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Letter to Editor

A case of erythema multiforme: a result of self-medication with unknown drugs

Sir,

There are several causes of erythema multiforme (EM), an acute, self-limiting, hypersensitivity mucocutaneous lesion. Erythema multiforme minor, erythema multiforme major, Steven Johnson Syndrome, and toxic epidermal necrosis are included in the spectrum of illnesses, with erythema multiforme minor being the mildest and toxic epidermal necrosis the most severe.[1] It is estimated that over 90% of cases involve a herpes virus infection. Less than 10% of cases are documented to be drug-associated EM. Teenagers and young adults are most frequently affected by EM, and they are more likely to be male. Oral lesions manifest as erythematous macules and bloody encrustations involving the lips and buccal mucosa. Since isolated oral lesions are uncommon, the diagnosis is uncertain. It has been thought that this uncommon variation is oral erythema multiforme.[2] A 70-year-old male patient reported with a chief complaint of burning sensation in his oral cavity in the last 1 month.

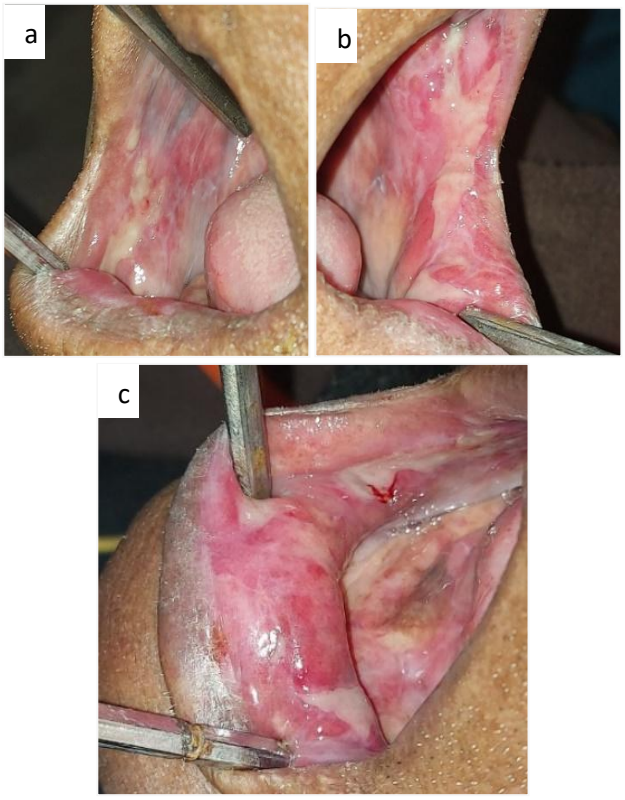

Figure 1: Clinical presentation. (a) Right buccal mucosa (b) Left buccal mucosa. (c) Lower Labial.

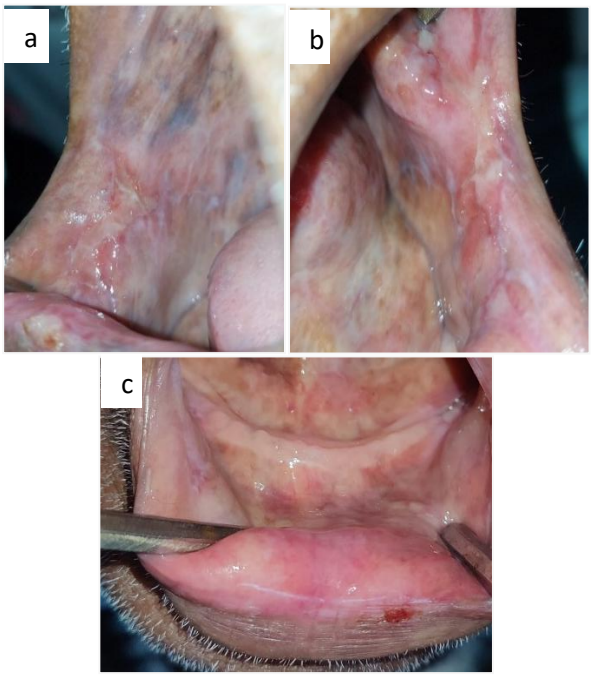

Figure 2: After 1st follow up. (a) Left Buccal Mucosa. (b) Lower Labial Mucosa. (c) Right buccal mucosa.

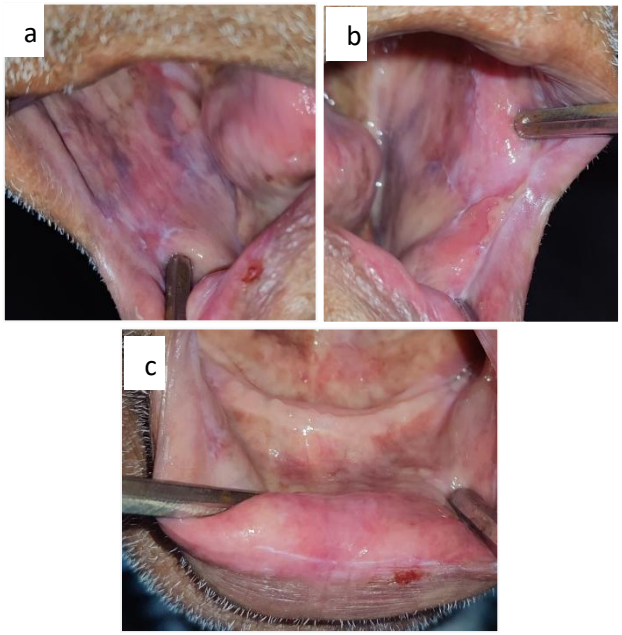

Figure 3: After 2nd follow up. (a) Right buccal mucosa. (b) Left buccal mucosa. (c) Lower labial mucosa.

Patient was a denture wearer from past 2 years and has a history of epileptic attacks and was on medication-Phenytoin (300 mg) for the same from past 3 years. 3 months back patient started experiencing burning sensation on his upper labial mucosa for which he visited to nearby medical store and purchased medication without any prescription or any medical assistance and got the symptomatic relief as illustrated by the patient. After 15 days the lesion occurs with sloughing and crustations involving labial mucosa. Patient opted for symptomatic relief without seeking any medical assistance with unknown drugs. 1 month later burning sensation became severe leading inability to eat and sleep, for which he reported for the same. On examination extensive ulcerations encrusted and crustations involving not only the labial mucosa but the complete buccal mucosa varying size 1-3 mm was seen. There was no history of fever. History of difficulty in swallowing and disturbed sleep was elicited due to burning sensation. No skin or ocular lesions were evident. Based on positive history to unknown drug and evidence of lesions, provisional diagnosis of drug induced erythema multiforme was given.

The patient was instructed to discontinue usage of the drugs and prescribed systemic steroid tab methyl prednisolone 8 mg/day (OD), Prednisolone 10 mg (swish and spit) (TDS) with topical application of ointment kenacort 0.1% (5 times a day), Tab Neurobion Forte (HS) for 15 days. and Levocetrizine (OD) for 5 days was prescribed. The patient came after the 5 days of follow up with reduced erythema and sloughing. The dosage of methylprednisolone was taper with 4 mg for the next 5 days. The patient is advised to take remaining medication with the same manner for 1 week. Drugs have two sides: they can have positive effects but, in some cases, they can also have negative ones. Adverse drug reactions can take many different forms, such as anaphylactic reactions, fixed drug eruption, and erythema multiforme.[2] An inflammatory oral condition that resembled erythema multiforme without involving the skin was described by Kenneth in 1968.[3]

Antibiotics and non-steroidal anti-inflammatory medicines are the most prevalent medications that cause responses, while EM brought on by pharmaceuticals is uncommon. In our situations, the lesion manifested itself subsequent to the initial drug use. The patient had not experienced any infections or food additive allergies. Therefore, it was believed that the etiological agent in patients was drug use because of the temporal incidence of drug intake and lesion manifestation. The most frequent site is the oral mucosa, with 70% of cases including the lips, buccal mucosa, and labial mucosa. The patient's ulceration was limited to the buccal mucosa and lips.

The skin showed no signs of classical target lesions. The most frequent differential diagnosis is an apthous ulcer, which frequently develops on the mucosal lining. A yellowish gray membrane encircling an erythematous halo surrounds these round or oval lesions. Herpes simplex infections are more common in small, connected mucosa, such as the palate, lips, and gingiva, and they have regular edges. In our instance, no such lesion was observed on the mucosa that was connected. Lips may be affected by recurrent herpes labialis, but the condition is viral in origin, and our patient exhibits no prodromal signs or clinical characteristics.[4]

EM has nonspecific histopathology, and biopsy is only possible when the lesion is in the vesicular stage. Finding and eliminating triggers is the foundation of EM treatment. These lesions typically react to corticosteroids; topical steroids can be begun for small lesions, and systemic steroids can be started for severe situations and tapered for one week. In our patients, the offending medication was stopped, and systemic steroids were provided for a week before being reduced. Induced by drugs as a rare variation, oral erythema multiforme must be distinguished from other oral ulcerative lesions in order to be promptly managed and monitored. The underlying causes of oral EM must be addressed in order to treat its symptoms.

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