(*Refer to page 94*)

Answer: Drug induced oro-laryngeal ulceration

Further history from patient revealed that two weeks prior to the symptoms, she was prescribed with oral Indapamide for her hypertension. Indapamide was immediately withheld with close monitoring of her blood pressure and was started on intravenous Amoxicillin/Clavulanate acid along with Thymol gargle and oral topical gel. After one-week her symptoms along with her oral and laryngeal ulceration resolved.

Adverse drug reaction (ADR) may occur immediately after consumption of any drug or delayed to a few weeks or years later, albeit the standard dose and form of application[1]. ADR following oral medication are not typical, thus it's often overlooked.[1] Oral ADR may masquerade other oral lesions including of viral aetiology. In our patient, possibility of viral origin of oro-laryngeal ulceration cannot be ruled out. Reported forms of systemic adverse reactions among others are hyposalivation, burning mouth syndrome, oral ulceration, erythema multiform, lichenoid reaction, gingival hyperplasia and angioedema.[2] The most common oral ADR are secondary to sulfamethoxazole and trimethoprim antibiotics and non-steroidal anti-inflammatory analgesics (NSAIDS).

Indapamide, a sulphonamide diuretics prescribed mostly for hypertension has been reported to caused ADR with onset of symptoms as early as 2 days or in our case, delayed by up to 14 days and symptoms can range from pruritus, urticaria, to more severe reaction such as angioedema, erythema multiforme, Steven-Johnson syndrome and toxic epidermal necrolysis.[3-5]

Most diagnosis of oral ADR are made after detailed medical history and clinical findings. In the previous years, radioallergosorbent test, basophil degranulation test and blastic transformation test were performed, but due to high false-positive and false-negative results, these tests are no longer commonly used. The only objective test to confirm diagnosis is a 're-challenge' which requires patient's to re-consume the offending drug causing the reaction after being discontinued which often is carried out in hospital setting owing to the devastating possibility of anaphylactic reaction.[1] 'Re-challenge' was not carried out in our patient, weighing the huge risk of developing anaphylaxis reaction in addition to her age. Management mainly involves instant discontinuation of the offending drug along with systemic or topical steroids.[1]

In conclusion, it is prudent for all physicians to inform their patients regarding adverse drug reactions especially, when prescribing a new drug and to seek urgent treatment in case of any reactions. Patients who suffered from any drug reaction should be alerted and be provided with a drug-alert card which should be presented to any physicians in the future.

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