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Fixed Drug Eruption in Infancy

Fixed drug erruptions are uncommon in children(1) and extremely rare in infants(2,3). We report a child who developed a fixed eruption at the age of 6 months. Provocation tests were able to identify the causative drug in this case.

At the age of 6 months the infant first developed a circular, well-defined erythematous lesion on his right arm while he was being treated for regurgitation of feeds. No other details of the primary illness were available. Suspecting a drug to be the cause of the lesion, the mother stopped all therapy. This led to the subsidence of the erythema and the development of macular hyperpigmentation at the site. The lesion remained quiescent till he was 8 months old when erythema developed around the hyperpigmented macule during therapy for fever. The erythema subsided spontaneously when treatment was stopped. Subsequently, he had 15-20 such exacerbations of the original lesion, over the next 2 years while receiving treatment for various illnesses including diarrhea, fever and respiratory infections. These exacerbations led to an increase in the size and the intensity of hyperpigmentation of the original macule and when seen by us at the age of 2½ years, he had a 5 × 6 cm hyperpigmented macule on the right arm. He had also developed lesions on the shaft of the penis and the left arm at the age of 18 months and 26 months, respectively. These macules too had flared up everytime there was an exacerbation of the lesion of the right arm. The child's parents were illiterate and did not know which drugs had been administered prior to the flare-ups. In view of the strong likelihood of recurrences (since a commonly prescribed drug appeared to be the cause), and the absence of a severe or life threatening reaction in the past, it was decided to subject the child to provocation tests to identify the causative drug. Informed consent was obtained from the mother, and the child was admitted to hospital. A single dose of the following drugs was administered orally, one every day: erythromycin, analgin, ampicillin, furoxone and co-trimoxazole and the skin lesions observed for a flare-up over the next 24 hours. While the first 5 drugs did not provoke any reaction, erythema, warmth and tenderness developed in the lesions 30 minutes after co-trimoxazole was administered. The reaction was controlled with topical flucinolone acetonide and the child discharged from hospital with instructions to the parents on avoidance of co-trimoxazole.

In view of well demarcated hyperpigmented lesions showing recurrence of inflammation with repeat exposure to the causative drug, a diagnosis of fixed drug eruptions was considered. Confirmation of the etiology was obtained by provocation testing. Fixed drug eruptions appear to be uncommon in children(1). As with other allergic drug reactions, the low incidence is probably due to the immaturity of the system in children(2) and absence of exposures to drugs required for sensitization to occur(3). Since co-trimoxazole is commonly prescribed for a variety of indications in our country, it is likely that our patient had developed sensitization during a

previous exposure and manifested a fixed eruption on re-exposure at the age of 6 months. This is, to the best of our knowledge, the youngest age at which a fixed drug eruption has been reported. Interestingly, the previously reported cases of infants with fixed drug eruptions were also caused by co-trimoxazole(4,5).

Although drug reactions are rare in infancy, the possibility of a drug eruption in an infant should not be discounted on grounds of age alone. The morphology, evolution and relationship of the rash to drug intake must be carefully evaluated before arriving at a diagnosis. Appropriate diagnosis and management is essential to control the eruption and prevent recurrences.

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NOTES AND NEWS

ICMR AWARDS

Dr Rashmi Kumar, Assistant Professor of Pediatrics at the King George's Medical College, Lucknow is the recipient of the H.B. Dingley Memorial Award of the Indian Council of Medical Research for contribution in Pediatrics. We extend our heartiest congratulations from the pediatric fraternity for this acheivement.

–Editor