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Two case reports of delayed-allergic reactions to clindamycin confirmed with a positive lymphocyte transformation test

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Introduction

Clindamycin is a lincosamide antibiotic that binds exclusively to the 50s subunit of bacterial ribosomes and suppresses intracellular protein synthesis. It is widely used in the prophylaxis and treatment of infections due to its broad spectrum of antimicrobial activity. Hypersensitivity to clindamycin seems to be not very common (less than 1% of drug-allergic reactions) (1), with mostly non-immediate or delayed ones: drug rash with eosinophilia and systemic symptoms (DRESS) (2), symmetric drug-related intertriginous and flexural exanthema (SDRIFE) (3), drug-induced hypersensitivity syndrome (DIHS) (4), generalized maculopapular exanthema (5), anaphylaxis (6) and acute generalized (7) and localised exanthematous pustulosis (8) have been described.

The diagnostic approach includes a detailed medical history, clinical examination, and skin testing and/or oral challenge with

Summary

Clindamycin is widely used in the prophylaxis and treatment of infections due to its broad spectrum of antimicrobial activity. Hypersensitivity to clindamycin seems to be not very common (less than 1% of drug-allergic reactions) and it mostly appears as delayed T-cell mediated. For the diagnosis, skin testing is considered to be highly sensitive and rather safe, but cutaneous and systemic reactions have been described. Provocation test is considered the “gold standard”. However, it includes the possibility of severe reactions. We reported two cases of delayed allergic reaction to clindamycin confirmed with a positive lymphocyte transformation test, showing this in vitro test like a promising diagnostic method because of its usefulness and safety.

clindamycin. Lymphocyte transformation test (LTT) in general has been shown to be more sensitive than skin testing for non-immediate reactions diagnosis (9,10,11), although there are only few studies that analyze the LTT in allergy to betalactams or quinolones, so its diagnostic value for other antibiotics remains uncertain (12).

We present two different cases of delayed allergic reaction to clindamycin with maculopapular exanthema in which LTT confirmed clindamycin as the culprit agent.

Clinical cases

Case 1. A 64-year-old woman who came to the allergy department from the emergency department to be studied for a possible allergy to clindamycin. She denied any past history of urticarial episodes or adverse reactions to the ingestion of food or medication. In September 2013 she took clindamycin for a

dental infection. After the fifth dose she developed a cutaneous eruption that began in the thighs, with erythematous pruritic plaques that spread through her back and trunk day by day in spite of the clindamycin discontinuation. She was treated with high doses of prednisone for several weeks. She had no fever or systemic symptoms. Laboratory studies did not find leukocytosis, eosinophilia, kidneys failure or elevated liver enzymes. Skin prick test (150 mg/ml) and intradermal test (1.5 mg/ml and 15 mg/ml) (13,14,15) with clindamycin results were negative after 30 minutes, 24 and 48 hours. Patch testing of skin with 10% clindamycin in petrolatum at 48 and 96 h according to the Spanish Society of Allergy and Clinic Immunology criterion, was also negative (13). As the patient refused to undergo any other in vivo tests, an oral challenge with the culprit drug was not performed.

Case 2. A 56-year-old man, who came to the allergy department from his general practitioner to study a possible allergy to clindamycin. He had not allergic background. His medical history was significant for hypertension, type 2 diabetes and hyperlipidemia. His long-term drug therapy consisted of metformin, acetylsalicylic acid, olmesartan / amlodipine and simvastatin. In January 2018 he had dermatitis in his legs by the application of hydrocortisone with broponol. He received clindamycin as treatment and three days after the cutaneous eruption spread through his body, except the head, with desquamation in his lower limbs. He was studied in dermatology being diagnosed with toxicoderma. He improved with systemic prednisone but he went worse after prednisone discontinuation. Laboratory studies found leukocytosis and eosinophilia (2100/ μ L) but no kidney failure or elevated liver enzymes. Cutaneous biopsy was not performed. In March 2018 he arrived to allergy department being asymptomatic. Patch testing of skin with 1% clindamycin in petrolatum was negative at 48 and 96 hours.

Material and methods

In an attempt to clarify the underlying mechanism, 3 months after the reaction we performed the LTT with clindamycin in both patients. The LTT using 6 different concentrations of clindamycin (0.01 - 250 μ g/ml) was performed.

Briefly, proliferation of lymphocytes from the allergic patients was measured as previously described (16,17,18). Mononuclear cells were separated over a density gradient (Histopaque 1077, Sigma-Aldrich) from fresh peripheral blood and were incubated for 6 days at 10^6 cells/mL in triplicate with 6 different concentrations of clindamycin. Phytohemagglutinin (5 μ g/mL) was used as a positive control. For the final 18 hours of the incubation period, proliferation was determined by the addition of (3 H) thymidine (0.5 μ Ci/well). Stimulation index (SI), defined as the ratio between the mean values of counts per minute in cultures with antigen and those obtained without antigen, calculate the proliferative responses. The positive response is defined as an $SI \geq 2$.

Results

In both patients, the result of the LTT was positive, with a SI of 5.9 at a concentration of 0.01 μ g/ml and with SI of 13.1 at a concentration of 250 μ g/ml, respectively (**table I**). LTT with clindamycin in four controls showed no proliferative responses. From this finding, we diagnosed maculopapular rash as delayed hypersensitivity to clindamycin.

Discussion

In drug hypersensitivity, the diagnostic approach usually includes a detailed clinical history, which is not always possible and can be unreliable. This is usually followed by appropriate in vivo tests (skin and/or drug provocation test). Although skin testing with this drug is considered to be highly sensitive and rather safe, cutaneous and systemic reactions have been described (19). Moreover, patch testing sensitivity in contact allergy is between 60-80%. They are also helpful for the study of some non-immediate adverse drug reactions, although they suffer from a lack of standardization. Sensitivity in non-betalactam antibiotics is low and there is also a high rate of false positive results due to irritation (9). Provocation test is considered the "gold standard" to establish or exclude the diagnosis of allergy to a certain substance, however, it includes the possibility of severe reactions.

Table I - Stimulation index with different concentrations of clindamycin, in our two patients (1 and 2), and in four non-allergic to clindamycin controls.

	Stimulation index					
	0.01 μ g/ml	0.1 μ g/ml	1 μ g/ml	10 μ g/ml	100 μ g/ml	250 μ g/ml
clindamycin						
patient 1	5.9	2.4	1.8	1.2	2.3	-
patient 2	-	-	2.8	1.1	6.4	13.1
controls (n = 4) mean \pm SD	-	-	0.8 \pm 0.2	0.9 \pm 0.5	0.8 \pm 0.3	0.8 \pm 0.2

SD, standard deviation; μ g/ml, micrograms/milliliter.

Given the limitations of *in vivo* tests, they can be helpful for diagnosis, and are the only alternative method when *in vivo* tests are not recommended. They are essential to clarify drug allergy status, despite having suboptimal sensitivity. The most widely employed technique for diagnosing non-immediate reactions is LTT. Its main disadvantage is that an *in vitro* proliferation of T cells to a drug is difficult to transfer to the clinical situation and that the test *per se* is rather cumbersome and technically demanding. In addition, its sensitivity is limited (for β -lactam allergy it is in the range of 60-70%), although it is higher than that of other test for drug hypersensitivity diagnosis (9). LTT in general has been shown to be more sensitive than skin testing for non-immediate reactions diagnosis (9,12).

In 2012, Nakamura et al (4) reported a case of delayed DIHS/DRESS due to clindamycin intake with a positive LTT (stimulation index of 17.5 the tenth day after the DRESS start) but also with a positive skin patch test.

To our knowledge, these are the first cases reported of maculopapular rash induced by clindamycin with a positive LTT and negative skin tests and since then, no other positive results have been published. However, further studies are needed to assess the validity of the LTT in allergic reactions to clindamycin.

Conflict of interests

The authors declare that they have no conflict of interest.

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