

Fixed Drug Eruption Due to Etoricoxib in a Patient With Tolerance to Celecoxib: The Value of Patch Testing[☆]

Exantema fijo medicamentoso por etoricoxib con tolerancia a celecoxib. Utilidad de las pruebas epicutáneas

To the Editor:

Etoricoxib is a nonsteroidal anti-inflammatory drug (NSAID) that inhibits cyclooxygenase 2 (cox-2); it was introduced recently onto the market and is used widely. It has been implicated in several skin reactions and has been described as an uncommon cause of fixed drug eruption. We present a new case confirmed by patch testing.

The patient was a 32-year-old woman with no relevant history of allergy. She came to our outpatients for evaluation of a pruritic and painful erythematous plaque measuring 1.5 cm on the cubital border of the left hand. The lesion had resolved leaving slight residual pigmentation. She reported 2 similar episodes that had occurred at the same site over the previous 3 months. The patient had taken various analgesics for episodes of pain secondary to a disc hernia. Those drugs had been ibuprofen, which she had taken again with no problem after the most recent skin reaction, and etoricoxib, which she had started to take 3 months earlier. Two months after the final episode, patch tests were performed on normal skin using the standard series of the Spanish Contact Dermatitis and Skin Allergy Research Group (GEIDAC), and an NSAID series (Marti Tor) that included celecoxib and etoricoxib (both at 10% in petrolatum). The results were negative. In addition, patches of 10% etoricoxib were applied to the site of the skin lesion, giving a positive result (++) at 48 and 96 hours (Fig. 1). A celecoxib patch was then applied to the previously damaged skin, with negative results, and controlled oral challenge with celecoxib was performed without observing any adverse reaction during the test or afterwards when taken regularly at the usual doses.

Etoricoxib combines a potent anti-inflammatory activity with a good safety profile. As with other drugs of the same family, such as celecoxib, it has been implicated in various skin reactions, although with a much lower frequency. There are reports of cases of urticaria and angioedema,¹ generalized exanthematous pustulosis,² exudative erythema multiforme,³ toxic epidermal necrolysis,⁴ and fixed drug eruption.⁵⁻⁹

Fixed drug eruption is an uncommon skin reaction in which numerous drugs have been implicated, the NSAIDs being among the most common.^{10,11} Fixed reactions to the NSAIDs that inhibit cox-2 have been reported since their development but, in the case of etoricoxib, only 6 cases have been published.⁵⁻⁹ Diagnosis is based on the medical history and the characteristic skin lesions: 1 or several well-defined erythematous lesions, occasionally affecting mucosas, that



Figure 1 Positive patch test with etoricoxib at 10% in petrolatum in the area previously affected by the fixed drug eruption.

appear not long after administration of the causative drug and that typically recur at the same site on rechallenge with the causative agent. However, the etiological diagnosis is occasionally more complex, as the patient can be taking numerous drugs or may be unaware of or have forgotten about a certain medicine. In these cases, an oral challenge test is the gold standard for making the diagnosis, but this is not risk-free, and reactions are occasionally severe. Patch testing is therefore a valid alternative, as it is a safe and non-invasive diagnostic method. These tests must be performed at least 6 weeks after resolution of the episode. Patches are applied both to healthy skin and to the skin at the site of previous damage, which is where positive results are usually obtained; positive results on healthy skin are very rare. The sensitivity of the test is variable and depends on the concentration, the vehicle used, the area affected, and, in particular, on the substance tested. In a retrospective study performed on 52 patients, a positive reaction was detected in 21 patients (40%); in all cases, the test was only positive on the previously affected skin and in all except one the implicated drug was an NSAID.¹⁰ A negative test does not exclude the diagnosis or the implication of the suspected drug, but a positive result confirms the diagnosis, avoiding the need for oral challenge, with its associated risks.

In our case, the imputation was confirmed by the patch test. Another pharmacologically similar molecule, celecoxib, is structurally different from etoricoxib, as it belongs to the sulfonamide family, whereas etoricoxib is a substituted bipyridine. The negative result of the patch test with celecoxib thus allowed us to perform an oral challenge test, providing the patient with a safe therapeutic option. This case illustrates the usefulness of these tests for the study of certain adverse drug reactions, such as fixed drug eruption.

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Dermatomyofibroma on the Nape of the Neck: A Report of 2 Pediatric Cases[☆]

Dermatomiofibroma en la nuca: descripción de 2 casos en la edad pediátrica

To the Editor:

Dermatomyofibroma is a rare benign tumor of myofibroblastic origin that was initially called plaque fibromatosis in the literature.¹ It is most common in young women, but has occasionally been described in pediatric patients. A recently published review gathered a total of 34 cases in children.² We present 2 pediatric cases (Fig. 1, A and B) recently diagnosed and treated in our hospital. These cases support the benign nature of the lesion and the tendency of the tumor to arise on the neck.

The first patient was a 5-year-old boy with no past medical history of interest. He was referred to the dermatologist for evaluation of a tumor on the neck (Fig. 1A) that his parents had noticed approximately 6 months earlier. There was no reported history of trauma. This asymptomatic lesion was palpable more than visible and it had a maximum diameter of 0.6 cm.

A punch biopsy taken from the center of the lesion revealed epidermal hyperplasia with mild hyperpigmentation of the basal layer. The full thickness of the dermis was affected by a proliferation of spindle-shaped cells in a fascicular arrangement, with their axes mainly oriented parallel to the epidermis; the lesion was paucicellular, and no cellular atypia or mitotic figures were observed. The spindle cells had slightly wavy nuclei (Fig. 2, A and B). No hyaline globules were observed in the cell cytoplasm. Immunohistochemistry was negative for protein s100, smooth muscle actin, muscle specific actin, desmin, Caldesmon, and CD34.

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Complete excision of the lesion was then performed and histology study reported identical findings.

The second patient was a 13-year-old boy with no relevant past medical history. He was referred to dermatology

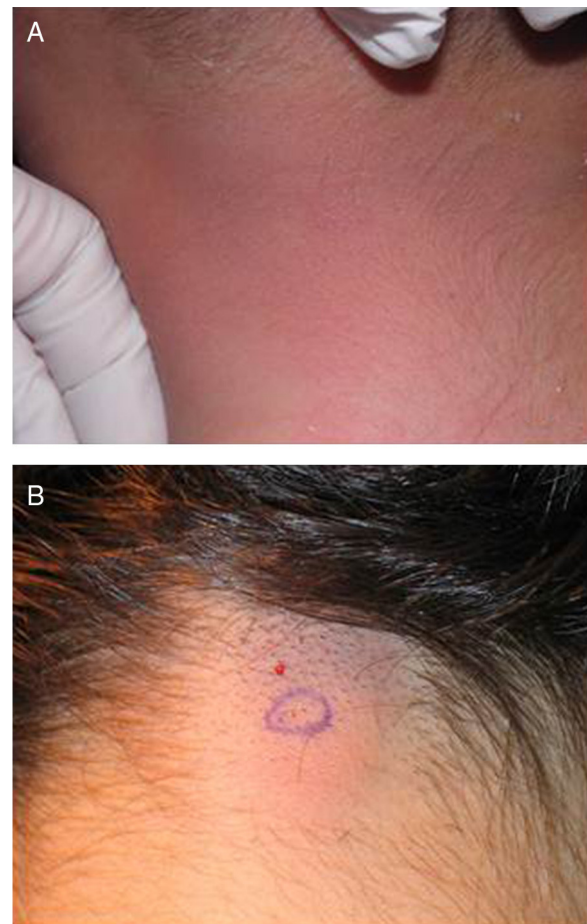


Figure 1 Clinical image of the tumors on the neck of patient 1 (A) and of patient 2 (B).