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Letter To The Editor

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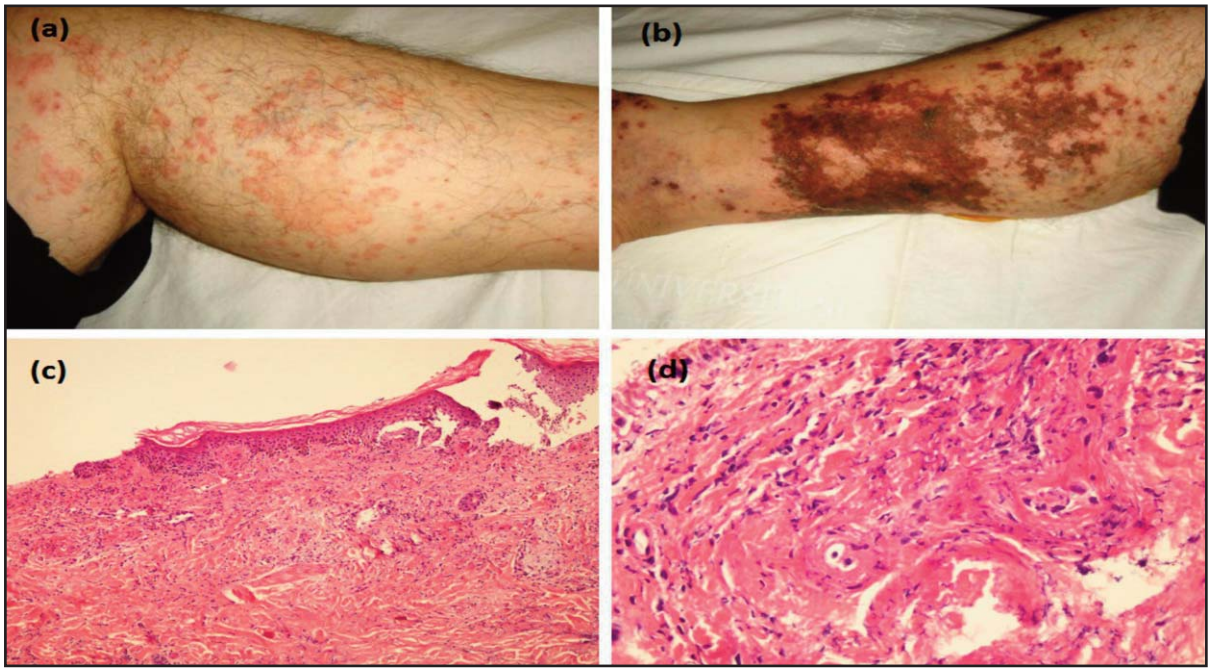
Penicillin-Induced Henoch-Schönlein Purpura In Adult Patient

To the Editor. - Henoch-Schönlein Purpura (HSP) is a systemic small-vessel leukocytoclastic vasculitis which usually evolves in pediatric group and clinically characterized by the classic clinical triad consisting of palpable purpura, joint symptoms, and abdominal pain. HSP in elder patients is less common disease. However, prognosis of HSP is poor in elder patients due to severity of renal involvement compare to childhood HSP [1]. HSP can damage joints, kidney and gastrointestinal system (GIS). But it can be also restricted to the skin. Most common precipitating factor of HSP is an upper respiratory tract infections (URTI) for pediatric group. Primary triggering factors of HSP in adult patients are drugs and malignancy [1]. β-lactam antibiotics are found more common triggering agents in one epidemiologic study [2]. Here we report a case, benzathine phenoxymethylpenicllin induced HSP in elderly patient, which was restricted to the skin and demonstrated bening course.

57-year-old male patient hospitalised in our department due to necrotic skin lesions on both lower extremities. He received benzathine phenoxymethylpenicillin for two days, due to insect bite of periorbital region. The erythematous, ithcing skin lesions evolved on molleus of lower extremity and rapidly progressed proximally within ten days after the administration of oral antibiotic. Upon dermatological evaluation, superficial necrotic lesions on molleus and tibia were noticed (**Figures 1a and b**). Itchy erythematous and palpable petechial skin lesions were detected on proximal lower extremeties. The insect bite site was completely healed and there were no sign of petechia. He suffered from metobolic syndrome and used oral



Figures 1a, b, c and d. Palpable purpuras and necrotic skin lesions on tibia (a, b). Subepidermal splitting and perivascular fibrinoid necrosis, polymorphonuclear leukocytes dominated mixed infiltrate in dermis H&E x 40 (c). Perivascular fibrin deposition and polymorphonuclear leukocyte infiltration H&E x 200 (d).

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antidiabetic and antihyperlipidemic drugs for five years.

Skin sample taken from petechial lesions showed fibrinoid necrosis and perivascular neutrophil infiltration in pappilary dermis (**Figures 1c and d**). In direct immunufluoresence examination granular IgA deposition was found. So patient diagnosed as HSP. Routin blood test showed slight elevation in acute fase reactans, white blood cells and eosinophil count. Platelate count was normal. Complement levels were in normal range. ANCA and other autoimmun markers were normal. Immunglobulin levels especially IgA were normal. Patient evaluated in terms of kidney, joint and GIS involvment of HSP. No abnormalities were found. Malignancy screening result was negative. There was no infectious source in our patient especially URI. So patient diagnosed according to EULAR/PRINTO/PRES diagnositc criterias as HSP, induced by drug in elder patient [**3**]. Patient was treated with short-term systemic corticosteroid and topical corticosteroid. The skin lesions resolved completely after 20 days. No recurrencies and systemic involvement were detected during one year follow-up.

In our case benzathine phenoxymethylpenicillin was a possible triggering factor of HSP. There are few cases reported in the literature regarding drug induced HSP. In one case clarithromycin was a possible main cause of HSP purpura in 48-year-old male patient which involved skin, joints and kidney [**4**]. In other report, HSP with systemic involvement developed due to acetaminophen and codein intake in 69-year-old male patient [**5**]. There is also a case of HSP which was induced by penicillin [**6**]. To our knowledge this is the first case described penicilline induced HSP [**6**]. However, there is a report where HSP was evolved at the site of insect bite in pediatric patient [**7**]. Our patient also has a history of insect bite, however HSP evolved in our case at the far distant area from insect bite and there was no sign of petechial lesions on insect bite area. So, we concluded that HSP in this patient developed due to antibiotic.

In conclusion, HSP in adulthood usually shows severe clinical course and has a risk of development renal insufficiency. In our case, HSP evolved due to benzathine phenoxymethylpenicillin which was restricted to the skin and had a bening clinical course.

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