Stevens-Johnson Syndrome Associated with Abacavir Therapy

Sir—Adverse cutaneous reactions to drugs are commonly observed in HIV-infected patients [1]. We describe what is, to our knowledge, the first case of Stevens-Johnson syndrome in an HIV-1–infected patient that is associated with use of abacavir, a nucleoside reverse-transcriptase inhibitor.

A 37-year-old man was admitted to the hospital in October 2001 because of neurological disorders and dyspnea. Diagnosis of toxoplasma encephalitis and Pneumocystis carinii pneumonia was made. At this time, the patient had HIV-1 infection diagnosed. The plasma HIV-1 RNA level was 118,000 copies/mL, and the CD4 cell count was 1 cell/mm³. Treatment with pyrimethamine-sulfadiazine was started. Ten days after he began receiving therapy, the patient presented with a febrile maculopapular rash; sulfadiazine was switched to clindamycin (for treatment of toxoplasmic encephalitis) and atovaquone (for treatment of P. carinii pneumonia), and pyrimethamine therapy was continued. Cutaneous manifestations resolved completely within 2 days. The patient was discharged from the hospital 15 days after the switch without neurological or pulmonary manifestations.

In December 2001, the patient began receiving antiretroviral treatment with zidovudine (300 mg b.i.d.), lamivudine (150 mg b.i.d.), and abacavir (300 mg b.i.d.). Thirteen days after he began receiving antiretroviral therapy, the patient presented with a nonfibrillar, generalized maculopapular rash. At admission to the hospital, his temperature was 37°C, his pulse was 86 beats/min, and his respiration rate was 16 breaths/min. The patient’s blood pressure was 130/60 mm Hg. Physical examination revealed a disseminated cutaneous eruption of discrete dark-red macules on 90% of the body surface area, a detachment of 5% of the epidermis, genital ulcerations, erosive stomatitis, and conjunctival lesions with hyperemia, and a pseudomembranous formation occurred without keratitis or corneal erosions. Nikolsky’s sign was noted.

Hematologic test findings, blood chemistry findings, enzyme values, and chest radiograph findings were normal. No infectious agent was found. Histopathologic evaluation of skin biopsy specimens yielded findings compatible with Stevens-Johnson syndrome. The results of immunofluorescence studies were negative.

Antiretroviral treatment was stopped, and therapy with pyrimethamine, clindamycin, and atovaquone was continued. A week later, the epidermis began to re-grow, and the condition resolved completely within 3 weeks. The patient was rechallenged with zidovudine and lamivudine and commenced therapy with ritonavir and indinavir without recurrence of clinical manifestations.

These findings clearly suggest that there is a link between abacavir use and Stevens-Johnson syndrome. In patients with HIV infection, cases of Stevens-Johnson syndrome have been reported in association with other antiretroviral agents, such as nevirapine [2]. Until now, to our knowledge, only hypersensitivity reactions to abacavir have been reported [3]. Abacavir should now be added to the list of antiretroviral agents associated with Stevens-Johnson syndrome.

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References

Successful Treatment of Enterococcus faecalis Prosthetic Valve Endocarditis with Linezolid

Sir—Linezolid possesses a broad spectrum of activity against gram-positive organisms, including Enterococcus faecalis [1]. Like other agents used for the treatment of E. faecalis endocarditis, linezolid possesses only bacteriostatic activity [2].