Severe Hypersensitivity Syndrome Due to Sulfasalazine Associated With Reactivation of Human Herpesvirus 6

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Background: A severe adverse reaction to sulfasalazine therapy has been associated with hypersensitivity syndrome, the clinical features of which are similar to infectious mononucleosis. No serologic evidence of viral infections has been reported with this syndrome; however, human herpesvirus 6 infection has not been specifically investigated, which could cause an infectious mononucleosilike syndrome.

Observations: We report 2 cases of hypersensitivity syndrome induced by the use of sulfasalazine. The clinical features of the syndrome appeared 18 and 32 days after administration of sulfasalazine. Clinical signs included a maculopapular rash progressing to exfoliative erythroderma, fever, and lymphadenopathy. Leukocytosis, atypical lymphocytes, liver dysfunction, and renal disturbance were also observed. In 1 patient, human herpesvirus 6 variant B was isolated from peripheral blood mononuclear cells, and in both patients anti–human herpesvirus 6 IgG titers increased considerably.

Conclusions: Two cases of hypersensitivity syndrome due to sulfasalazine use were associated with the reactivation of human herpesvirus 6, which may be a required cause of hypersensitivity syndrome.

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ULFASALAZINE IS a common therapeutic drug used to treat inflammatory bowel disease, rheumatoid arthritis, and psoriatic arthritis. A severe adverse reaction to sulfasalazine has been identified as a type of hypersensitivity syndrome. The reaction, including fever, skin rash, lymphadenopathy, and internal organ involvement, usually occurs 2 to 5 weeks after initiating treatment with sulfasalazine. The clinical features of hypersensitivity syndrome are similar to those of infectious mononucleosis.

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Recently, a severe infectious mononucleosilike syndrome was reported to be caused by human herpesvirus 6 (HHV-6) infection in immunocompetent adults. Its clinical features are characterized by skin rash, generalized lymphadenopathy, high fever, liver dysfunction, leukocytosis, and atypical lymphocytosis. We report 2 cases of sulfasalazine-induced severe hypersensitivity syndrome associated with the reactivation of HHV-6.

REPORT OF CASES

CASE 1

A 29-year-old Japanese man with an 8-year history of psoriatic arthritis had been treated with numerous agents, including loxoprofen, cyclosporine, and prednisolone, which moderately controlled the disease. Treatment with 0.5 g/d of sulfasalazine was started after all medications except loxoprofen had been discontinued. The dosage was increased to 2 g/d several weeks later. Thirty-two days after treatment with sulfasalazine was initiated, the patient developed a sore throat, nausea, vomiting, diarrhea, and high fever. Sulfasalazine therapy was discontinued 4 days later. Nevertheless, the patient developed a generalized eruption and was admitted to Ehime University Hospital, Ehime, Japan.

Results from a physical examination revealed a high fever (body temperature, 39.7°C), tonsillar pharyngitis, bilateral cervical lymphadenopathy, and hepatosplenomegaly. A generalized maculopapular rash was observed over the patient’s face, trunk, and extremities (Figure 1). Edema of the...
face was also present. Abnormal laboratory findings included a white blood cell count of 23.6 \( \times 10^9 \) cells/L (20% atypical lymphocytes and 11% eosinophils). Liver and renal dysfunction were found, with increased serum creatinine levels of 141.44 µmol/L (1.6 mg/dL), aspartate aminotransferase levels of 88 U/L, alanine aminotransferase levels of 148 U/L, and lactate dehydrogenase levels of 1892 U/L. An analysis of peripheral blood lymphocyte surface markers showed 35% CD4+ T cells and 30% CD8+ T cells. A skin biopsy specimen obtained from the upper portion of the patient’s right arm showed lymphocytic infiltration in the epidermis with necrotic keratinocytes, partial liquefaction degeneration of basal cells, and perivascular lymphocytic infiltration in the dermis (Figure 2).

The skin eruption progressed to erythroderma, and the patient was diagnosed as having hypersensitivity syndrome due to sulfasalazine use with multivisceral involvement. Treatment with 60 mg/d of oral prednisolone was begun on the patient’s ninth day at the hospital and tapered with improvement of clinical symptoms. By the seventh week of hospitalization, the patient’s condition had resolved other than symptoms of psoriatic arthritis.

A skin biopsy specimen obtained from the upper portion of the patient’s right arm shows infiltration of lymphocytic cells in the epidermis with necrotic keratinocytes, partial liquefaction degeneration of basal cells, and perivascular infiltration of lymphocytic cells in the dermis (hematoxylin-eosin, original magnification \( \times 100 \)).

### CASE 2

A 22-year-old Japanese woman who presented with abdominal pain and bloody diarrhea was diagnosed as having ulcerative colitis. Treatment with 1.5 g/d of sulfasalazine and 1 mg/d of betamethasone suppository was commenced, and the patient’s symptoms resolved 2 weeks later. Betamethasone therapy was discontinued while treatment with sulfasalazine was increased to 2 g/d. Eighteen days after sulfasalazine therapy was initiated, the pa-
A drug-associated hypersensitivity syndrome has been reported with administration of sulfasalazine, anticonvulsants, dapsone, allopurinol, and several other medications.1-4,12,13 Its clinical features resemble those of infectious mononucleosis and appear 2 to 3 weeks after administration of the drugs. Clinical signs include a maculopapular rash that often progresses to exfoliative erythroderma, fever, lymphadenopathy, and multisystemic involvement. Eosinophilia, atypical lymphocytosis, liver dysfunction, and renal disturbance are also frequently observed with this syndrome. The symptoms are often progressive for several weeks after treatment with the drug is discontinued. Systemic corticosteroid therapy generally improves the condition. We describe 2 patients who experienced the sudden onset of severe infectious mononucleosis-like illness 18 and 32 days after the initiation of therapy with sulfasalazine. We believe these cases represent hypersensitivity syndrome due to sulfasalazine therapy.

No serologic evidence of Epstein-Barr virus, cytomegalovirus, or other viral infections have been reported in hypersensitivity syndrome, although HHV-6 infection has not been specifically investigated. In 2 patients, we found an association between HHV-6 infection and hypersensitivity syndrome. Human herpesvirus 6 has been identified as the cause of exanthem subitum.14 Most people are infected with HHV-6 in early childhood. Then, HHV-6 latently infects monocytes and salivary glands. The mechanism and frequency of the reactivation of HHV-6 are unknown. In immunocompromised patients, it appears that the reactivation of HHV-6 is not infrequent.15-17 Human herpesvirus 6 was first isolated from immunocompromised patients with lymphoproliferative disease.18 One of these patients experienced drug-induced dermatologic lymphadenopathy with skin eruption.

Several methods may be used to confirm HHV-6 infection, including measurement of anti–HHV-6 titers, PCR analysis, and isolation of HHV-6. The evaluation of HHV-6 antibody titers is controversial. A marked increase in anti–HHV-6 IgG titers strongly indicates a primary or reactivated infection of HHV-6. In general, the appearance of anti–HHV-6 IgM antibodies suggests primary infection, while a remarkable increase in IgG titers without IgM antibodies indicates reactivated HHV-6 infection. However, PCR analysis is more sensitive, detecting HHV-6 DNA in 49% to 88% of PBMCs in healthy seropositive adults.19,20 A recent study suggested that the detection of HHV-6 DNA

Figure 3. DNA from peripheral blood mononuclear cells (Pt) showed amplified human herpesvirus 6 DNA product with 776 base pairs (bp) using common primers for variant A and variant B (left), and with 259 bp using variant B–specific primers (right). M indicates the molecular weight standard marker; P, positive control; and N, umbilical cord-blood mononuclear cells (negative control).
in serum by quantitative PCR defined the border between latency and active viral replication. In contrast, isolating the virus is the most reliable method of proving infection, because HHV-6 is rarely isolated from the PBMCs of healthy subjects. Our observations of the isolation of HHV-6 from PBMCs and the remarkable increase in anti-HHV-6 IgG titers without the appearance of IgM antibodies indicated reactivated HHV-6 infection.

The clinical symptoms of patients with HHV-6 infection should be evaluated carefully. Other viral infections must be excluded, because coinfections with HHV-6 and other herpesviruses have been reported. The 2 patients in our study showed no increase in anti–HHV-7, anticytomegalovirus, and anti–Epstein-Barr virus IgG titers. Accordingly, the reactivation of HHV-6 did not result from coinfection with these viruses. The patients showed similar clinical courses associated with reactivated HHV-6 infection. These findings support the relevance of HHV-6 infection in their clinical diseases. In addition, the increase in the anti–HHV-6 IgG titers was observed more than 2 weeks after the onset of disease. The period from the onset of a primary symptom to the increase in anti–HHV-6 IgG titer seems too long, although the exact time from onset is unknown for reactivated HHV-6 infection. We examined HHV-6 DNA from skin biopsy specimens of patient 1 using PCR. The DNA was detected from frozen skin specimens obtained on the patient’s 19th hospital day, but not from paraffin-embedded skin specimens obtained on the 6th day. This observation suggests active replication of the virus after the initiation of clinical symptoms. To confirm this observation, it must be further investigated in other patients.

Recently, a severe infectious mononucleosis-like syndrome caused by HHV-6 infection was reported in immunocompetent adults. Clinical signs included high fever, skin rash, generalized lymphadenopathy, liver dysfunction, and leukocytosis with the appearance of atypical lymphocytes. Although the 3 reported cases were described as primary HHV-6 infection, the possibility of reactivated HHV-6 could not be excluded because of an absent or low anti–HHV-6 IgM response. If the infectious mononucleosis-like syndrome was precipitated by reactivated HHV-6 infection, possible causes of the reactivation were not delineated. However, 1 of the 3 patients described by Sumiyoshi et al had been treated with phenobarbital for 3 weeks prior to onset of the illness, and peripheral blood eosinophilia had been found on admission (Y. Sumiyoshi, written communication, June 1997). Phenobarbital has been reported to cause hypersensitivity syndrome; therefore, the patient could have developed hypersensitivity syndrome with reactivated HHV-6 from treatment with phenobarbital.

Hypersensitivity syndrome due to the use of sulfonamides and anticonvulsants may be related to individual genetic polymorphisms in the enzymes involved in the metabolism cascade of these drugs. It is hypothesized that the reactive metabolite binds to tissue macromolecules and causes cell damage or acts as a hapten and elicits an immune response. Mauri-Hellweg et al have demonstrated drug-induced activation and proliferation of PBMCs in vitro in patients with hypersensitivity syndrome. However, the pathologic mechanisms mediating the symptoms resembling infectious mononucleosis have not been elucidated. Interestingly, it has been considered that the reactivation of HHV-6 from latently infected PBMCs requires T-cell activation. On investigation of 4 patients who developed adverse drug reactions but not hypersensitivity syndrome, an increase in anti–HHV-6 IgG titer was not found and the virus was not isolated. It seems likely that the reactivation of HHV-6 is specific to hypersensitivity syndrome. These findings led us to hypothesize that severe drug-induced hypersensitivity syndromes have a 2-stage course: first, T-cell activation develops as an immune response to reactive drug metabolites and second, HHV-6 reactivated by activated T cells affects the general condition of the patients and causes infectious mononucleosis-like symptoms.

However, these proposed pathomechanisms do not fully explain the phenomenon of hypersensitivity syndrome, which is induced by only a select group of medications. Many drugs may cause allergic reactions via T-cell activation, but the reactions do not always develop into hypersensitivity syndrome. Therefore, the adverse drug reaction causing hypersensitivity syndrome requires additional factors. Sulfasalazine has been reported to modulate the immune response by inhibiting the secretion of IgA and the production of interleukin 1 and tumor necrosis factor α. These effects of sulfasalazine on the immune system may facilitate the reactivation of HHV-6 by activated T cells and induce the constellation of symptoms and signs of hypersensitivity syndrome.

It should be noted that the patients’ clinical conditions improved with the use of systemic corticosteroids. One explanation for this finding might be that the corticosteroids suppressed an excessive immune response to drug metabolites and/or inhibited the production of cytokines caused by massive replicated viruses, which in turn induced severe illness. We would like to suggest possible treatment with an antiviral drug such as ganciclovir for hypersensitivity syndrome, since our observations indicate that HHV-6 infection occurs in a late stage of hypersensitivity syndrome.

In conclusion, we demonstrate that a drug-induced hypersensitivity syndrome due to sulfasalazine use is associated with reactivation of HHV-6 and an infectious mononucleosis-like illness. We suggest that HHV-6 infection may be a required cause of hypersensitivity syndrome.

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