Ziprasidone-induced skin reaction: A case report from Indian subcontinent.

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ABSTRACT

Ziprasidone, yet another atypical antipsychotic, has been associated, in this report, with development of photo-allergic skin reaction in therapeutic doses.

Key words: Ziprasidone, schizophrenia, skin reaction.

Ziprasidone is a novel antipsychotic agent with a distinct pharmacological profile (Guinovak et al. 2002). It has antagonistic effects at 5HT₂ and D₂ receptors and is claimed to have no extrapyramidal, muscarinic, anti-α, or antihistaminic adverse effects and also a negligible effect on body weight (Zorn et al. 1999; Arnt et al. 1998). There is research evidence that side effects of ziprasidone are minimal in contrast to other many antipsychotics. The overall incidence of treatment emergent adverse events in Ziprasidone treated patients did not exceed those in placebo-treated patients in two short term, double blind, randomized, multicentric studies. (Keck et al. 1998; Daniel et al. 1999). Commonly reported adverse events with Ziprasidone include dyspepsia, nausea, dizziness, somnolence, abdominal pain and constipation. Skin reactions though reported, but rarely seen.

The drug has been recently introduced in India. So far, no case of skin reaction with Ziprasidone has been reported. Ethnic issues are of importance in psychopharmacology and therefore, we wish to place the following case on record.

CASE

Ms. S, a 30-year-old housewife presented to our out-patient clinic with complaints of hearing voices of suspiciousness, fearful, abusive and aggressive towards neighbours for last 1½ years which began after land dispute with her aunt-in-law.

History revealed that initially she perceived accusatory voices of relatives. Later, she started hearing commanding and commenting voices of her neighbours and parents due to which she remained fearful and suspicious. Occasionally, she became abusive and aggressive towards them. Since the onset of her illness, she had disturbed sleep, with declining performance and self-care. After 3 months of illness, consultation was sought from a private psychiatrist but she discontinued treatment after 2 months. This was followed by consultation with faith healers without any improvement. At last, they brought the patient to our Psychiatry outpatient clinic. She had no past or family history of psychiatric illness. Mental status examination revealed persecutory delusions and auditory hallucinations. The latter were accusatory as well as commanding in nature and mainly persecutory in content.

Routine laboratory investigations revealed no abnormality. A diagnosis of Schizophrenia-paranoid type (as per ICD-10, WHO 1992) was made and she was put on oral Ziprasidone 40mg/day, titrated to 80mg/day at the end of first week. Additionally, she was also prescribed oral Lorazepam 2mg/day for her restlessness and sleep.

Within the first week, she developed skin rashes over face which gradually extended to neck and back (Figure 1 and 2) region at the end of fortnight, by which time her psychotic symptoms had started improving remarkably. Her husband became concerned of this skin reaction and brought her back to the outpatient clinic. Skin specialist diagnosed this reaction to be polymorphonuclear light eruptions (PMLE) probably due to some drug. The patient was advised to refrain from that drug and prescribed topical steroids and oral antihistaminic and antibiotics.

After stopping oral Ziprasidone, skin rashes gradually subsided within a week. During this period, oral Lorazepam was continued. A repeat dermatologic consultation was taken and the dermatologist opined that the skin lesions had subsided, however, there were post-inflammatory scars. Oral Risperidone 6mg/day along with oral Lorazepam 2mg/day were started at this point. Ms. S maintained her improvement with this treatment and no fresh skin lesions have appeared.

DISCUSSION

The appearance and disappearance of skin reaction in association with the introduction and withdrawal of Ziprasidone, indicate that the symptoms were likely to have been drug induced. Photosensitive reactions are produced by interactions of a drug with light energy that, depending on the particular interaction, can range from the ultraviolet spectrum to the visible light spectrum. The drug eruption is thus limited to body areas exposed to light such as face, neck, arms, back of the hands, the V area of the chest and the anterior and the inferior aspect of the legs. (Deswarte
Drug induced photosensitivity can be either phototoxic (direct thermal injury) or photoallergic. In photoallergic reactions, the solar radiation alters the drug or its metabolites in vivo forming a reactive compound or complete hapten that elicits an immune response in form of skin lesions. (Kaplan 1984).

In premarketing trials with Ziprasidone, about 5% of patients developed rash and/or urticaria which led to discontinuation of treatment in about one-sixth of these cases. Most patients improved promptly with adjunctive treatment with antihistamines or steroids and/or upon discontinuation of Ziprasidone, and all patients experiencing these events were reported to recover completely (data on file; Pfizer, 2002). Ziprasidone should be discontinued in patients who develop a rash for which an alternative etiology can not be found (Gunasekara et al 2002).

Re-challenge with the drug was not tried in this case as the patient maintained improvement with Risperidone. Pooling similar reports may be more rewarding.

To conclude, although Ziprasidone is a promising new antipsychotic that has shown significant efficacy in the oral treatment of patients with schizophrenia and schizo-affective disorder, but its safety profile should be explored in detail in Indian subcontinent. The present work is a single case report, hence more reporting is essential to confirm our views.

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