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Case Study

Ornidazole Induced Fixed Drug Eruption: A Case Report

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Fixed drug eruption is an immune-mediated cutaneous adverse drug reaction characterized by recurrent lesions at fixed anatomical sites. Generalized bullous fixed drug eruption is rare but clinically significant, often mimicking severe conditions such as Stevens–Johnson syndrome or toxic epidermal necrolysis. We report a case of a 60-year-old male who developed generalized bullous fixed drug eruption following six days of ornidazole and ofloxacin therapy. Clinical presentation included multiple hyperpigmented patches, bullous lesions over the trunk and extremities, and mucosal erosions involving lips and oral cavity. Immediate withdrawal of the offending agents, systemic corticosteroids, topical therapy, and infection prophylaxis led to stabilization and recovery. This case underscores the importance of differentiating generalized bullous fixed drug eruption from other severe cutaneous adverse reactions, recognizing its recurrence at fixed sites, and documenting pigmentation on healing as distinguishing features. Prompt drug withdrawal, supportive therapy, and pharmacovigilance reporting are essential to ensure patient safety and improve drug monitoring practices.

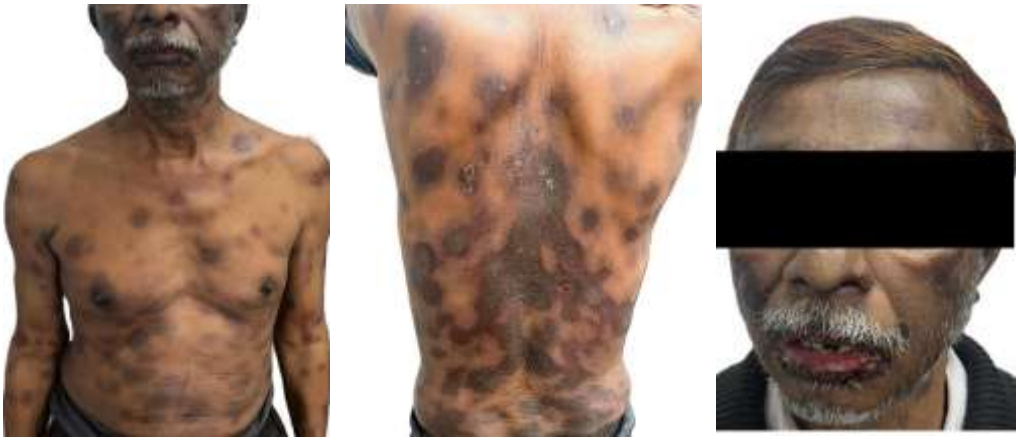
Keywords: fixed drug eruption, generalized bullous fixed drug eruption, ornidazole, adverse drug reaction, pharmacovigilance, cutaneous drug reaction.

INTRODUCTION

Fixed drug eruption is an immune-mediated cutaneous adverse drug reaction characterized by recurrent lesions at fixed anatomical sites[1]. Generalized bullous fixed drug eruption is rare but clinically significant, often mimicking Stevens–Johnson syndrome or toxic epidermal necrolysis[5],[6].

Case Presentation

A 60-year-old male presented with generalized fixed drug eruption characterized by multiple hyperpigmented patches and bullous lesions distributed over chest, abdomen, limbs, and back (1). He also had raw mucosal lesions involving lips and oral cavity. He was on ornidazole and ofloxacin fixed dose therapy for 6 days before onset (2,3).



Images representing: A case of fixed drug eruption induced by ornidazole involving chest, abdomen, trunk, lips and oral cavity.

Differential Diagnosis

1. Erythema multiforme
2. Herpes simplex virus infection
3. Cellulitis Stevens–Johnson syndrome / toxic epidermal necrolysis[5],[6]
4. Fixed drug eruptions
5. Fixed food eruptions

DISCUSSION

Generalized bullous fixed drug eruption is rare but clinically significant, often mimicking Stevens–Johnson syndrome or toxic epidermal necrolysis[5],[6]. Both fluoroquinolones and nitroimidazoles are documented triggers[2],[3]. Mucosal involvement is frequent, with oral and genital erosions[1],[2]. Immediate withdrawal of the causative drug is essential[7]. Systemic corticosteroids, topical therapy, and antihistamines help control inflammation[5]. Pharmacovigilance reporting ensures drug safety monitoring[7].

Management and Outcome:

Immediate withdrawal of the offending drugs, systemic corticosteroids, topical therapy, and infection prophylaxis led to stabilization

CONCLUSION

This case highlights generalized bullous fixed drug eruption as a serious adverse drug reaction requiring prompt recognition and management[6]. Differentiation from Stevens–Johnson syndrome or toxic epidermal necrolysis is crucial, with recurrence at fixed sites and pigmentation on healing as distinguishing features. Adverse drug reaction reporting remains vital for patient safety[7].

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Conflict of Interest

The authors declare no conflict of interest.

REFERENCES

1. Sehgal VN, Srivastava G. Fixed drug eruption (FDE): changing scenario of incriminating drugs. Int J Dermatol. 2006;45(8):897–908.
2. Mahajan VK, Sharma NL, Sharma RC, Ranjan N. Fixed drug eruption: clinical features, causative drugs, and recurrence pattern. J Dermatol. 2005;32(12):951–7.
3. Shiohara T, Mizukawa Y. Fixed drug eruption: pathogenesis and diagnostic tests. Curr Opin Allergy Clin Immunol. 2002;2(4):317–21.
4. Sharma VK, Sethuraman G, Kumar B. Cutaneous adverse drug reactions: clinical pattern and causative agents — a 6-year series from Chandigarh, India. J Postgrad Med. 2001;47(2):95–9.
5. Roujeau JC, Stern RS. Severe adverse cutaneous reactions to drugs. N Engl J Med. 1994;331(19):1272–85.
6. Sehgal VN, Srivastava G. Generalized bullous fixed drug eruption: an overview. J Dermatol. 2007;34(6):361–6.
7. World Health Organization. Pharmacovigilance: ensuring the safe use of medicines. Geneva: WHO; 2004.

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