LETTERS TO THE EDITOR
EDİTÖRE MEKTUPLAR
Sulfasalazine-induced hypersensitivity: A case report of DRESS syndrome

Sulfasalazine bağlı hipersensitivite: Dress sendromu olgu sunumu

To the Editor,

A 38-year-old man was hospitalized because of elevated serum liver enzyme levels, hepatomegaly, fever, bilateral lymphadenopathies on cervical chain, and extensive bullous skin lesions on his trunk, face and extremities (Figure 1). Symptoms appeared four weeks after the initial dose of sulfasalazine for rheumatoid arthritis. The medication was stopped. He had no alcohol history. Initial laboratory tests were as follows: white blood cell count (WBC) 19.3 (NR: 4.3–10.3x 10^3/µL), aspartate transaminase (AST) 127 U/L (NR: 10-40), alanine aminotransferase (ALT) 192 U/L (NR: 10-40), total bilirubin 3.3 mg/dl (NR: 0.2-1), alkaline phosphatase (ALP) 562 U/L (NR: 38-155), lactate dehydrogenase (LDH) 1118 U/L (NR: 220-450), and albumin 3.5 g/dl (NR: 3.5-5.5). All test results for viral and autoimmune hepatitis were negative. Serum anti-human herpes virus-6 (HHV-6) titer was interpreted as a weak level (Pasteur Cerba Laboratory, France). Serum Ig E level was remarkably high (>5000 kU/L). Blood film revealed 9% eosinophilia (NR: <6%) and 57% lymphocythemia (NR: 19.4-44.9%).

The Doppler ultrasonographic examination of the liver confirmed the enlargement with cranio–caudal length of 182 mm. Sonographic findings of liver vascular flows were normal.

Lymph node and skin punch biopsies were performed and histopathologic diagnoses were consistent with drug reaction. Surprisingly, pulmonary involvement developed, which was confirmed with laboratory and computed tomography (CT) scan during the hospitalization period, for which antibiotics were started.

Pulmonary, hepatic, skin, and lymph node involvements, hematological abnormalities like eosinophilia and lymphocythemia, marked elevation of Ig E, exclusion of other reasons for hepatitis, history of sulfasalazine treatment, and histopathologic examination results suggested sulfasalazine-induced DRESS syndrome (Drug Rash with Eosinophilia and Systemic Symptoms) as described by Bocquet et al. (1).

On day 5 of hospitalization, a tapering dose of methyl prednisolone 60 mg was prescribed over five weeks. The initiation of corticosteroid therapy led to an immediate symptomatic improvement. Three months later, complete recovery was observed.

DRESS syndrome carries an approximately 10%

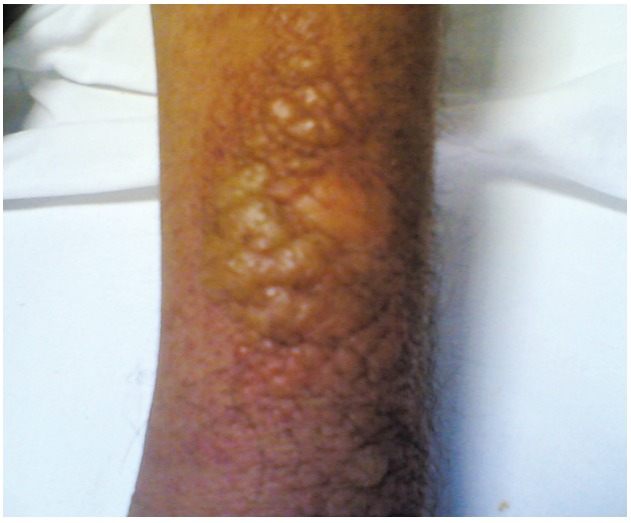

Figure 1. Bullous lesions of the forearm.

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mortality rate (1-3) and in quite a few articles, mortality is reported to associate with HHV-6, which is a "harmless" virus in normal individuals (4). Although there was no sign of HHV-6 activation in our patient during or after corticosteroid therapy, in cases with high serum titers, it might be mortal under immunosuppressive drugs. Therefore, screening for HHV-6 in patients with DRESS syndrome before administration of immunosuppressive drugs should always be on the agenda.

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Spontaneous cutaneous fistula of infected liver hydatid cyst

Cilde spontan fistüle enfekte karaciğer kist hidatiği

To the Editor,

Hydatid disease is a parasitic infection usually caused by Echinococcus granulosus. It is endemic in the Middle East, South America and the Mediterranean region. Patients with hydatid disease are mostly asymptomatic until incidentally diagnosed or complications occur (1). A 93-year-old female patient was admitted to the emergency service with the complaints of fever, abdominal pain, nausea, vomiting, and yellowish green drainage from the abdominal wall for the last two days. Her physical examination revealed a skin defect located 4-5 cm superior to the umbilicus and approximately 1 to 2 cm in size; a whitish membranous structure was seen protruding from the defect (Figure 1). She had a history of cholecystectomy 40 years before.

Laboratory examination revealed the following: hemoglobin (Hb): 9.8 g/dl, white blood cell (WBC) count: 18400/mm3, platelet count: 4350000/mm3, and indirect hemagglutination test (IHAT): 1/2400. Other biochemical parameters were normal. On abdominal computed tomographic examination, a hypodense irregular mass of 6 to 9 cm in size at liver segment 4 was seen, which contained a calcific area of 2 to 4 cm consistent with hepatic cyst hydatid. There was also an incision tract from the cyst to skin.

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