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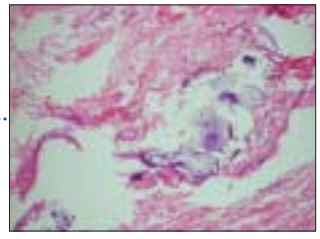

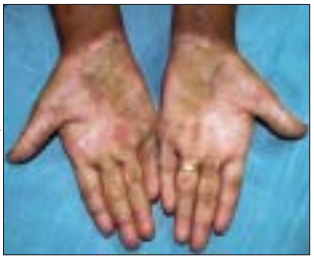

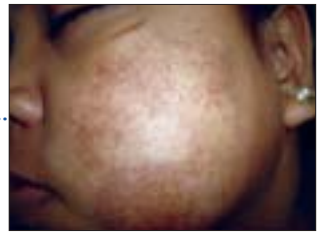

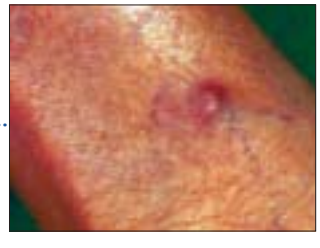

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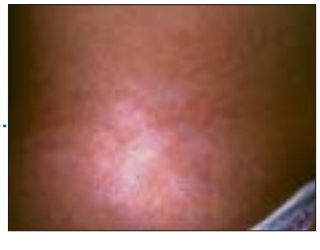

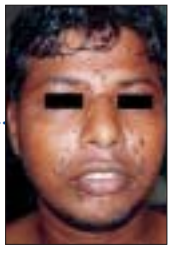

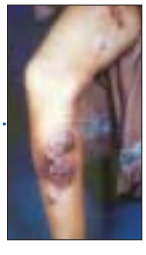

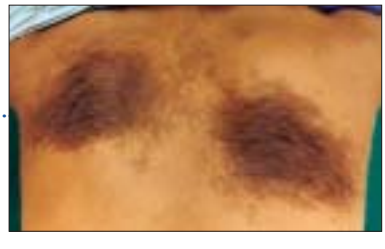

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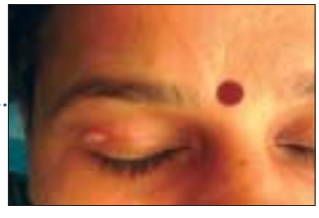

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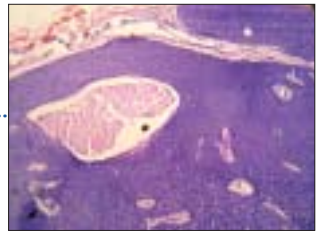

Fixed drug eruption due to cross reaction between two azoles used for different indications

Sir,

It is well known that an eruption caused by one drug can be reactivated by another chemically related drug. Usually, these chemically related drugs belong to a single class of therapeutic agents, e.g., antibiotics or anticonvulsants. Such patients are usually advised to avoid the causative drug and chemically similar drugs used for the same indication. However, it is unusual for cross reactions to chemically related drugs to occur across therapeutic categories.

A 27-year-old gynecologist noticed six itchy, oval-to-irregular, erythematous, edematous, hyperpigmented plaques and macules on the face, forearms, fingers, neck and thigh that developed within 1 h of intake of a tablet of fluconazole 150 mg. The macules varied in size from 0.5 to 2 cm. A plaque on the left preauricular region showed blistering. She was treated with clobetasol propionate 0.05% twice daily; and hydroxyzine, 25 mg orally twice daily, with which the lesions subsided leaving behind post-inflammatory hyperpigmentation.

She had had two previous episodes of a similar eruption at the same sites. The first, 4 years ago, following intake of a combination of ciprofloxacin and tinidazole taken for the treatment of diarrhea; and the second, 2 years ago, after taking tablet fluconazole, 150 mg. The second episode was less severe than the first. She had taken ciprofloxacin in the past without any complaint or cutaneous eruption. She had also developed cutaneous wheals and facial swelling after intake of tablet paracetamol and nimesulide, four times in the past. She had episodes of recurrent wheezing after cold and dust exposure, which was relieved with inhaled bronchodilators. There was no family history of atopy.

As cross reactions between chemically related drugs are well known, patients who develop a drug reaction are advised to avoid the causative drug and other drugs prescribed for the same indication, e. g. sulfonamides, cephalosporins and penicillins and the aromatic anticonvulsants, among others. This advice is usually phrased thus: 'When taking antibiotics (or anticonvulsants or painkillers), avoid this drug and related drugs.' Our patient's case represented an uncommon situation, where the cross-reacting drugs were administered for quite different indications- vaginal candidiasis and intestinal amebiasis. Such cross reaction among agents of different therapeutic classes has also been described among the sulfonamide group of drugs.[1]

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The azoles include compounds that are used as antibacterial and antiprotozoal agents: metronidazole, tinidazole, secnidazole, benznidazole; as antifungal agents: imidazoles (ketoconazole, miconazole, clotrimazole) and triazoles (fluconazole, itraconazole, voriconazole) and as anthelminthic agents: albendazole, mebendazole and thiabendazole.

Drug reactions due to azoles, including fixed drug eruptions to fluconazole.[2-10] and tinidazole,[11-12] have been described; however, cross reaction between azole drugs used for different indications does not appear to have been reported. Patients sensitive to one azole drug should be advised to avoid all other azole drugs, irrespective of the indication.

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