MELODICAM-INDUCED ERYTHEMA MULTIFORME

To the Editor:

Erythema multiforme is an acute inflammatory skin reaction characterized by macules and edematous papules, primarily of the hands, palms, soles, extensor forearms, and mucosal membranes (1–3). Viral and bacterial infections, autoimmune rheumatic diseases, internal malignancies, and many drugs, including sulfonamides, phenytoin, barbiturates, penicillins, carbamazepine, and nonsteroidal anti-inflammatory drugs (NSAIDs) have been suggested as possible causes (4–8). We describe a patient who developed erythema multiforme after receiving the new NSAID meoxicam, a
specific cyclooxygenase-2 inhibitor (9,10).

A 19-year-old soldier visited the military doctor complaining of musculoskeletal discomfort in his right lower extremity. He was diagnosed with tendinitis of the adductors and treated with meloxicam (15 mg/day). His tendinitis improved, but 8 days later he developed oral discomfort during mastication and maculopapular skin lesions on his palms and soles. He was diagnosed with acute streptococcal infection and started on erythromycin (500 mg every 6 hours). Twelve hours later, the skin eruptions worsened, and he was transferred to University Hospital for further evaluation.

Physical examination revealed diffuse maculopapular skin lesions affecting the patient's face, chest, palms, and soles with target-like lesions (Figure). Bullous lesions of the oral conjunctiva and genital mucosa were also seen.

Laboratory evaluation revealed a hematocrit of 43% and a white blood cell count of 16,700 cells per mm³, with 80% polymorphonuclear cells. Antistreptolysin antibodies were within normal limits, and throat, blood, and urine cultures were negative. Antibodies for hepatitis A, B, and C viruses, echovirus, Coxsackie virus, Epstein-Barr virus, and influenza were also negative. The patient was diagnosed with erythema multiforme, based on the characteristic symmetrical "target" lesions affecting the palms and soles. Meloxicam and erythromycin were discontinued, and he was treated with intravenous prednisone (50 mg/day) with substantial improvement.

Three factors could be implicated in the etiology of erythema multiforme in our patient: acute streptococcal infection, erythromycin, or meloxicam. Acute streptococcal infection was not a likely cause; the patient's oral discomfort could also be attributed to the mucosal involvement of erythema multiforme, and both antistreptolysin antibodies and throat cultures were negative. Erythromycin was also unlikely to have induced erythema multiforme, as the skin and mucosal lesions were present before its administration. Our patient's erythema multiforme is thus best attributed to meloxicam. His skin lesions and oral manifestations presented 8 days after he began taking meloxicam, and erythema multiforme is a delayed hypersensitivity reaction that usually occurs 1 to 3 weeks after the exposure to a stimulus.

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