glomeruli would explain why significant proteinuria was not found.

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Lichenoid Eruption Due to Chlorpropamide

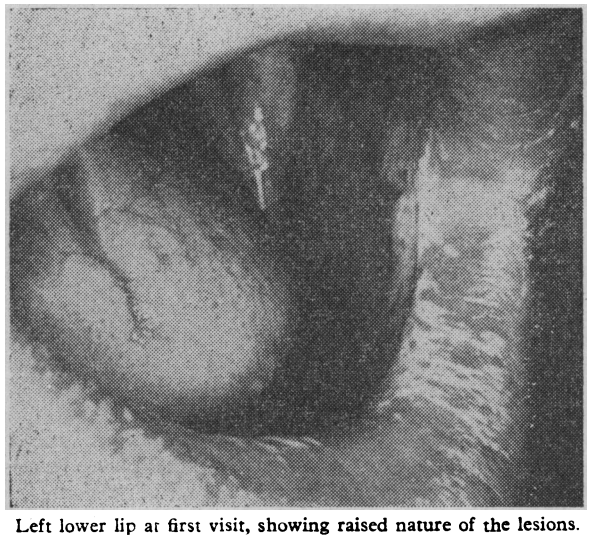
Brit. med. J., 1968, **1**, 100

In this paper we describe a lichenoid eruption occurring inside the mouth of a patient receiving chlorpropamide (Diabinese) for diabetes mellitus. This drug is a widely used sulphonylurea derivative and may cause various rashes in a minority of patients, but its association with a lichenoid eruption does not seem to have been previously reported.

CASE REPORT

The patient, a temperature-taker in a steel works, aged 53, presented in December 1965 with nine months' thirst and polyuria. A random blood sugar of 480 mg./100 ml. confirmed the diagnosis of diabetes. He was treated initially by a restricted carbohydrate diet, but chlorpropamide 100 mg. daily was given in March 1966; the dose was increased in June to 250 mg. and in August to 500 mg. daily with subsequent good diabetic control.

On 1 November he attended the dental hospital with "white ulcerated sloughs" on the lips (see Fig.). In retrospect he believed these to have begun in June. By 4 November lesions had spread to the mucosa of his tongue and cheeks, and a biopsy at this time showed "appearances suggestive of lichen planus but with more cellular disturbances than average" (Professor J. J. Hodson). Careful examination failed to show any lesions elsewhere on the skin or other mucous membranes. On 22 November his mouth became worse and he could not wear his dentures, so the chlorpropamide was stopped. Five days after this he stated that his mouth symptoms had cleared, and when we saw him on 6 December there was no longer any evidence of the lichenoid eruption.



Left lower lip at first visit, showing raised nature of the lesions.

During January 1967 the patient had glycosuria again and restarted chlorpropamide on his own accord. After two days on 500 mg. daily, followed by two days on 250 mg. daily, the mouth lesions recurred, but subsided within four days after he ceased to take the tablets. The next week he again repeated chlorpropamide therapy on his own, and on the third day of treatment the lichenoid eruption recurred inside the mouth and was observed by us on 17 January; but once more it soon cleared when the tablets were withdrawn. Subsequently Dibotin (phenformin hydrochloride) slow-release capsules 50 mg. twice daily have controlled his diabetes and his mouth has remained clear.

COMMENT

Lichen planus is the commonest cause of lichenoid eruptions inside the mouth, but because of the prompt appearance and disappearance of this patient's lesions in relation to taking and stopping chlorpropamide on three different occasions, it seems certain that the lichenoid eruption was induced by this drug. The rapid clearing of the eruption is also quite unlike the slow resolution of the mucosal lesions of lichen planus. It is of interest that the eruption probably occurred only when the daily dose of chlorpropamide was raised to 250 mg.

Maculopapular eruptions, urticaria, exfoliative dermatitis, erythema multiforme, erythema nodosum, Stevens–Johnson syndrome, photosensitivity, purpura, and proctitis (Rothfeld *et al.*, 1960; Tullett, 1966) have been described as rare skin and epithelial complications of chlorpropamide therapy, but lichenoid eruptions due to this drug do not appear to have been previously reported. Lichenoid eruptions may also occur after treatment with gold, organic arsenic, bismuth, mepacrine, chloroquine, hydrochloroquine, and amiphenazole (Sneddon, 1965; Dinsdale and Walker, 1966), and represent yet another condition in which diagnosis and treatment are greatly helped by knowing what drugs the patient has been taking.

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