Erythema multiforme (Stevens-Johnson) precipitated by Fansidar

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Summary: A case of Stevens-Johnson syndrome precipitated by the sulphonamide-containing anti-malarial drug, Fansidar, is described.

Introduction

The combination of pyrimethamine and sulphonamide is effective prophylaxis against *Plasmodium falciparum* malaria (Lucas *et al.*, 1969) and is specifically recommended for use in areas where chloroquine-resistant malaria is encountered such as Kenya (British National Formulary, 1983). The sulphonamide component of Fansidar is sulfadoxine, and we believe it is this sulphonamide which precipitated the severe Stevens-Johnson form of erythema multiforme in a young, healthy man.

Case report

A 30 year old man was seen in the dermatology clinic on the eve of a holiday in Kenya. He had a severe, extensive bullous eruption affecting his hands, feet, limbs and trunk. His face was also severely affected; he had buccal mucous membrane ulceration and sore eyes with marked conjunctival injection.

Fansidar (Roche) (sulphadoxine 500 mg and pyrimethamine 25 mg) had been prescribed by his general practitioner as anti-malarial prophylaxis. He had taken two tablets.

There was no significant past medical history: in particular there was no suggestion of recent herpes simplex or *Mycoplasma pneumoniae* infection nor was the patient known to be sulphonamide sensitive.

A diagnosis of erythema multiforme major (Stevens-Johnson) probably induced by sulfadoxine was made and his Fansidar was stopped. Oral corticosteroids were prescribed as 45 mg/d prednisolone and the patient made a full and uneventful recovery.

Further challenge with sulphonamide was considered unwise and the patient was advised never to take Fansidar again.

Discussion

Both pyrimethamine and the sulphonamides interfere with folinic acid synthesis in plasmodium and the combination exerts an additive effect, so making a more effective anti-malarial agent (Rollo, 1952; Hitchings & Burchall, 1965). This combination is commonly prescribed for travellers to countries such as Kenya, the destination of our patient, where chloroquine-resistant *Plasmodium falcipare* is endemic. Fansidar represents one such available formulation.

Erythema multiforme varies in its clinical expression from the more common 'minor' form, in which typical target lesions appear in crops, affecting the dorsa of the hands, the feet and distal parts of the limbs, through increasing degrees of severity when the lesions may be bullous, to the Stevens-Johnson form where, as in this patient, severe mucous and conjunctivae are affected, and the genitalia, oesophagus and respiratory tract may be involved with, in the latter case, an ensuing pneumonitis. Herpes simplex virus and *Mycoplasma pneumoniae* are well recognised as precipitants of the condition, as are sulphonamides, particularly the long acting ones (Carroll *et al.*, 1966; Ström, 1977).

We believe that this patient developed the Stevens-Johnson variant of erythema multiforme to the sulphonamide component of his anti-malarial prophylaxis, Fansidar. This is important because increasing numbers of individuals are travelling to malarious countries for vacation and business purposes and it behoves the practitioner to be reminded of the sulphonamide component of this effective drug and the unpleasant sequelae that may occur in cases of sensitivity.

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