DRESS syndrome from Degarelix, a first association

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BACKGROUND

Drug reaction with eosinophilia and systemic symptoms (DRESS) syndrome is a severe adverse drug reaction characterized by a cutaneous eruption, lymphadenopathy, hematologic abnormalities, and multi-organ involvement. The European’s Registry of Severe Cutaneous Adverse Reactions diagnostic criteria include three necessary criteria (acute rash, reaction suspected to be drug related and hospitalization), with an additional three of these four criteria (enlarged lymph nodes involving ≥2 sites, involvement of ≥1 internal organ and blood count abnormalities such as lymphocytosis/lymphopenia, eosinophilia and thrombocytopenia). The diagnosis of DRESS syndrome remains a clinical one. There are a number of cases that do not fully meet one of the established criteria or the manifestation is gradual, thus delaying the diagnosis. Several agents have been previously linked with DRESS syndrome. The most well-known culprits are allopurinol, aromatic antiepileptic agents, sulfonamides and vancomycin. There are progressively more and more HLA allele variants associated with increased DRESS syndrome risk in different populations. We describe a case of DRESS syndrome after initiation of a GnRH antagonist, Degarelix.

CASE SUMMARY

A 62-year-old male with a past medical history of ESRD on hemodialysis, T2DM, HTN, previous MI and adenocarcinoma of the prostate stage III C diagnosed one month prior to admission, presented to the ED with fatigue, fever, chills and a generalized erythema of the skin. He had a previous history of DRESS syndrome a few years ago, when he was started on allopurinol by his PCP for gout and presented 6-7 weeks later with fever, malaise, and a diffuse erythematous rash. He was treated with glucocorticoids with eventual resolution of symptoms.

Five days prior to presentation, he was started on Degarelix, for his newly diagnosed adenocarcinoma. Initially, he had a mild eosinophilia at 0.53k/uL, and a mild elevation of his AST at 36U/L. His erythema initially progressed to pustules around his neck and axillae, with a large bulla on his left upper extremity. He was started on solumedrol. His symptoms and clinical status initially improved, however his rash progressed to desquamation on his face, neck, bilateral axillae, and forearms. His eosinophilia increased to 2.19k/uL and his AST and ALT increased to 100U/L and 236U/L respectively. His clinical status initially improved over the course of a week and he was discharged with a 7-day-course of prednisone 40mg and was warned to avoid further Degarelix injections.

CONCLUSION

A high index of suspicion should be maintained when a patient, with a previous diagnosis of DRESS syndrome presents with a new exanthem, hematologic abnormalities and multi-organ involvement. We are first to document the association between Degarelix and incidence of DRESS syndrome, in an individual who likely had a genetic predisposition to the condition.

REFERENCES


Figures 1 and 2: Facial and upper thoracic skin findings on initial presentation

Figures 3 and 4: Healing process ~ 1 week after presentation