

Esomeprazole fixed drug eruption

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Fixed drug eruption (FDE) is a unique type of cutaneous adverse drug reaction characterized by one or multiple erythematous and edematous plaques that recur in the same locations within 48 hours after re-exposure to the offending drug and resolve leaving residual postinflammatory hyperpigmentation.¹ A bullous form can also occur.² To date, only seven cases due to proton-pump inhibitors (PPIs) have been reported.

CASE REPORT

A 65-year-old man presented for a diffuse pruritic and painful rash of the lower limbs, abdomen, and scalp that had gradually developed over the past 2 months. He had a medical history of hypertension, diabetes, and coronary artery disease. His medications included moxonidine, sitagliptin, metformin, and aspirin. The patient also reported occasional self-medication with rabeprazole, which he had recently replaced with esomeprazole.

Physical examination revealed well-demarcated erythematous plaques with secondary blistering and crusting, mainly affecting the trunk, upper, and lower extremities (Figures S1 and 1). Mucous membranes were not involved. A skin biopsy performed from one of the lesions on the back revealed a normal basket-weave epidermis and a lichenoid infiltrate in the dermis with scattered lymphocytes and eosinophils. FDE was diagnosed based on clinical examination and supportive histopathology. The patient was advised to stop esomeprazole and was prescribed topical betamethasone. His symptoms improved quickly, and the skin lesion resolved with residual postinflammatory hyperpigmented patches.

Three months later he accidentally took esomeprazole again and the same symptoms recurred 48 hours later at the sites of the old lesions. This re-exposure confirmed that esomeprazole was actually the culprit medication, and it was subsequently discontinued for good.

DISCUSSION

Despite the good overall safety profile of PPI, PPI-associated cutaneous adverse effects are common and can range from localized



FIGURE 1 Multiple erythematous plaques on the upper back

dermatitis to severe, life-threatening eruptions.³ However, PPI-induced FDE is rare. This otherwise relatively common drug-induced skin eruption is usually caused by nonsteroidal anti-inflammatory drugs and antibiotics.² FDE has been reported in three patients with omeprazole use,⁴⁻⁶ and only one case of a diffuse nonpigmented FDE was described with esomeprazole and confirmed with a patch test as well as an oral provocation test.⁷ Other reported esomeprazole-related dermatologic side effects include immediate hypersensitivity reactions,⁸ maculopapular eruption,⁹ drug rash with eosinophilia and systemic symptoms syndrome,¹⁰ Stevens-Johnson syndrome, and toxic epidermal necrolysis.¹¹

All PPIs currently on the market are composed of a benzimidazole ring and a pyridine ring. While omeprazole, esomeprazole, and pantoprazole have changes in their benzimidazole rings, lansoprazole and

rabeprazole have changes in their pyridine ring.¹² This could explain why our patient did not cross-react to omeprazole and rabeprazole. To date, four general patterns of cross-reactivity between PPIs have been identified: whole-group hypersensitivity, omeprazole-esomeprazole-pantoprazole hypersensitivity, lansoprazole-rabeprazole hypersensitivity, and selective sensitization to a single PPI.¹²

In conclusion, PPIs are one of the most frequently prescribed class of drugs and their cutaneous adverse effects are diverse. These molecules should be added to our list of culprits when considering a patient with an FDE, taking into account that occasional “over-the-counter drugs” are not always reported by the patient.

CONFLICTS OF INTEREST

None to declare.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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