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Von Zumbusch's pustular psoriasis associated with oral terbinafine

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Abstract

Adverse skin reactions have been reported in 2.7% of patients receiving oral terbinafine. Less common but life-threatening reactions include acute generalized exanthematous pustulosis (AGEP), Stevens-Johnson syndrome, toxic epidermal necrolysis, exacerbation or induction of psoriasis.

We report a case of a 28 year-old woman with no history of psoriasis, the patient presented generalized pustular eruption, erythroderma, prolonged fever and altered general conditions, associated with initiation of oral terbinafine. The histological analysis of the cutaneous biopsy was compatible with pustular psoriasis. The intake of terbinafine was discontinued and treatment by acitretin 25 mg/day associated with emollient cream was started. The evolution was marked by resolution of skin eruption and disappearance of the fever in a few days. The complete remission was reached 2 months later.

The diagnosis of severe generalized pustular psoriasis (GPP), type Von Zumbusch associated with initiation of oral terbinafine was made.

The present case indicates that terbinafine is a drug that may be associated with the development of psoriasis de novo or its exacerbation.

Keywords: Von Zumbusch; Generalized pustular psoriasis; Adverse effects; Terbinafine

1. Introduction

Terbinafine is a broad spectrum antifungal, which have been used effectively to treat dermatophyte infections of the skin and nails (Duckworth et al., 2012). Although generally well tolerated, several cutaneous adverse effects have been reported in patients receiving oral terbinafine.

Pustular eruptions associated with terbinafine have rarely been reported in the literature. Terbinafine may be associated with the development of psoriasis de novo or its exacerbation (Wilson and Evans, 1998).

We report a new case of severe generalized pustular psoriasis, type von zumbusch associated with initiation of terbinafine in a patient with no history of psoriasis.

2. Case report

A 28 year-old woman was admitted in our medical center for a febrile pustular erythrodermia. There was no personal or family history of psoriasis. The patient had taken oral terbinafine 250 mg/day for clinically diagnosed onychomycosis for 19 days until the initial eruption. The

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patient did not recognize any other drug history within two months.

The erythematous eruption with pustules occurred on the lower limbs and spread to the upper limbs and the trunk, with fever and altered general conditions. The intake of terbinafine was discontinued and oral corticosteroids and antihistamines were started. Despite these treatments, the eruption continued to spread and became aggravated.

On admission, the patient presented generalized erythematous annular lesions and plaques. Small pustules were present at the active borders of the eruptions. There was a palmo-plantar desquamation with facial erythema (Figs. 1 and 2), associated with a fever of 39.6 °C. There was no enlargement of lymph nodes, liver or spleen.

Laboratory test results revealed a white blood cell count of 20590 cells/ml with 85% neutrophils. Liver and renal explorations were without abnormalities. The bacteriological study of the contents of the pustules did not reveal any organism.

The histological analysis of the cutaneous biopsy showed psoriasiform acanthosis with intraepidermal pustules and spongiform pustules of Kogoj, consisting exclusively of neutrophils without eosinophils, and perivascular inflammatory process in the dermis, no sign of keratinocytic necrosis, no sign of vasculitis (Figs. 3 and 4).

The clinical and histopathological findings were consistent with a diagnosis of severe generalized pustular psoriasis type von zumbusch.

The patient was treated by acitretin 25 mg/day associated with emollient cream. The evolution was marked by resolution of skin eruption and disappearance of the fever in a few days.

After 2 months of treatment, there was no clinical symptomatology (Figs. 5 and 6) and the biological parameters returned to normal. Advice was given to the patient regarding terbinafine.

3. Discussion

Systemic adverse reactions have been reported in 10.5% of patients receiving oral terbinafine (Hall et al., 1997), and

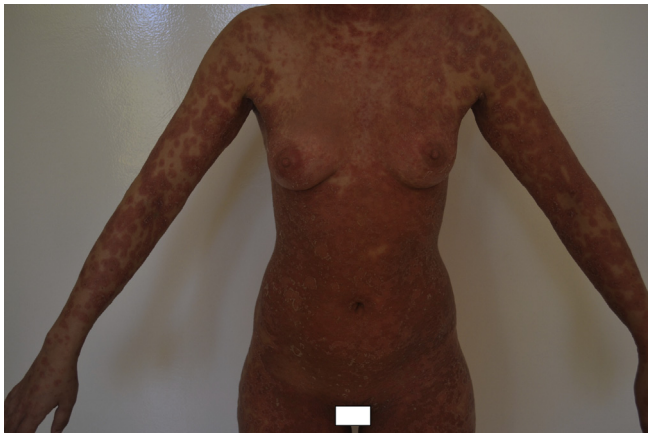

Figure 1. Generalized erythematous lesions and plaques with pustules.

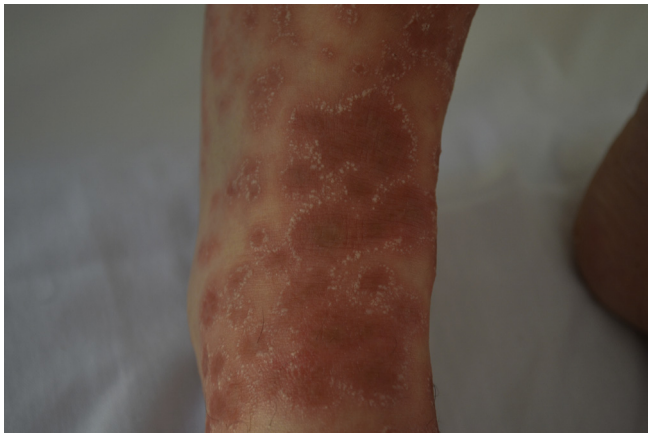

Figure 2. Annular lesions and plaques with pustules at the borders.

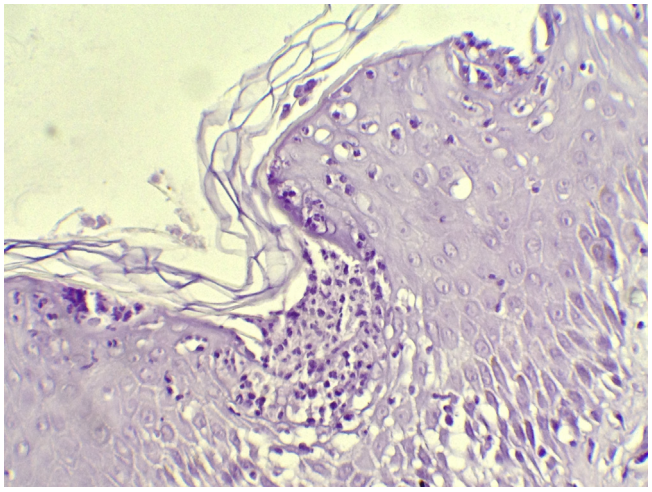

Figure 3. Psoriasiform acanthosis with intraepidermal pustules and spongiform pustules. (×20).

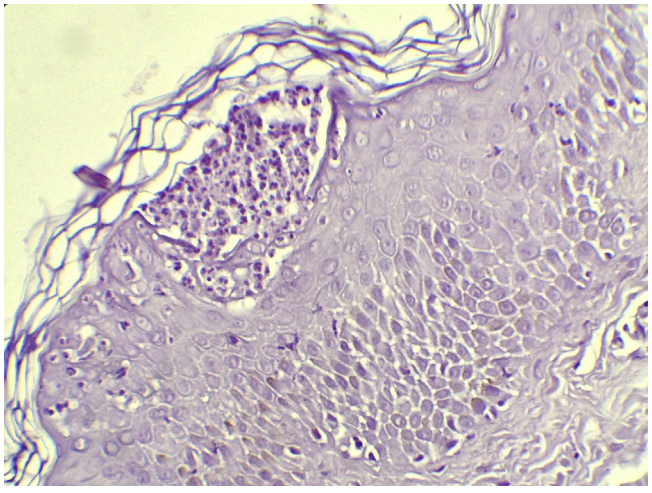

Figure 4. Pustules of Kogoj, consisting exclusively of neutrophils without eosinophils, and perivascular inflammatory process in the dermis.

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