

Baboon Syndrome Associated with Ampicillin Sulbactam



Cüneyt Karagöl, MD, Ayşegül Ceran, MD, Ali Güngör, MD, Alkım Öden Akman, MD, and
Emine Dibek Misirlioğlu, MD, PhD *Ankara, Turkey*

Baboon syndrome (BS) is typically characterized by a well-contoured erythematous eruption localized in gluteal, perianal, inguinal, and perigenital regions. Eruption occurs within hours after intake of the same allergen by the individuals who had previous sensitization by topical exposure or in people who had no sensitization.^{1,2} In this report, a 14-year-old patient who developed BS due to ampicillin-sulbactam is presented as this syndrome is rare in childhood.

A 14-year-old male patient with a history of epilepsy and cerebral palsy was admitted with pneumonia and treatment with intravenous ampicillin-sulbactam was initiated. On the second day of the treatment, well-contoured, bright-red-colored erythematous eruptions that faded with pressure were recognized in the anogenital region, groins, inner surfaces of the thighs, and inner surfaces of the hands and fingers (Figures 1 and 2). There were no additional findings. The patient was not exposed to any other drugs or chemicals. Complete blood count and liver and kidney function tests were normal. There was no growth in the throat culture. The punch skin biopsy taken from the erythematous lesion revealed subepidermal edema and predominantly mononuclear cell inflammation accompanied by eosinophils and infrequent neutrophils in the papillary dermis. BS was diagnosed, ampicillin-sulbactam therapy was discontinued, and clarithromycin and antihistamine therapy were started. The eruptions resolved within 1 to 2 days after discontinuation of the medicine. Patch test with ampicillin-sulbactam was planned, but it could not be performed because his family did not give consent.

BS is a characteristic form of systemic contact dermatitis. Drug-related forms of BS are also termed as SDRIFE (symmetrical drug-related intertriginous and flexural exanthem). SDRIFE is a rarely seen exanthematous form of drug eruption and typically occurs suddenly after a few hours or days of drug intake. The eruption is characteristically in the form of well-contoured erythema in the gluteal/perianal, inguinal, and perigenital regions. It also involves at least 1 intertriginous area



FIGURE 1. Well-contoured erythematous eruptions on the inner surfaces of the groins, thighs, and around the abdomen of the patient.



FIGURE 2. Erythematous eruptions on the inner surface of the hands, and fingers of the patient.

Department of Pediatrics, University of Health Sciences, Ankara Child Health and Diseases Hematology Oncology Training and Research Hospital, Ankara, Turkey
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Corresponding author: Ali Güngör, Department of Pediatrics, University of Health Sciences, Ankara Child Health and Diseases Hematology Oncology Training and Research Hospital, Şehit Ömer Halisdemir Street, 06110, Altındağ, Ankara, Turkey. E-mail: gungorali19@gmail.com.

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such as the axilla, knee, and elbow. The involved areas are symmetric and palms, soles, and face are rarely involved, and no systemic signs and symptoms are seen.^{3,4} Our patient was diagnosed with BS because erythema was detected in the

flexural regions that is a typical finding of BS, the eruptions regressed when the drug was stopped, there were no systemic signs and symptoms, and the diagnosis was supported by the histopathological findings.

Although the pathogenesis of BS is not clear, it is thought to be associated with delayed type T-cell reactions as for other exanthematous drug reactions. Amoxicillin, ceftriaxone, penicillin, and erythromycin are the most common drugs that cause BS.^{1,2} BS eruptions may be misdiagnosed in children because they resemble childhood viral and bacterial infections and dermatoses. Regression of eruptions after discontinuation of the drug supports the diagnosis. Antihistamine drugs and topical corticosteroids may be used for symptomatic treatment.

In conclusion, although BS is rare, allergists should be aware of its presentation when evaluating patients with drug allergy. When needed, a dermatology consultation should be considered. Management includes stopping the suspected drug.

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