was carried out with metronidazole at 5% aq. with itchiness in the residual lesion from 6 h after a patch test was applied to 3 days (D). Topical provocation with metronidazole at 10% aq. was also carried out later with positive results, reproducing the symptoms of itchiness, erythema and vesicles in the residual lesion from D1 after application to D4. Topical provocation was done with spiramycin, with negative results. Topical provocations on involved skin were done with patch tests applied closed, removed after D1 and then read 30 min, 1, 3 and 4 days later.

Discussion

5 cases have been reported of fixed drug eruption due to metronidazole (1, 3, 5–7). Gastaminza et al. have recently described the first case of fixed drug eruption caused by metronidazole with positive topical provocation (3); for their test preparation they used Flagyl® crushed and dispersed at 50% pet. In our patient we used metronidazole (pure drug) at concentrations of 5% and 10% aq., based on our experience, because there are no previous published data with metronidazole and the different vehicles. Even when dilution series might be preferable, topical provocation on previously involved skin would be very difficult to carry out.

We report another patient with positive topical provocation due to metronidazole, and suggest that this test could be useful as a routine method in fixed drug eruption due to

metronidazole, avoiding not-always safe oral provocation (2). Such topical provocation should be done on previously affected skin, in an appropriate vehicle (2), and with due regard to cross-reactivity (4).

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