

Correspondence

Nonoccupational allergic contact dermatitis from ranitidine

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Ranitidine hydrochloride (HCl) is a widely used H₂ receptor antagonist, with few adverse effects reported. Occupational allergic contact dermatitis (ACD) from ranitidine HCl has been described on several occasions, and in fact, seems to be one of the most important contact allergens for healthcare workers.¹ However, nonoccupational cases are extremely rare. We present a case of ranitidine HCl contact dermatitis in a non-occupational setting.

A 73-year-old woman was referred to our clinic with pulpitis involving her dominant hand and with eyelid eczema. The lesions had been present for a year despite treatment with numerous topical steroids. The patient was a housewife. She was taking a number of medications (acetylsalicylic acid, lansoprazole, valsartan/hydrochlorothiazide, nifedipine, atorvastatin, bisoprolol, doxazosin, vildagliptin), but there was no relevant history of skin conditions, and she had no history of sensitization to common allergens. Laboratory investigations, including tests for autoimmunity, creatine kinase and lactate dehydrogenase, had not yielded any relevant results.

The patient was asked about whether she had any contact with any other drugs. She reported that her husband had become ill about a year previously, and she crushed and administered his drugs to him. The husband's medications were risperidone drops, rivastigmine, lercanidipine, folate acid, clopidogrel, ranitidine, tamsulosin and memantine. ACD to these drugs was suspected, and so the patient was patch-tested under conventional conditions. The Spanish Group of Investigation of Contact Dermatitis standard series (GEIDAC), diallyl-disulfide 1% vas, and the husband's drugs were applied to the patient's back. She showed positive reactions to nickel sulfate and ranitidine HCl at days 2 and 4. Some weeks later, further patch tests were performed with ranitidine HCl at several dilutions (1%, 5%, 10% and 30% in petrolatum; Finn

Chambers®; SmartPractice, Phoenix, AZ, USA). Moderately positive (2 +) results (erythema, papules and vesicles) were seen at days 2 and 4 for all dilutions (Fig. 1). These positive results were considered relevant to the diagnosis of ACD from ranitidine HCl.

Ranitidine HCl is known to be a cause of ACD. Most reported cases have been occupation-related, with cases reported from workers in the chemical and pharmaceutical industries, and in healthcare.^{1–4} By contrast, nonoccupational cases seem to be extremely rare; we could only find one other case described.⁵

Most reported cases of ACD to ranitidine present as eczematous lesions on fingers and hands; however, ACD on the face is possible through airborne contact or direct transfer via the hands after handling the drugs.^{1,2,5} The diagnosis is confirmed by patch testing (ranitidine 1%, 5% pet) and avoiding contact with ranitidine generally resolves the lesions.^{2,5} This was



Figure 1 Positive results for ranitidine HCl 1%, 5%, 10% and 30% in petrolatum at day 4.

the case with our patient, who was instructed to avoid contact with ranitidine, resulting in a marked improvement in her symptoms, with total healing achieved after 1 month despite no specific treatment, and no further lesions occurred during the 6 months of follow-up.

In conclusion, we report a case of nonoccupational ACD from ranitidine, which is only the second such case, to our knowledge. Such a reaction is extremely rare in a nonoccupational setting, but it is possible that it may be underdiagnosed because of lack of suspicion. We consider that any patients presenting with hand eczema who have handled medications, either for themselves or for others, should be tested for ACD to these drugs.

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