Erythema multiforme to amoxicillin with concurrent infection by Epstein-Barr virus

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ABSTRACT

Background: The incidence of rashes following the intake of aminopenicillins during an acute episode of infectious mononucleosis is high, but severe cutaneous reactions as erythema multiforme or Stevens-Johnson syndrome are rare manifestations in childhood.

Material and methods: We report the case of a 7 year old girl that developed a generalized purpuric rash with target shaped areas, 9 days after starting treatment with amoxicillin-clavulanic acid. Laboratory investigation revealed a significant increase of Epstein Barr virus (EBV) specific IgM antibody. After skin biopsy she was diagnosed as erythema multiforme syndrome. Prick, intradermal and patch tests were performed with penicilloylpolylysine, minor determinant mixture, benzylpenicillin, ampicillin, amoxicillin, cefazoline and cefotaxime, the 24 hours reading was positive for aminopenicillins. Patch tests were also positive only for amoxicillin, other betalactams were negative.

Conclusions: The interaction between an infectious agent (EBV) and amoxicillin could precipitate the severe skin reaction. Patch test and delayed intradermal reading with amoxicillin were an useful tool for the diagnosis of the etiological agent in this reaction. The negative response to other beta-lactams, suggests that the aminobenzyl group of the side chain of amoxicillin plays a predominant role in this reaction.


CASE REPORT

A seven year old girl, previously in good health had a clinical picture of fever, pharyngitis and lymphadenopathy, that was treated with some doses of paracetamol and amoxicillin–clavulanic acid. Nine days after starting such antibiotic she developed a maculopapular rash. She was diagnosed as mononucleosis syndrome (she showed activated lymphocytes in peripheral blood) and amoxicillin–clavulanic acid was withdrawn, but her clinical condition deteri-
Erythema multiforme (EM), Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are mucocutaneous diseases associated with significant morbidity and mortality, being relatively uncommon disorders in children. The causative factors of these disorders that have been identified include infectious agents and drugs. Herpes simplex and mycoplasma pneumoniae are the most common infectious agents and have been casually associated with EM and SJS. All three of the disorders have been linked to drugs, with TEN being exclusively attributed to this factor. More than 100 drugs have been associated with these diseases being sulphonamides, hydantoins, nonsteroidal antiinflammatory drugs and allopurinol the most common implicated agents. Studies examining the incidence in patients receiving amoxicillin therapy in particular, find that it is rare.

In some cases, both factors: drugs and infectious agents have been identified as possible precipitants to the disease. It is well known that viral infections enhance the risk of drug allergic reactions. Although the exact mechanism for this eruptions is not known, breakdown of tolerance or enhancement of the immune reaction to drugs following viral infection could involve two mechanism: a change in the antigenic expression of the drug or its metabolites probably due to changes in the expression of drug-metabolizing enzymes or an alteration of immune regulation systems. Although, the exact mechanism for this eruptions is not known, breakdown of tolerance or enhancement of the immune reaction to drugs following viral infection could involve two mechanism: a change in the antigenic expression of the drug or its metabolites probably due to changes in the expression of drug-metabolizing enzymes or an alteration of immune regulation systems. In some cases, both factors: drugs and infectious agents have been identified as possible precipitants to the disease. It is well known that viral infections enhance the risk of drug allergic reactions. Although the exact mechanism for this eruptions is not known, breakdown of tolerance or enhancement of the immune reaction to drugs following viral infection could involve two mechanism: a change in the antigenic expression of the drug or its metabolites probably due to changes in the expression of drug-metabolizing enzymes or an alteration of immune regulation systems. So in this case, as proposed previously in the literature, is biologically plausible that the interaction between Epstein Barr virus and amoxicillin could precipitate the skin reaction.

Levine reported delayed positive IT, consisting of erythema and variable induration in patients with skin rashes after penicillin intake, since then a number of studies have reported that PT can also be used as a diagnostic procedure for studying nonimmediate reactions to drugs such as maculopapular exanthems, urticaria and/or angioedema, TEN, erythrodermia, erythema multiforme and generalized eczema. Both IT and PT seem valuable instruments for the diagnosis of NIP to AP.
Renn et al. also suggest that allergy testing may be helpful in patients with aminopenicillin-induced skin rashes in infectious mononucleosis and would enable to identify sensitized patient and to avoid severe exanthemas, especially in young adults an children.

In our patient, both patch test and delayed intradermal reading with aminopenicillins were an useful tool for the diagnosis of the aetiological agent in this unusual reaction to amoxicillin with concurrent Epstein Barn infection, moreover the positivity of such tests suggests a cell mediated hypersensitivity. The negative response to BP and cephalosporins indicates that amino-benzyl group plays a predominant role and the side-chain determinants would be the responsible of the reaction as suggested by other authors with larger series of patients.

Perhaps some reactions after treatment with aminopenicillins during an episode of mononucleosis represent true sensitizations to aminopenicillins and not a transient phenomenon as proposed by other authors, in this case skin tests performed again one year later, went on positives.

REFERENCES