Photodistribution of Blue-Gray Hyperpigmentation After Amiodarone Treatment

Molecular Characterization of Amiodarone in the Skin

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Background: For decades, the photodistributed blue-gray skin hyperpigmentation observed after amiodarone therapy was presumably attributed to dermal lipofuscinosis. Using electron microscopy and high-performance liquid chromatography, we identified amiodarone deposits in the hyperpigmented skin sample from a patient treated with this antiarrhythmic agent. Our findings therefore indicate that the hypothesis relating the blue-gray hyperpigmentation to lipofuscin should be challenged.

Observations: A 64-year-old man, skin phototype III, presented with asymptomatic skin hyperpigmentation that had been slowly developing on sun-exposed areas since April 2004. He had been taking amiodarone for 4 years (cumulative dose, 277 g). Electron microscopy did not show lipofuscin pigments in his skin. Conversely, abundant electron-dense membrane-bound granule deposits were observed in most of the dermal cells (fibroblasts, macrophages, pericytes, Schwann cells, and endothelial cells), especially in photoexposed skin. High-performance liquid chromatography confirmed that the skin deposits were composed of amiodarone. These results demonstrate that amiodarone hyperpigmentation is related to drug deposition on photoexposed skin.

Conclusion: Amiodarone-related hyperpigmentation should be considered a skin storage disease that is secondary to drug deposition.

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pigmentation of the face and ears, sparing the area under the nose, nasolabial folds, and wrinkles (Figure 1). Phototests revealed a polychromatic minimal erythema dose at 600 mJ/cm² (reference value, ≥400 mJ/cm²). The results of the UV-A phototest (13 J/cm²) were negative after 24 hours, with mild hyperpigmentation. Histologic examination of a pigmented skin specimen revealed numerous macrophages accumulated around superficial dermal vessels. The cytoplasm of these cells showed brownish deposits that were positive on periodic acid–Schiff and Fontana stains (Figures 2, 3, and 4).

Electron microscopy of a nonpigmented skin sample showed the presence of a few homogeneous strongly electron-dense granules confined to the upper dermis, whereas a pigmented skin sample revealed numerous similar granules within the thickness of the dermis. These deposits were localized mainly in fibroblasts as well as in other cells, particularly macrophages, endothelial cells, and Schwann cells (Figure 5). At high magnification, they appeared to be surrounded by a membrane. There were no abnormal deposits within the epidermis, hair follicles, or sebaceous glands. No lipofuscin deposits were observed in the pigmented skin sample from our patient.

**TECHNIQUE**

The first step of the molecular identification of amiodarone deposits in the skin involved the extraction of amiodarone from a skin biopsy specimen. A skin biopsy (punch, 4 mm; 8 mg) was performed on the pigmented skin of the face to demonstrate the presence of drug deposits by extracting the active molecule of amiodarone. Accordingly, the skin specimen was homogenized with 10 mL of methanol and kept at 5°C for 24 hours. The homogenate was then crushed and filtered. The filtrate was evaporated to dry-
Amiodarone hydrochloride (2-butyl-3-benzofuranyl 4-[2-(diethylamino)-ethoxy]-3,5-diiodophenyl ketone hydrochloride) is an iodinated compound that is widely used in the treatment of cardiac arrhythmias and is known to cause photosensitivity and cutaneous hyperpigmentation. Although amiodarone photosensitivity is quite common and occurs in more than 50% of treated patients, blue-gray cutaneous hyperpigmentation occurs in fewer than 10%. The clinical features of the photosensitivity response represent a phototoxic reaction to both amiodarone and its major metabolite, mono-N-desethylamiodarone. Also, it has been shown that amiodarone therapy might induce photoallergy in guinea pigs. However, the photoallergic effect of the drug has generally been masked by its phototoxic potential. Phototoxic reactions can be experimentally elicited with UV-A; the UV-A minimal erythema dose is significantly reduced after 12 months of treatment. The photoactivating wavelengths are primarily found in the long-wave UV-A spectrum between 350 and 380 nm. However, phototests may show acute reactions to UV-A and UV-B and significant delayed reactions to UV-A and/or UV-B. Zinc oxide–containing preparations appear to be the most effective agents for reducing cutaneous photosensitivity. Under the regimen commonly used, photosensitivity can be expected to occur after 4 months of continuous treatment and a minimal cumulative dose of 40 g. It appears to be unrelated to the skin type. Photosensitivity gradually decreases and returns to normal between 4 and 12 months after discontinuation of amiodarone therapy. However, it can sometimes last for several years after drug withdrawal. Amiodarone hyperpigmentation develops mainly in patients with skin type I. It occurs after an average of 20 months of continuous treatment and a minimal cumulative dose of 160 g. The slow rate of elimination of amiodarone and the high uptake by fat-associated tissues may explain the delayed spontaneous disappearance of cutaneous photosensitivity and the late resolution of the blue-gray discoloration. In 1 patient, massive amiodarone-induced hyperpigmentation was found to be reversible 33 months after the use of the drug was discontinued. However, in cosmetically stigmatizing hyperpigmentations, treatment with a Q-switched ruby laser has shown impressive results. In our case, photosensitivity toward amiodarone or another drug was ruled out because phototests showed a normal polychromatic minimal erythema dose and a negative UV-A phototest result. Therefore, this case corresponds clinically, histologically, and ultrastructurally to typical amiodarone-photodistributed blue-gray hyperpigmentation, which occurred after 52 months of continuous treatment and a cumulative dose of 277 g.

Previous electron microscopy studies of amiodarone-pigmented skin demonstrated 6 distinctive morphological types of intracytoplasmic inclusions in many dermal cell types. The pathogenesis may be related to the action of the drug on cell membranes, local metabolic damage, and accumulation of the drug on the lysosomes, with acceleration of the physiological aging cell...
process. In a previous report, the presence of high concentrations of iodine, which was observed on electron probe analysis, suggested that the cutaneous deposits are made up of amiodarone itself or a metabolite. Our results confirm this hypothesis. After the extraction procedure that was performed on the hyperpigmented skin of our patient’s face, HPLC of the skin sample showed 4 peaks corresponding to 4 retention times: 0.707 minutes, 0.868 minutes, 1.447 minutes, and 8.207 minutes. Later on, after each sequential addition of commercial amiodarone (extracted from Cordarone tablets), HPLC revealed a clear increase of the peak at 8.207 minutes. This finding suggests that the molecule corresponding to the retention time of 8.207 minutes and the commercial amiodarone that was added are the same compound. To be more precise, the UV absorption spectrum of each peak was determined at 8.207-minutes. These UV absorption spectra were perfectly identical (Figure 6). Therefore, in this case, the molecule extracted from the skin, which showed a peak at 8.207 minutes, is amiodarone. We were not able to identify the nature of the other 3 molecules corresponding to yellow and not blue fluorescence.14,15 Conversely, electron microscopic examination of the sun-exposed skin of patients without amiodarone discoloration shows pigment deposits similar to those already described in patients with amiodarone hyperpigmentation. Lipofuscin is a naturally occurring autofluorescent lipopigment that accumulates in aging cells as a normal part of senescence; it is called the wear-and-tear or aging pigment. Because this material exhibits fluorescence, lipofuscin has been described by its spectral properties, with an excitation between 320 and 480 nm and an emission wavelength between 460 and 630 nm, with a peak at 580 nm corresponding to yellow and not blue fluorescence.14,15

In conclusion, our results confirm that amiodarone hyperpigmentation to lipofuscin should be challenged. Also, direct evidence of massive amiodarone deposits in the hyperpigmented skin on electron microscopy provides a strong argument in favor of a direct pathogenic role for amiodarone. There are numerous reasons to question the role of lipofuscin as a causative factor in amiodarone hyperpigmentation. Lipofuscin is a naturally occurring autofluorescent lipopigment that accumulates in aging cells as a normal part of senescence; it is called the wear-and-tear or aging pigment. Because this material exhibits fluorescence, lipofuscin has been described by its spectral properties, with an excitation between 320 and 480 nm and an emission wavelength between 460 and 630 nm, with a peak at 580 nm corresponding to yellow and not blue fluorescence.14,15 Conversely, electron microscopic examination of the sun-exposed skin of patients without amiodarone discoloration shows pigment deposits similar to those already described in patients with amiodarone hyperpigmentation in exposed and nonexposed skin. Finally, the presence of amiodarone deposits in the skin, with or without lipofuscin, is able to induce the blue-gray hyperpigmentation. This pigmentation could be explained by the Tyndall effect, in which dermal pigment, whether melanin, iron, or other pigment, is perceived as blue, gray, or blue-gray.

In conclusion, our results confirm that amiodarone blue-gray hyperpigmentation should be considered a skin storage disease that is secondary to drug deposition.
comparative study with nonpigmented, photoprotected skin would need to be carried out to find out whether the other 3 unidentified molecules (0.707 minutes, 0.868 minutes, and 1.447 minutes) on HPLC are photoproducts of amiodarone.

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REFERENCES


Error in Spelling of Author Name. In the Off-Center Fold feature titled “Goosefleshlike Lesions and Hypohidrosis” by Simon et al, published in the October issue of the Archives (2007;143[10]:1323-1328), the first author’s name was spelled incorrectly. The correct spelling is Naomi Soroosh Simon, MD.