

Erythema Multiforme–Like Allergic Contact Reaction to Topical Triamcinolone

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DISCUSSION

A 26-year-old woman presented to clinic for evaluation of a new pruritic eruption on her arms that began 3 to 4 days after initiation of 0.1% topical triamcinolone in petrolatum to treat a pruritic dermatitis on her right forearm. The new eruption consisted of well-demarcated erythematous, annular, edematous plaques on both upper arms and forearms. These plaques then coalesced to form larger serpiginous plaques with central clearing over the bilateral antecubital fossae (Fig. 1). She did not report any other new or suspicious contacts, nor did she report a recent illness of any kind.

Erythema multiforme–like (EM-like) contact dermatitis secondary to triamcinolone was suspected, and a skin biopsy was performed. Histologic examination showed a superficial perivascular lymphocytic inflammatory infiltrate with spongiosis and parakeratosis. Periodic acid–Schiff staining was negative for fungal elements. Triamcinolone was promptly discontinued, and clobetasol was substituted to treat her EM-like reaction. The eruption was fixed and persisted for 3 days before responding to treatment.

The patient was subsequently patch tested to 0.05% desonide and 0.1% triamcinolone in IQ Chambers (Chemotechnique Diagnostics, Vellinge, Sweden) and found to have a positive reaction to desonide (a known cross-reactor to triamcinolone) at 48 and 96 hours but was negative to triamcinolone itself. A use test was then performed by applying the triamcinolone daily to a 2-cm clinically clear region on her arm. After 4 to 5 days, the ointment evoked the identical EM-like reaction that she had on initial presentation (Fig. 2). The diagnosis of EM-like eruption to triamcinolone was then made. We assume that a threshold amount of triamcinolone was required to trigger this unique EM-like eruption and that the small amount placed in the IQ Chamber was not sufficient. Thus, the patient was patch test negative.

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Figure 1. Circular plaque with central clearing upon use test with triamcinolone 0.1% pint.

Although allergic contact dermatitis to topical corticosteroid is uncommon, it is generally thought to be underdiagnosed. Any clinical situation in which a chronic dermatitis is exacerbated or fails to clear with topical corticosteroids should raise suspicion and consideration of patch testing.¹

Erythema multiforme–like reaction is a well-documented but rare manifestation of allergic contact dermatitis and has been reported to various potent and common allergens including compositae, sesquiterpene lactone, epoxy resins, nickel, and paraphenylenediamine among others.² Clinical presentations include typical targetoid lesions, purpura, vesicles, and annular or urticarial plaques (as in our patient). The histologic finding seems to be variable, with features typical of erythema multiforme reported.³ However, more nonspecific findings of spongiotic dermatitis and perivascular infiltrate, as in our case, are frequently described as well.² The precise mechanism of EM-like reaction secondary to allergic contact dermatitis is unknown, but it is still felt to be a delayed-type hypersensitivity (type IV), and

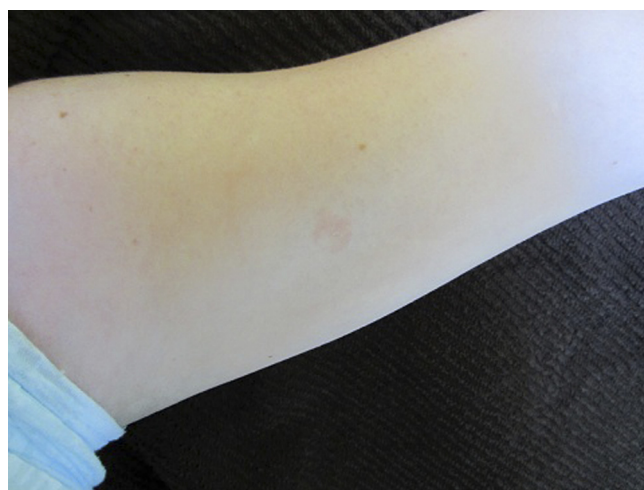


Figure 2. Circular plaque with central clearing upon use test with triamcinolone 0.1% pint.

EM-like reactions have been reported that span the spectrum of severity.² For this reason, we feel that it is important for the clinician to consider allergic contact dermatitis as a possible etiology when faced with a new EM-like eruption.

To our knowledge, this is only the second reported instance of EM-like reaction secondary to contact allergy to triamcinolone and the first from topical exposure. The previously reported case was from intraarticular injections with triamcinolone acetonide.⁴

PEARL OR ZEBRA

This is a zebra, given the rarity of occurrence. It is also a pearl, however, to consider the possibility of contact allergy to EM-like eruptions.

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