

Disseminated Pustular Eruption Following Antibiotic Therapy: A Diagnostic Challenge

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Figure 1. A. Anterior trunk and B. Back showing multiple sterile, non-follicular pustules, some coalescing, on an infiltrated erythematous background, bilaterally distributed over the trunk, representing the characteristic clinical presentation of Acute Generalized Exanthematous Pustulosis (AGEP) induced by amoxicillin/clavulanate.

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Acute Generalized Exanthematous Pustulosis (AGEP) is a rare, severe cutaneous hypersensitivity reaction predominantly triggered by medications, particularly β -lactam antibiotics [2]. It is characterized by the abrupt onset of numerous sterile, non-follicular pustules arising on an erythematous base, frequently accompanied by fever, leukocytosis, and, in more severe cases, mucosal involvement and systemic manifestations [1]. Early recognition of this condition and prompt withdrawal of the offending agent are essential for clinical resolution and prevention of complications [3].

A 36-year-old woman with a history of hepatitis B diagnosed 11 years earlier, without regular follow-up, was admitted to the hospital after the sudden onset of disseminated pustular lesions approximately 48 hours following tooth extraction. At the time, she had been receiving amoxicillin/clavulanate 500 mg every 8 hours, oral dexamethasone 4 mg, paracetamol 500 mg every 6 hours, and ibuprofen 600 mg every 8 hours. She reported

a similar episode approximately 15 days earlier after exposure to prednisone, which resolved spontaneously following drug discontinuation. The current episode initially involved the face and oral cavity, subsequently spreading to the anterior trunk, back, and genital region, and was associated with severe odynophagia and hematuria.

Dermatological examination revealed numerous whitish, sterile, non-follicular pustules ranging from a few millimeters to confluent lesions, arising on intensely erythematous and infiltrated skin, bilaterally distributed over the anterior trunk (Figure 1A) and back (Figure 1B). Some pustules coalesced centrally to form pustular plaques surrounded by an inflammatory halo, whereas others remained isolated at different stages of evolution. Oral mucosal involvement was characterized by painful aphthous ulcers and erosions. In addition, a single ulcerative lesion with a yellowish base was observed on the right labium majus; it was painful on palpation and showed no active discharge, indicating extensive mucocutaneous involvement.

Laboratory investigations demonstrated leukocytosis (17,300 cells/mm³), mildly elevated alanine aminotransferase (ALT, 62.7 U/L), proteinuria (+++), hemoglobinuria (+++), and ketonuria (+). Serological tests were negative for HIV, hepatitis C, and syphilis, while hepatitis B serology remained positive, consistent with the patient's previous diagnosis. The EuroSCAR score was 5, classifying the case as probable AGEF. Given the strong temporal relationship between initiation of antibiotic therapy and lesion onset, together with the characteristic clinical findings, a diagnosis of amoxicillin/clavulanate-induced Acute Generalized Exanthematous Pustulosis was established. Withdrawal of the antibiotic, together with topical corticosteroid therapy, emollient skin care, and supportive treatment, resulted in progressive regression of the lesions and complete clinical recovery, underscoring the importance of early recognition of this potentially severe cutaneous adverse drug reaction.

The significance of this case lies in its extensive clinical presentation, characterized by widespread cutaneous involvement associated with simultaneous oral and genital mucosal lesions, hematuria, and a recent history of a similar drug-related episode, suggesting prior sensitization. These findings strongly supported the diagnosis of AGEF and emphasize the importance of including this condition in the differential diagnosis of acute pustular eruptions, including impetigo, disseminated bacterial folliculitis, generalized pustular psoriasis (von Zumbusch type), drug reaction with eosinophilia and systemic symptoms (DRESS), Stevens–Johnson syndrome/toxic epidermal necrolysis (SJS/TEN), subcorneal pustular dermatosis, and IgA pemphigus [1,2,3]. Prompt recognition of AGEF allows immediate discontinuation of the causative drug, thereby reducing morbidity and preventing progression to more severe disease [3].

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