the possibility of spontaneous resolution of KLS could not be ruled out. Further study is needed to clarify this.

Conclusion

KLS is often misdiagnosed as BD, so it should be considered in its differential diagnosis. Lithium has been shown to improve the outcome. However, different symptom domains of KLS may respond differently, with an early response seen in the behavioral domain.

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Allergic Cutaneous Drug Eruptions with Quetiapine: A Case Study

To the Editor,

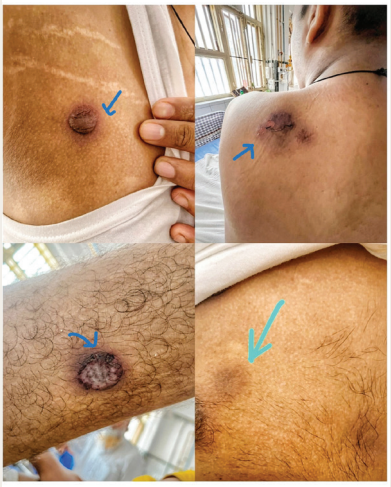
Multiple psychotropic medications (mood stabilizers, antipsychotic drugs, benzodiazepines) are often prescribed to patients with bipolar affective disorder with severe and difficult-to-treat mood episodes. The use of medications in higher doses and in combination is associated with adverse drug reactions. Cutaneous eruptions are not uncommon with certain psychotropic medications. Here, we report a rare cutaneous adverse drug reaction associated with quetiapine dose increment in a young male with bipolar affective disorder.

A 22-year-old man with heavy built (weight 92 kg and height 185 cm; body mass index: 26.88) with bipolar affective disorder developed fever followed by generalized bullous eruptions after two days of increment of quetiapine dose (from 600mg/day to 800 mg/day), which were not there at the time of quetiapine initiation. The patient had developed similar (in their morphology and distribution) drug eruptions with chlorpromazine (1000 mg/day) and clozapine (150 mg/day), given previously to treat the same episode, both of which were discontinued due to the development of the eruptions (before initiation of quetiapine, two weeks back). The patient was initiated on quetiapine since skin eruption is a very rare side effect of this medication.[1] He was also taking sodium valproate as a mood stabilizer at a dose of 2000 mg/day and lorazepam 4 mg/day. Opinion was taken from dermatology and medicine departments to evaluate the causes of fever and cutaneous eruptions. The patient was investigated with liver function and kidney function tests and complete blood counts. All the investigations were within normal limits except for a marginal increase in eosinophil percentage (7%).

The lesions were characterized by circular, discrete, bullous eruptions surrounded by erythema (**Figure 1**). The erosive lesions had a well-defined border surrounded by ill-defined hyperpigmentation after rupturing of the bulla. The lesions were mostly distributed over the trunk and the extremities (both flexure and extensor surfaces) and were itchy; however, they were not photosensitive.

FIGURE 1.

Bullous Eruptions Over the Trunk and Extremities, Which Are Round, Distinct, and Covered in Erythema.



They responded well to topical antibiotic cream and oral pheniramine 25 mg twice a day. The same dose of quetiapine was continued, and the eruptions healed over one week, without any scar but with hyperpigmentation. In the follow-up visit, the patient was maintained on the same dose of valproate and quetiapine. The dose of lorazepam was reduced as the patient's sleep improved. Informed consent was taken from the parents for the use of information for publication without disclosing the identity.

Cutaneous adverse drug reactions are relatively common side effects of drugs such as carbamazepine, lamotrigine, and chlorpromazine in comparison to other psychotropic medications.[2] Evidence suggests that following a cutaneous hypersensitivity reaction to one drug, the possibility of similar side effects may increase to other drugs.[2] With antipsychotic use, dermatological side effects are rarer than other systemic side effects; hence, they are rarely discussed in the literature.[3,4]

Cutaneous hypersensitivity reactions are rare with quetiapine.[1] Among the dermatological side effects, pigmentation is relatively common with quetiapine.[1] Some evidence suggests that quetiapine may cause cutaneous vasculitis.[5,6] However, the symptoms resolved on conservative treatment without dose reduction or stoppage of quetiapine. The patient was taking valproate for a long time without any side effects. A dose increment of quetiapine resulted in the development of the eruptions. Hence, it is unlikely to be due to valproate. It is important to understand the interaction of multiple medications prescribed together (in this case, valproate and quetiapine). Co-prescription of valproate and quetiapine increases the risk of side effects (mostly neurocognitive: sedation, cognitive slowing, slurring of speech, motor incoordination, and delirium).[7,8] The clinician needs to be aware of such uncommon adverse effects and judiciously monitor the progress of the adverse effects before stopping medications.

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