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Case Report

CHLOROQUINE INDUCED STEVENS - JOHNSON SYNDROME – A RARE ASSOCIATION

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ABSTRACT
Stevens - Johnson syndrome is a severe adverse drug reaction associated with various drugs. We report a case of Stevens - Johnson Syndrome caused by chloroquine which is a very rare association.

Keywords: *Chloroquine, Stevens Johnson Syndrome*

INTRODUCTION
Stevens - Johnson syndrome (SJS) is a severe adverse drug reaction characterized by widespread lesions affecting skin, genitalia, larynx, pharynx, eyes and oesophagus. The main offending drugs which cause SJS are antibiotics (penicillins most common), NSAID's, cough and cold medications. Here we report a case of SJS caused by chloroquine which is a very rare association (Bamber *et al.*, 1986; Beedimani and Rambhimaiah, 2004).

CASES
A 25 year old male was brought to the emergency department with painful skin blisters and erosions all over the body accompanied by fever and myalgia. It started on the 3rd day following the completion of a course of chloroquine (tab. Lariago DS; 2 tablets stat, 1 tablet after 6 hrs, 1 tablet after 24 hrs, and 1 tablet after 48 hrs) for empirical treatment of malaria started by a local physician. The rashes initially started on the trunk (Figure1) and then slowly progressed to involve the extremities and mouth (Figure2). Rashes were erythematous papular eruptions associated with itching. It was diagnosed as a case of SJS which was confirmed by dermatologist. He also had difficulty in swallowing due to painful erosions of the mouth and oropharynx. It was associated with bilateral conjunctivitis but there was no visual impairment.

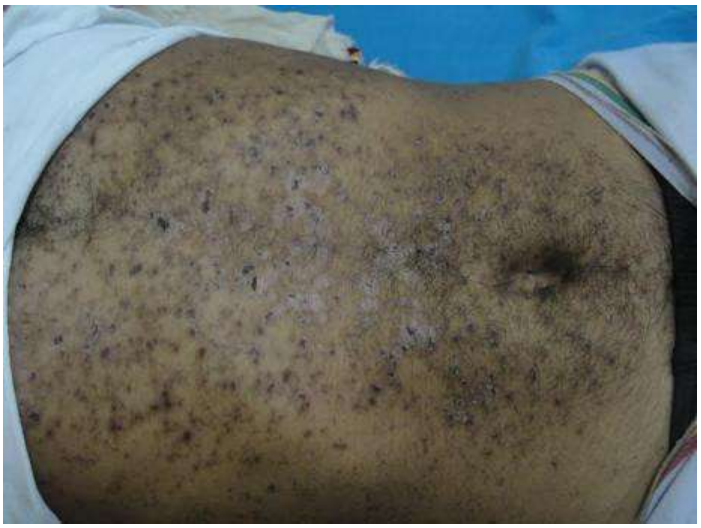

Figure 1: This photograph illustrates erythematous papular eruptions on the trunk

The patient was treated for one week with IV fluids, ciprofloxacin 200 mg 8 h IV to prevent secondary infections, hydrocortisone sodium hemisuccinate 100 mg 8 hour IV, ranitidine 150 mg BD orally, cetirizine 10 mg OD orally, local application of glycerine for soothing effect and gentian violet as

antiseptic for 7 days (Evans, 2009). The patient improved and discharged. Investigations revealed the following: malaria parasite and Widal test - negative, blood urea -38 mg%, serum creatinine - 1.1 mg%, total count - 8100 cells/mm³, P-73%, L-26%, E-1%, ESR-14 mm/h, platelets -310,000/mm³, HIV-Non reactive.

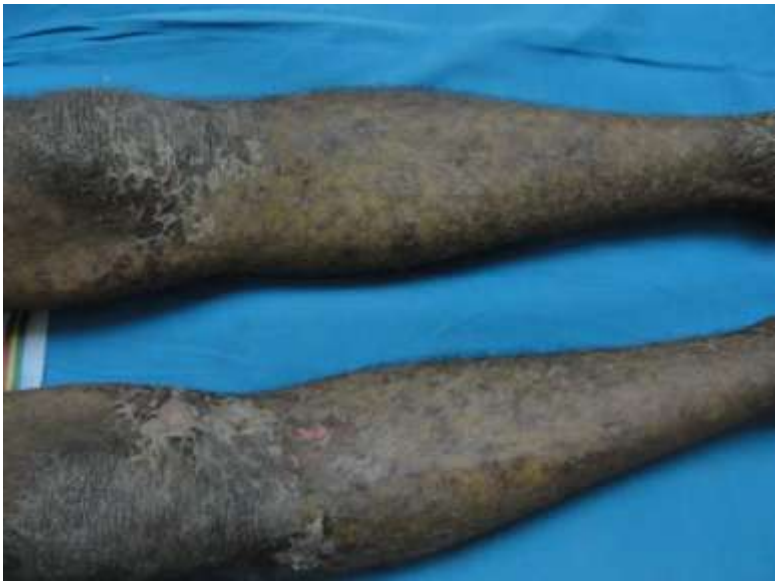

Figure 2: This photograph illustrates erythematous papular eruptions on the legs

The patient had not taken chloroquine in the past and there was no history of drug allergy. No other drugs like paracetamol were taken. No burning sensation on exposure to sunlight was present. Other blistering skin diseases like pemphigus vulgaris and bullous pemphigoid, mucocutaneous diseases like Behcet's syndrome and Reiter's syndrome, vasculitides like systemic lupus erythematosus and polyarteritis nodosa were excluded on clinical grounds.

Thus the above outlined SJS has a temporal relationship to chloroquine administration. However, rechallenge is not justified due to ethical constraints and fatal consequences. This adverse reaction is not dose related and can be labelled as Type B class of adverse effect. It can be considered as Probable / Likely adverse drug reaction as per causality assessment of suspected adverse drug reactions (Edwards and Aronson, 2000).

DISCUSSION

The estimated incidence of the SJS ranges between 1.2 and 6 per million populations per year but the mortality rate is 15%. Patients with HIV infection seem to be at an increased risk of developing the SJS. There are reports of chloroquine induced SJS but it is often overlooked in its adverse effect profile. Thus the idea of this written statement is to create awareness about the rare but potentially fatal drug reaction like SJS with chloroquine which is commonly used for malaria in India.

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