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Drug rash with eosinophilia and systemic symptoms syndrome due to quinine

Sir,

Quinine has been available for centuries and is commonly used for the treatment of leg cramps. However, it can cause a variety of adverse reactions including fever, skin rash, hematological abnormalities and organ failure. We present a patient with drug rash with eosinophilia and systemic symptoms (DRESS) syndrome due to quinine.

A 58-year-old man was admitted to the hospital with a one-week history of jaundice. He had been unwell with myalgia, fever, chills and rigors for two weeks and had noticed a generalized, pruritic, skin rash two days before admission. He had a past history of well-controlled hypertension and Type 2 diabetes and was taking insulin, ramipril 5 mg, amlodipine 5 mg and aspirin 75 mg for a few years. His general practitioner had commenced him on 300 mg of quinine for symptoms of leg cramps 10-12 weeks before admission. He was a non-smoker and consumed about six units of alcohol per week and was not taking any herbal medicines. There was no history of any travel abroad. On examination he had no signs of chronic liver disease, was febrile (38°C), jaundiced and had generalized maculopapular rash (progressed to exfoliative dermatitis). Central nervous system, cardiovascular, respiratory and abdomen examination was unremarkable. With a possible diagnosis of cholangitis and hepatitis he was commenced on antibiotics and insulin sliding scale. Quinine and all other drugs were stopped. The blood picture showed hemoglobin (Hb) 14.5 g/dL, platelet (Plt) 137 x 10^9/L, white cell count (WCC) 15.44 x 10^9/L, eosinophils 2.47 x 10^9/L (0-1), C-reactive protein (CRP) 38, bilirubin 210 umol/L, alanine transaminase (ALT) 173 IU/L and alkaline phosphatase (ALP) 230 iu/L. Serology for hepatitis (A, B, C), brucella and leptospira was negative. Stool was negative for ova, cyst and parasite. Blood and urine cultures were sterile. Autoantibody and vasculitis screen was negative. A computed tomography scan of abdomen showed normal gall bladder, common bile duct, liver, spleen and pancreas. Liver biopsy [Figure 1] revealed portal tract fibrosis, cholestasis, a mixed infiltrate with prominent eosinophils and presence of non-caseating epitheloid granulomas. A diagnosis of drug-induced granulomatous hepatitis and DRESS syndrome was made. He gradually made a good recovery with supportive treatment. His blood counts returned to normal levels at four weeks with Hb 14.1g/dL, Plt 177 x 10^9/L, WCC 9.69 x 10^9/L, eosinophils 0.30 x 10^9/L, CRP 6, bilirubin 16 umol/L, ALT 45 iu/L and ALP 65 iu/L. He is back on his regular medication (insulin, ramipril, amlodipine and aspirin) and remains well at six months follow-up.

DRESS syndrome sometimes also known as hypersensitivity syndrome is a serious and potentially fatal adverse drug reaction which starts within eight weeks of initiation of the offending drug. The characteristic features include fever, dermatitis, internal organ involvement, hematological abnormalities (eosinophilia > 1.5 x 10^9/L) and lymphadenopathy (> 2 cm). Various drugs such as antiepileptics, nonsteroidal anti-inflammatory drugs, allopurinol, sulphonamides and antibiotics have been associated with DRESS syndrome. DRESS syndrome is associated with significant morbidity and a mortality of about 10%. Treatment is symptomatic and supportive and early recognition and withdrawal of the drug is essential for better prognosis.

Our patient presented with fever, skin rash and jaundice; and had eosinophilia, thrombocytopenia and granulomatous hepatitis. The symptoms started within 8-10 weeks of initiation of quinine, improved after withdrawing quinine and there was no other identifiable cause for his condition. On Naranjo scale it scored 5, classifying it as a probable adverse drug reaction. Hematological abnormalities associated with quinine are due to quinine-dependent-antibodies, however, eosinophilia has not been reported in the past and granulomatous hepatitis is not common. Quinine remains an important and lifesaving drug (falciparum malaria), however, physicians should be aware of the possibility of DRESS syndrome and quinine should be added to the list of drugs associated with DRESS syndrome.

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References


Sir,

Liposarcomas are one of the most common sarcomas of adulthood. The following case discusses a gentleman who presented with a massive abdominal myxoid liposarcoma associated with significant hyperferritinemia. We present the case and a discussion of hyperferritinemia and neoplasms, with reference to the potential of ferritin as a marker of disease recurrence.

A gentleman of 82 years of age presented with epigastric pain. Initial investigations were unremarkable except for a serum ferritin of 1542 ng/ml. An ultrasound scan was performed, which showed a large complex cystic mass in the epigastrium slightly to the left of the midline, containing echogenic material with thickened walls and septae in parts [Figure 1]. A repeat serum ferritin assay was 2190 ng/ml. All other routine blood tests were again unremarkable. The patient wanted no further investigations. Six months later in June of the following year he developed acute abdominal pain. A CT scan at that time revealed a mass 30 x 30 cm with calcification within it. It displaced the colon around it and engulfed the stomach and duodenum. The patient underwent a laparotomy and the huge mass was resected. Histology later confirmed the mass to be a myxoid liposarcoma with clear resection margins and no involvement of surrounding organs [Figure 2].

He was reviewed in the outpatients department four months after surgery. His serum ferritin had returned to the normal range. He failed to attend further outpatient follow-up appointments and contact was lost with him. Two years later the patient presented acutely with a palpable lump at the site...