# Drug-induced Rowell syndrome due to omeprazole

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## Background

- Rowell syndrome is a rare entity consisting of overlapping features of erythema multiforme (EM) and cutaneous lupus erythematosus (CLE) with characteristic serological markers.
- Typically considered idiopathic, there have been rare case reports of drug-induced presentations, which may be more difficult to manage.[1]

## Case Report

- A 68-year-old female who had recently been diagnosed with an esophageal ulcer presented with a two-week history of a pruritic, primarily photodistributed eruption.
- One month prior to presentation, she had started a course of the proton-pump inhibitor (PPI), omeprazole.
- Physical exam demonstrated annular and targetoid, dusky pink to red papules and plaques with necrotic centers on the face, neck, lower arms and legs and superior trunk.
- Labs found +ANA 1:640 and both SS-A/Ro and SS-B/La were >8. RF was 47, and infectious studies including HSV/Mycoplasma were negative.
- Biopsy demonstrated an acute interface dermatitis with epidermal necrosis. There was adnexal involvement and increased dermal mucin. Direct immunofluorescence (DIF) was negative.
- Based on these findings, the patient met criteria to be diagnosed with Rowell syndrome,[2] with EM and subacute CLE overlap.

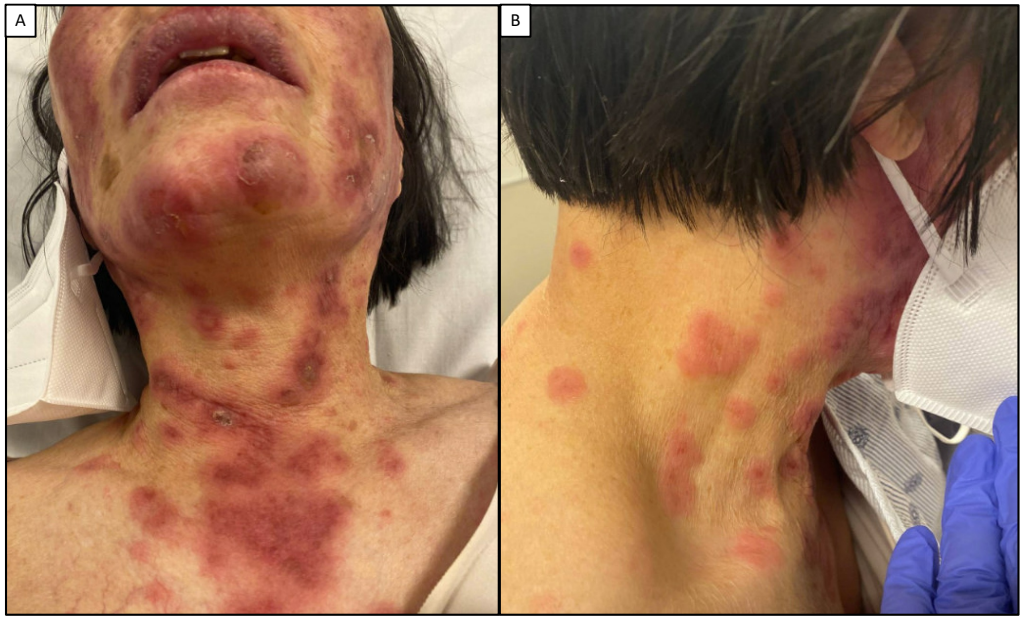


***Figure 1. Initial presentation of Rowell syndrome (A)*** *The cheeks, chin, anterior neck and upper chest of our patient demonstrated dusky, annular and targetoid necrotic pink and red papules and plaques with central pseudobullae.* ***(B)*** *The lateral neck demonstrated pink edematous targetoid papules, many with a central necrotic zone.*

## Treatment

- Omeprazole was discontinued and substituted with famotidine.
- Oral prednisone at a dose of 1 mg/kg/day as well as topical corticosteroids led to improvement.
- Prednisone was tapered and initially transitioned to cyclosporine. This was tolerated poorly and her rash persisted, so hydroxychloroquine was started instead. Her eruption resolved.
- Gastroenterology felt strongly that the patient needed a PPI for her esophageal ulcer, so she was cautiously trialed on pantoprazole, which she has tolerated without recurrence of her eruption.

## Conclusions

- Rowell syndrome can be diagnostically challenging, both because of its rarity and its inherently overlapping features with other conditions. However, presence of both EM- and CLE-like lesions with a positive ANA, SS-A/SS-B, reactive RF and negative DIF point to the diagnosis.
- Some proposed diagnostic criteria for Rowell syndrome have included lack of a pharmacologic trigger as a criterion.[3] Yet our case and others demonstrate that, like CLE, Rowell syndrome likely can be induced by a culprit medication.
- Our patient has been able to tolerate the alternative PPI pantoprazole, suggesting that drugs in the same class as the culprit medication may be cautiously retrialed when absolutely necessary.

## References

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