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DRUG INDUCED PSEUDOLYMPHOMA SYNDROME

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Five cases of pseudolymphoma syndrome (PS) in children aged 6 to 12 years were observed after anticonvulsant drugs. In 2 cases PS was observed after 10 days and in 3 after 15 days therapy with offending drug. 3 cases of P S were due to carbamazepine and had morbilliform rash and 2 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 offending drug led to cure in 4/5 cases and 1 died due to congestive cardiac failure.

Key Words : Pseudolymphoma syndrome, Anticonvulsant drugs

ntroduction

The 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] Diphenylhydantoin, mephytoin, tridione and phenobarbitone etc. can produce a peculiar response of reticuloendothelial system resulting in PS.[2] PS may be either hypersensitivity reaction or possibly a genetically determined enzymatic defect as seen in primaquin sensitivity.[3] P S may present as generalised exfoliative dermatitis.[4] P S may have generalised or localised lesions and may result from non-anticonvulsant drugs.[5] Histopathology may reveal mycosis fungoides or sezary like syndrome.[4-6]

Case Report

Case 1

One 10-years-boy tolerated phenobaroitone (60 mg twice/day) for $1^1/_2$ half years and was shifted to carbamazepine 200 mg twice/day). 10 days later he developed fever, hepatosplenomegaly, generalised erythematous maculopapular rash and generalised lymphadenopathy. Lymph nodes were 1 to 2.5 cm, discrete, mobile, firm and nontender. Fever subsided and lymphadenopathy started regressing within 4 days of starting 15 mg prednosolone daily. All investigations were normal except TLC which was 22,000/ cmm.

Case 2

One 12-years-female tolerated phenobarbitone for the last 8 years and was shifted to carbamazepine (200 mg twice day). 15 days later she developed low grade fever, generalised erythematous maculopapular rash and generalised lymphadenopathy (2-3 cm, discrete, mobile, firm and non-tender). Mantoux test was positive. ESR was 80 mm. X-ray chest revealed hilar lymphadenopathy and was diagnosed as a case of tuberculosis. Lymph node biopsy ruled out tuberculosis. Peripheral smear showed occasional atypical lymphocytes. Dermatologists recognised pseudolymphoma syndrome and was treated after 2 weeks therapy with 15 mg prednisolone daily.

Case 3

One 10-years-female had febrile convulsions and was given carbamazepine (200 mg twice/day). After 2 weeks therapy,

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she developed low grade fever, generalised morbilliform rash with interspersed purpura, ecchymosis, haemorrhagic bullae, hepatosplenomegaly and visible generalised lymphadenopathy (2-4 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 3 days haemorrhagic bullae and purpura subsided and lymph nodes started regressing. Patient was treated after 2 weeks therapy.

Case 4

One 10-years-boy had febrile convulsions and was given phenobarbitone (60 mg twice/day). 15 days later he developed high grade fever, erythroderma and generalised lymphadenopathy. Liver was enlarged by two fingers and spleen was just palpable. Hb was 8.0 gm%. DLC showed P 30, L 50, M 2 and E 18. ESR was 108 mm. Other investigations were normal. Child was given 2 cc intramuscularly Dexamethasone daily. On 5th day child developed congestive cardiac failure and died.

Case 5

One 6-years-male was given phenobarbitone (60 mg twice/day) and 10 days later developed fever, erythroderma, heaptosplenomegaly and generalised lymphadenopathy. On 4 day, he developed malena. Hb was 7.5 mg%. TLC was 11,400/cmm. DLC was: P 40, L 39, E 20 and M L. Stools for occult blood was positive. Other investigations were normal. Patient was treated with 2 cc intramuscular Dexamethasone daily. He started improving on 4 day and was treated after 2 weeks therapy.

Comments

Pseudolymphoma syndrome in 5 children were observed. 3 were due to carbamazepine and 2 due to phenobarbitone. 2 cases with phenobarbitone had erythroderma, other 3 cases had morbilliform rash and one of them had additional purpura, haemorrhagic bullae and thrombocytopenia. All the cases occurred within 2 weeks of starting offending drug. It has been reported that P S occurs within 2 to 8 weeks of starting therapy with diphenylhydantoin.[7] Due to fever, lymphadenopathy and rash, the P S 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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