OBJECTIVES
To report a potentially lethal systemic dermatologic complication associated with Daclizumab (DAC) use.

BACKGROUND
- 11% of patients using DAC report rash.
- Autoimmune disorders including hepatitis associated with liver failure have been reported.
- Stevens-Johnson (SJS) has not been reported with use of DAC.
- SJS together with toxic epidermal necrolysis (TEN) form a spectrum of dermatologic disease.

METHODS
Two cases of SJS associated with the use of DAC were evaluated.

RESULTS
Case 1. A 52 year old black woman with MS complained of flu-like symptoms and had low grade pyrexia after 5 injections of DAC. She was taking no other medications. REMS blood work was normal up until the event. Her myelopathy worsened and EDSS score deteriorated from 2.5 to 4.5. She developed a confluent macular rash over her face, torso, back, and limbs. The rash was pruritic.

Fig. 1: Confluent macular rash over the back of patient following 5th injection of DAC associated with intense pruritis.

After several days the patient developed pronounced alopecia and blister-like bullous lesions on her skin that formed raw areas with intense pain. Cystic lesions were also present in the oropharynx.

Fig. 2: Severe alopecia because of DAC use.

Fig. 3: Rupture of large bullous cystic lesion in the palm of the hand.

Fever persisted with temperature spikes to 103 degrees, WBC count rose to 18.6 with shift, and a sedimentation rate was 84. She declined hospitalization but was treated with high dose steroids and antihistamines. Over several weeks blood labs normalized and with resolution of leukocytosis. The patient's skin exfoliated, and alopecia gradually resolved over weeks. No super infections occurred. Several skin biopsies were performed and revealed spongiotic and interface dermatitis with histologic features consistent with drug reaction.

Fig. 6: Bullous eruption following macular rash that was associated with intense pain, induration, and secondary infection.

Fig. 7: Generalization of bullous eruption with subsequent exfoliation.

Case 2. After 6 months of DAC, a 68 year old Caucasian man developed the insidious onset of a diffuse macular rash associated with pruritis, which appeared initially to be in a photo sensitive area but eventually generalized.

Fig. 4: Initial outisiduous development of what appeared to be a photo sensitive area of diffuse macular rash associated with pruritis following 6th injection of DAC.

Fig. 5: Macular rash on forearm.

REMS blood work was normal up until the event. He was initially treated with antihistamines. Over several days the rash appeared to be generalizing and eventually involved at least 50% of his body. Repeat temperature spikes of up to 103 degrees were recorded. Over several days the macular rash evolved into intense painful blisters with induration. Headache, malaise, and arthralgia were noted. WBC count was initially 23.5 with shift and sedimentation rate was 77. His skin soon exfoliated.

Fig. 8: Bullous eruption following macular rash that was associated with widespread pain, induration, and secondary infection.

Fig. 9: Generalization of bullous eruption with subsequent exfoliation.

He was hospitalized and treated aggressively with steroids and antihistamines. Skin biopsy had revealed epidermal necrosis with inflammatory change. After a period of several weeks, the patient improved.

CONCLUSION
This is the first report of SJS associated with DAC use. The cases suggest that vigilance is mandatory when using DAC since more serious and potentially lethal dermatologic complications can occur.

DISCLOSURE
The authors have nothing to disclose.