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Clinical Image

Allergic Maculo-Papular Exanthema Due To Terbinafine

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Abstract

We report on a 76-year-old male patient who developed a maculopapular generalised exanthema due to terbinafine. Prick test was negative; patch test revealed a positive reaction after 48 h confirming the delayed-type allergic reaction. Non-pustular exanthema has only rarely been reported for terbinafine.

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A 76-year-old male patient presented to our department for Allergology diagnostic. He reported about an itchy dermatosis that developed the year before. He suffered for many years from onychomycosis and recurrent tinea pedum. In May 2016 he was treated for the first time by systemic terbinafine because of tinea pedum. About four weeks later he developed of a generalised maculopapular exanthema. Terbinafine therapy was stopped. The exanthema completely disappeared within two weeks by oral prednisolone in tapering-down doses.

The medical history was negative for atopic diseases and known allergies, but he suffered from a mild depression treated with clomipramine. No other medical drugs were used by our patient.

On examination, we observed a photo skin type II according to Fitzpatrick, tinea pedum, but no urticarial dermographism.

We performed patch test and pricked test with terbinafine. After 20 in, prick test remained negative. Positive control with 0.1% histamine showed an urticarial response of 3 mm to 30 mm with some pseudopodia.

Patch test revealed a positive reaction to the offending drug with multiple papules and erythema (++) after 48 h (Fig. 1).

Terbinafine is a frequently used allylamine antimycotic drug that inhibits squalene epoxidase and thereby ergosterols biosynthesis of fungi [1]. Adverse reactions have been documented with an incidence of 2.7% [2]. The most common findings are acute generalised pustulosis, urticaria, gastrointestinal symptoms, taste loss, and liver toxicity [2-5].

An uncommon adverse effect is the development of drug-induced lupus erythematosus, mostly of the subacute-cutaneous subtype [6], and induction or exacerbation of psoriasis [7].

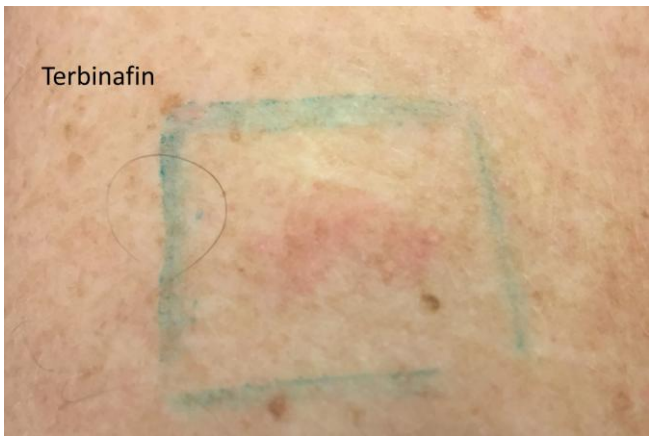

Figure 1: Positive patch test reaction with terbinafine after 48 h

In contrast, to pustular exanthema non-pustular erythema has rarely been described. George et al. (2015) observed a case of pityriasis rosea-like eruption due to terbinafine. Zheng et al. (2017) described a lichenoid drug eruption by terbinafine two weeks after initiation of treatment. Maculo-papular exanthema due to terbinafine has not been described, although it might be underrepresented in the medical literature.

We could confirm the allergic reaction to terbinafine. Although a generalised exanthema had been observed, we identified a type-IV reaction not a type-I reaction to terbinafine. Maculo-papular exanthema and systemic drug-related intertriginous and flexural exanthema (SDRIFE) are the most common symptoms of a delayed drug reaction [8, 9].

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