A Probable Case of Mucosal Fixed Drug Eruption Following Treatment with Silodosin

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A fixed drug eruption (FDE) consists of well-circumscribed erythematous patches on the skin and/or mucous membranes that occur between days and a few weeks following the administration of a drug. The patches recur on the same body site after the drug is reintroduced and heal leaving hyperpigmentation. Although the most common clinical presentation of FDE involves the skin, Zaouak et al. recently reported a case of mucosal FDE due to mefenamic acid. To the best of the author’s knowledge, this is the first potential case of mucosal FDE following silodosin intake.

Case Report

A 76-year-old male presented to the dermatology outpatient clinic of the Thriasio General Hospital, Athens, Greece, in 2016 due to lesions on his lower lip and glans penis which had first appeared five days prior. Over the preceding 20 days, he reported having taken 8 mg daily of silodosin as prescribed by his urologist for benign prostatic hyperplasia. He was not currently taking any other medications and had no history of atopy, immune disease or cancer.

A clinical examination revealed erythema and oedema of the lower lip and a well-circumscribed erythematous patch on the glans penis with a blister on one side [Figure 1]. The patient reported that a burning sensation had preceded the appearance of both lesions. A FDE was suspected; however, he refused a biopsy and a patch test. As a urologist confirmed that no further medication was needed in view of the minor nature of the patient’s urinary symptoms, silodosin was discontinued. Within two weeks, regression of the lesions was observed [Figure 2]. Subsequently, a steroid cream of moderate potency was applied. A rechallenge protocol was not attempted as the patient was wary of the reappearance of the lesions.

Discussion

Overall, FDE is a rare type of adverse drug reaction. The clinical picture of a FDE involves a well-circumscribed erythematous patch on the skin and/or mucous membranes, with or without blisters, which recurs at the same site following the re-administration of the responsible drug and leaves hyperpigmentation after regression. In more severe cases, mucosal erosions or

References


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On the other hand, intraepidermal CD8+ T cells function as protective immune cells against bacterial and viral infections. This explains why certain predilection sites for FDE, like the oral and genital mucosa, coincide with those of herpes simplex virus infections.9–11 The resolution of the FDE lesions occurs when regulatory T cells from other parts of the body are recruited at the affected site. This process accounts for the self-limiting nature of FDE in which the tissue damage is minor compared with the extensive and more destructive tissue damage seen in TEN cases.9–11

Silodosin, an alpha adrenergic receptor blocker, is commonly prescribed to relieve the urinary symptoms of benign prostatic hyperplasia.12 However, adverse skin reactions have been reported with its use, including pruritus, urticaria and maculopapular drug eruptions.13,14 According to the updated French causality assessment method, the likelihood of silodosin being the causative agent of FDE in the current case is suggestive, with an imputability value of I3.15 To the best of the author’s knowledge, there have been no previous reports to date of mucosal FDE associated either with silodosin or similar drugs like tamsulosin.

Conclusion
The current case increases awareness of the potential occurrence of FDE following silodosin administration which could be easily misdiagnosed for other conditions. Drug intake history should therefore be taken into account in cases of genital and oral ulceration.

References


