

Visual Treats in Dermatology

Fixed drug eruption (FDE) secondary to paracetamol

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An 8-year-old male child was brought to the Dermatology OPD with a history of cutaneous lesion associated with itching and burning sensation over left buttock for 1 day. There was a preceding history of drug intake (tab. paracetamol 500 mg) for high-grade fever one day back at 8 am which was followed by itching and burning sensation with a reddish lesion at 3 pm that is after 7 hours of paracetamol intake. There was a past history of a similar lesion at the same site 3 months back after 48 hours of diclofenac plus paracetamol intake taken for fever and headache. That lesion had healed after 1 month with residual hyperpigmentation. On cutaneous examination, a single sharply-defined oval central dusky, violaceous to the hyperpigmented plaque of size 7 × 5 cm with the peripheral erythematous halo was present over the left upper buttock extending to gluteal cleft [Figure 1].



Figure 1: Single sharply-defined oval central dusky, violaceous to hyperpigmented plaque of size 7 × 5 cm with peripheral erythematous halo over left upper buttock extending to gluteal cleft.

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On the basis of this characteristic clinical presentation, a diagnosis of Fixed Drug Eruption (FDE) secondary to Paracetamol was made. FDE typically presents 30 minutes to 8 hours after drug exposure. NSAIDs (25%), paracetamol (24%), and co-trimoxazole (5%) are the most frequent triggers.^[1] It is a form of classical delayed-type hypersensitivity reaction with skin resident CD8+ T cells as key mediators. Parents and child were told to avoid paracetamol in the future and was started on oral antihistamines and topical corticosteroid for 2 weeks with complete recovery in 10 days.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflict of interest

There are no conflicts of interest.

REFERENCE

1. Savin JA. Current causes of fixed drug eruption in the UK. *Br J Dermatol* 2001;145:667–8.

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