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DRUG-INDUCED PSEUDOLYMPHOMA SYNDROME

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Five cases of pseudolymphoma syndrome (PS) in children aged six to twelve years were observed after anticonvulsant drugs.In two cases PS was observed after ten days and in three after fifteen days of therapy with the offending drug. Three cases of PS were due to carbamazepine and had morbilliform rash and two cases due to phenobarbitone had erythroderma. All had fever, generalised lymphadenopathy and 4/5 had hepatosplenomegaly. Therapy with 15 mg prednisolone daily and withdrawal of the offending drug led to cure in 4/5 cases and one died due to congestive cardiac failure.

Key Words : Pseudolymphoma, Anticonvulsant drugs

Introduction

Pseudolymphoma syndrome (PS) consists of the triad of fever, generalised rash and lymphadenopathy. In addition malaise, hepatosplenomegaly, arthralgia, congestive cardiac failure, eosinophilia, thrombocytopenia and blood dyscrasias may be present.[1] Diphenylhydantion, mephytoin, tridione and phenobarbitone etc. can produce a peculiar response of reticuloendothelial system resulting in PS.[2] PS may be either hypersensitivity reaction or possioly a genetically determined enzymatic defect as seen in primaquin sensitivity.[3] PS may present as generalised exfoliative dermatitis.[4] PS may have generalised or localised lesions and may result from non-anticonvulsant drugs.[5] Histopathology may reveal mycosis fungoides or sezary like syndrome.[4]

Case Report

Case I : A 10-years boy tolerated phenobaroitione (60 mg twice/daily) for ½ years and was shifted to carbamazepine (200 mg twice/day). Ten days later he developed fever, hepatosplenomegaly, generalised erythematous maculopapular rash and generalised lymphadenopathy. Lymph nodes were 1 to 2cm, discrete, mobile firm and non-tender. Fever subsided and lymphadenopathy started regressing within four days of starting 15 mg prednisolone daily. All investigations were normal except total leukocyte count (TLC) which was 22,000/cmm.

Case 2 : A 12-years girl tolerated phenobarbitone for the last eight years and was shifted to carbamazepine (200 mg twice day). Fifteen days later she developed low grade fever, generalised erythematous maculopapular rash and generalised lymphadenopatny (2 to 3 cm, discrete, mobile, firm and non-tender). Mantoux test was positive. ESR was 80 mm/hour. X-ray chest revealed hilar lymphadenopathy and she was diagnosed as a case of tuberculosis. Lymph node biopsy ruled out tuberculosis. Peripheral smear showed occasional atypical lymphocytes. Dermatologists recognised pseudolymphoma syndrome and she was treated with 15 mg prednisolone daily.

Case 3 : A 10-years girl had febrile convulsions and was given carbamazepine (200 mg twice/daily). After two weeks therapy, she developed low grade fever, generalised morbilliform rash with interspersed purpura, ecchymosis, haemorrhagic bullae, hapatosplenomegaly and visible generalised

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lymphadenopathy (2 to 4 cm, discrete, firm, mobile and non-tender). All investigations were normal except presence of occult blood in stool and platelet counts which were 60,000/ cmm. Carbamazepine was deleted and patient was given 15 mg prednisolone daily and within three days haemorrhagic bullae and purpura subsided and lymph nodes started regressing.

Case 4 : A 10-years boy had febrile convulsions and was given phenobarbitone (60 mg twice/day). Fifteen days later he developed high grade fever, erythroderma and generalised lymphadenopathy. Liver was enlarged by two fingers and spleen was just palpable. Haemoglobin was 8.0gm%, differential count showed P 30, L 50 M 2 and E 18. ESR was 108 mm/hour. Other investigations were normal. Child was given 2 cc intramuscularly dexamethasone daily. On fifth day child developed congestive cardiac failure and died.

Case 5 : A 6-years boy was given phenobarbitone (60mg twice/day) and ten days later developed fever, erythroderma, hepatosplenomegaly and generalised lymphadenopathy. On fourth day, he developed melena. His haemoglobin was 7.5mg%. TLC was 11,400/cmm, differential count was P 40, L 39, E 20 and M1. Stools for occult blood was positive. Other investigation were normal. Patients was treated with 2 cc intramuscular dexamethasone daily. He started improving on fourth day and was cured after two weeks of therapy.

Discussion

Five cases of pseudolymphoma syndrome in children were observed. Three were due to carbamazepine and two due to phenobarbitone. Two cases with phenobarbitone had erythroderma. Other three cases had morbilliform rash and one of them had additional purpura, haemorrhagic bullae and thrombocytopenia. All the cases occurred within two weeks of starting the offending therapy. Due to fever, lymphadenopathy and rash, the PS has to be differentiated from viral and bacterial infections. Early diagnosis is very important as it can easily be treated by systemic steroids and omitting the offending drugs.

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