EA DV CONGRESS
BERLIN 11-14 OCTOBER 2023
EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

Abstract N°: 6229

Acute generalized exanthematous pustulosis (AGEP) induced by terbinafine

Radostin Yankov[1], Yanko Popov[1], Dimitrina Serafimova[1], Martin Shahid[1], Valeria Mateeva[1], Sheri Shefked[1], Snejina Vassileva[1], Lyubka Miteva[1], Kossara Drenovska[1]

[1]Medical University of Sofia, Sofia, Bulgaria

Acute generalized exanthematous pustulosis (AGEP) induced by terbinafine

Radostin Yankov, Yanko Popov*, Dimitrina Serafimova, Martin Shahid, Valeria Mateeva, Sheri Shefked, Snejina Vassileva, Lyubka Miteva, Kossara Drenovska

Department of Dermatology and Venereology, Medical University – Sofia, Sofia, Bulgaria

*N.I. Pirogoff Multi-profile Active Treatment and Emergency University Hospital, Sofia, Bulgaria

Introduction & Objectives:

Acute generalized exanthematous pustulosis (AGEP) is a rare acute eruption characterized by numerous, small, non-follicular, sterile pustules arising within large areas of edematous erythema. The incidence of AGEP ranges between 3-5 cases per million population per year. More than 90% of the cases are drug-induced and it is usually classified as one of the severe cutaneous adverse reactions (SCARs) which usually develop within 48-96 hours after the drug administration. Any age may be affected and systemic involvement of the liver, kidneys, or lungs may only seldomly be observed. The most common culprits are antibiotics such as penicillins, cephalosporins, quinolones or tetracyclines, followed by calcium channel blockers, carbamazepine, non-steroidal anti-inflammatory drugs (NSAIDs) and antifungals, mostly terbinafine.

Materials & Methods:

We report a 40-year-old woman who presented to the clinic with exfoliating erythroderma of 4 days duration starting from the décolletage and rapidly spreading to the whole body with multiple non-follicular pustules affecting lower extremities. Few weeks prior to this episode, the patient was hospitalized in our department for generalized exanthematous drug eruption considered to be related to new NSAIDs intake. Complete remission of the initial rash was achieved by moderate doses of corticosteroids and antihistamines. The detailed drug history identified that the only agent to which the patient had been exposed prior to both skin rash episodes was terbinafine, hence, the diagnosis of terbinafine-induced AGEP was presumed. The diagnostic procedures included routine laboratory tests and histological examination.

Results:

Routine laboratory investigations demonstrated mild leukocytosis with neutrophilia and elevated inflammatory markers. The histological examination showed mild acanthosis, subcorneal collection of neutrophils, mild spongiosis and perivascular round cell infiltrates. Based on the clinico-laboratory findings the diagnosis of terbinafine-induced AGEP was accepted and the culprit drug was discontinued. Treatment with methylprednisolone 40mg, chloropyramine hydrochloride, infusions with serum glucose 500ml daily, and topical clobetasol dipropionate resulted in rapid complete remission.

Conclusion:

AGEP induced by terbinafine has only rarely been reported and the drug is not on the shortlist of medications responsible for this form of SCARs as it is mainly known to cause erythema multiforme, severe urticaria, erythroderma or worsening of pre-existing psoriasis. Terbinafine-induced AGEP may demonstrate slow recovery compared to other causative agents which is due to the presence of the drug in the skin for several weeks after exposure. Contrary to that experience, a rapid and complete recovery was observed in our patient after terbinafine withdrawal. Identification of the culprit agent may be difficult but is crucial for the disease duration and prognosis.