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Etodolac-induced erythroderma

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To the Editor:

Erythroderma is an uncommon entity, with a reported incidence of 9.4 cases/year [1]. The etiology can be an exacerbation of underlying skin disease, malignancy, or a drug reaction.

A 71-year-old woman was admitted to the emergency department with pruritic, desquamative erythema that started a week before and enlarged over days, with very little areas of sparing. With no prior skin conditions, there was only a past history of an orthopedic surgery two weeks before; a prescription for etodolac for pain relief had been given postoperatively, but no other new medications were given. The use of new products for hygiene or cleaning was denied. There were no other associated symptoms.

At admission, the patient was lethargic, hypothermic, bradycardic, and hypotensive; a widespread cutaneous eruption was noted with confluent flaking scale affecting more than 90% of the body surface area (**Figure 1A**), with no mucosal involvement. There was no evidence of Nikolsky sign. Palmoplantar keratoderma (**Figure 1B, C**) and ocular ectropion with purulent exudate were also present. Laboratory findings showed elevation of inflammatory markers, but no eosinophilia or organ involvement. Autoimmunity, viral markers, and serologies were negative.

The diagnosis of drug-induced erythroderma was based on the history of exposure and a Naranjo Score of 6 (score used to estimate the probability of



Figure 1. A, B, C) Diffuse erythema and desquamation of the skin and palmar keratoderma.

adverse drug reactions, in this case indicating the dermatitis was probably induced by etodolac). Skin biopsy histology revealed inflammatory infiltrates, but was overall non-specific.

The patient was hospitalized for clinical surveillance and treatment, hydration, external warming, oral prednisolone, topical betamethasone, antiseptic baths, and emollients. After three weeks of treatment and cessation of etodolac, there was complete resolution of skin lesions.

Erythroderma can be a dermatological emergency, leading to hospitalization in more severe cases [2]. The diagnosis is based on clinical manifestations, laboratory, and histopathological findings [3]. The abnormal skin barrier function leads to loss of

thermoregulation, increasing blood perfusion in the skin and loss of fluids related to exudation [4]. Hydration is often essential. Skincare measures include bland emollients and topical corticosteroids. Treatment recommendations also include systemic corticosteroids in more severe cases, antihistamines

to relieve pruritus, and the cessation of unnecessary medication [4,5].

Potential conflicts of interest

The authors declare no conflicts of interest.

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