Stevens-Johnson Syndrome Induced by Clofibrate

Sir,

Clofibrate and other fibric acid derivatives are commonly prescribed for the treatment of hyperlipidaemia. Skin rashes have been reported in about 2% of patients (1), including severe generalized erythema (2), urticaria (3), purpura (4) and vesiculobullous eruptions (5). Clofibrate-induced erythema multiforme has previously been reported in one patient 12 months after taking the drug (6). The Committee on Safety of Medicine in the United Kingdom has had a report of one other case of erythema multiforme associated with the use of the drug (personal communication). This is the first report of a patient who developed Stevens-Johnson syndrome.

A 33-year-old man was found to have hypertriglyceridaemia of 5.23 mmol/l (normal < 1.86) on routine testing. He was commenced on 500 mg three times daily of clofibrate by his general practitioner. Ten days later, he developed a high fever, generalized malaise and severe pain on swallowing. He also had a severe generalized erythematous rash, affecting the entire skin and mucous membranes. There was no past medical or other drug history of note.

Examination revealed an ill-looking patient with a temperature of 38°C. He had bilateral conjunctivitis and marked ulcerative lesions on the lips, oral and nasal mucosae as well as the genitalia. There were tense erythematous patches of varying sizes in the entire trunk and limbs. Vesicles, bullae and target lesions were noted in the extremities.

Apart from a leukocytosis of 15×10^9/l, blood, urine and viral cultures were all negative. There was no rise in the titres for mycoplasma.

A skin biopsy of a typical lesion on the right thigh showed epidermal cell necrosis and desquamation, basal cell hydropic degeneration with numerous cytoid bodies and marked oedema, telangiectasia and perivascular infiltrates of polymorphs and eosinophils in the upper and mid dermis. The diagnosis of Stevens-Johnson syndrome was established and clofibrate was discontinued on admission to hospital.

The patient was treated with intravenous fluids initially, and 40 mg of oral prednisolone daily was given subsequently 48 h after admission because of increasing painful dysphagia. Seven days later, he could tolerate oral fluids and there was gradual improvement in the skin and mucous membranes. Prednisolone was tailed off over 10 days and the skin lesions gradually and completely resolved over 20 days. There was no recurrence of any rash at follow-up after 3 months.

The lack of other etiological factors, especially infections, the close temporal relationship between the onset of the syndrome and the commencement of clofibrate as well as the improvement on drug withdrawal strongly suggest drug-induced Stevens-Johnson syndrome. The patient was not rechallenged with the drug because of the severity of the syndrome.

Though clofibrate-induced serious skin diseases are rare, clofibrate should be included in the list of drugs capable of inducing Stevens-Johnson syndrome.

REFERENCES

1. Blane GF. Comparative toxicity and safety profile of fenofibrate and other fibric acid derivatives. Am J Med 1987; 93 (5B): 26–36.
2. Cumming A. Acute renal failure and interstitial nephritis after clofibrate treatment. BMJ 1980; 281: 1529–1530.
3. Physicians' Desk Reference. 44th edn. 1990: 2349–2350.
4. Arif MA, Vahrman J. Skin eruption due to clofibrate. Lancet 1975; ii: 1202.
5. Heid E, Samsoen M, Juillard J, Eberst E, Foussereau J. Eruptions papulo vesiculeuses endogenes a la methyldopa et au clofibrate. Ann Dermatol Venereol 1977; 104: 494–496.
6. Murata Y, Tani M, Amano M. Erythema multiforme due to clofibrate. J Am Acad Dermatol 1988; 18: 381–382.

Received April 12, 1994.

Sai Siong Wong, Department of Dermatology, Evangel Hospital, 222 Argyle Street, Kowloon, Hong Kong.