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Erythema Multiforme Due to Methaqualone

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Abstract. A 23-year-old white man developed erythema multiforme after ingesting methaqualone "lude and coke".

A 23-year-old white man presented in the Emergency Room with a temperature of 103°F and rose-colored bumps over his body. Forty-eight hours before he had taken 150 mg of methaqualone with Coca-Cola. We identified the drug by its code number of 714. Within an hour, he described his skin as having claws climbing over it. Fever and sweats soon developed, and he felt so poorly that he stayed in bed over the next 2 days. An hour before examination diffuse erythematous lesions became apparent over his entire body.

Past history revealed that the patient had had a similar episode 2 years before, when he had also taken "lude and Coke". Erosive lesions also developed over his body. Eight months ago, he had had a bout of hepatitis, precipitated by shooting a variety of street drugs. He had since recovered and denied using any habituating substance since that time. He has no known allergies.

Physical examination revealed erythematous, macular-to-large, iris-shaped and target-shaped le-



Fig. 1. Diffuse target lesions on the patient's body.

sions enveloping his entire body. Tense bullae were also seen on his shoulder, palms, soles, and penis. Some erosions were visualized on his penis and lips but the buccal mucosae were clear. CBC with differential, urinalysis, and SMA 12 were within normal limits.

He was treated with 100 mg of prednisone daily for 5 days followed by a tapering dose for the next 7 days. The lesions resolved rapidly and no scarring was evident.

DISCUSSION

Methaqualone was initially synthesized in 1951 as a potential antimalarial agent. It was later found to be a central nervous system depressant. At first, addiction was not thought possible but by 1970 the drug was being abused both legally and illegally in a number of countries. Methaqualone is popularly thought to be an aphrodisiac. This action, however, has not been proven. The drug is metabolized by

the liver and seems to have no known cross reactions with other regularly used medicaments. (1)

Although methaqualone has been found to cause a multitude of side effects ranging from polyneuropathy to epistaxis (2) and irregular menses (3), cutaneous reactions are rarely encountered. Our patient is the first reported person to have developed erythema multiforme while on the drug. The manufacturer knows of two additional, similar cases, both undocumented (4).

Drug abusers are recognized for using a wide variety of habituating chemicals. Our patients had drug-induced hepatitis 8 months ago and a similar dermatologic problem from "lude and coke" 2 years before. This history, coupled with the patient's identification of the labelling 714, makes a strong case for methaqualone. Fellner agrees with us that these facts clearly implicate the drug in the production of erythema multiforme (5).

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Ethambutol-induced Lichenoid Eruption

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Abstract. The tuberculostatic drug ethambutol is an infrequent skin offender. A lichenoid skin eruption restricted to the light-exposed areas in a 67-year-old male was proved by withdrawal and challenge to be caused by

ethambutol. Patch tests with ethambutol 0.1%, 0.5% and 1% in watery solution were negative.

Key words: Lichenoid skin eruption; Drug eruption; Ethambutol

In 1961 ethambutol or myambutol, the d-isomer of ethylene-di-imino-di-one-butanoldihydrochloride was found to have a pronounced tuberculostatic activity. The drug has no effect on other bacteria and suppresses the growth of isoniazide- and streptomycin-resistant tubercle bacilli. The precise mechanism for its activity is unknown (5).

Ethambutol is administered orally and is usually well tolerated. Cutaneous side effects are infrequently reported in the literature.

CASE REPORT

A 67-year-old male was admitted for dermatological evaluation, when, 2 months after initiation of tuberculostatic treatment with isoniazid 0.1 g×3, ethambutol 400 mg×3 and rifampicin 450 mg a day for pulmonary cavernous tuberculosis, he developed a widespread skin eruption.

No family history of skin diseases was reported, but for many decades the patient himself had had yellowish discolored and thickened nails on fingers and toes and a persistent desquamation of the palms and soles, clinically suggestive of psoriasis. His light tolerance was hitherto normal.

The present skin eruption was moderately itchy, and restricted to the light-exposed areas with a quite sharp horizontal demarcation on the upper thigh. The lesional skin in most of the affected areas was characterized by hyperpigmentation and macular and reticular brownish-red desquamating elements without or with very slight infiltration.

On the backs of his hands and fingers and on the anterior aspects of the lower legs, lichenoid, waxy, bluish-red, partly confluent papules were present (Fig. 1).

Withdrawal of isoniazid did not result in any improvement of the skin condition. However, when ethambutol and rifampicin simultaneously were subsequently withdrawn as well, a remarkable change for the better took place within the course of a week.

In order to establish the identity of the offending drug conclusively the patient was challenged, first uneventfully with rifampicin, subsequently with ethambutol. Eight hours after ethambutol had been given the skin flared and drug fever arose.

No symptoms of alterations in his sight were recognized in the course of the skin disease. Routine laboratory investigations, including eosinophils, immunoglobulins and complement C₂ and C₄, were within normal limits.

The histological findings in the elements from the dorsum of a finger and from the upper arm were consistent with drug-induced lichenoid eruption (Fig. 2).

Direct immunofluorescence investigation of lesional skin revealed colloid bodies, particularly containing IgM