The introduction of the first antihistaminic drug in this country in 1945 was followed by widespread acceptance of these agents by both specialists and general practitioners. Practically all of our major drug manufacturers rushed to place their own modification on the market. Of course, allergic manifestations remain among the more puzzling and difficult conditions to control so it is not hard to understand why the physician grasps at such agents as a substitute for time consuming, expensive and often unsatisfactory investigations. Furthermore, most manufacturers beside claiming that his product is the most effective of the group, has pointed with pride to the low toxicity of his preparation.

Considering the volume of antihistaminics administered in the past three years, the reports of significant toxicity have been few. This is particularly true of dermatologic complications. Two cases of dermatitis due to tripelennamine hydrochloride (pyribenzamine hydrochloride) were recorded in June 1947 (1). Since that time, a number of similar cases have been observed personally. A few cases due to benadryl have also been seen. Harris and Shure (2) reported the case of a patient with "allergic rhinitis" who developed an eczematoid dermatitis of the hands, anterior surface of the chest and the anterior surfaces of the thighs due to pyribenzamine. Scratch, intradermal, patch and passive transfer tests were negative but the eruption could be reproduced after the ingestion of a dose of pyribenzamine. The authors felt that this dermatitis was not due to other substances in the tablets such as gum tragacanth, talcum, lactose, magnesium stearate, etc. since the patient had been taking many other tablets over a long period of time without difficulty. Rattner and Graffin (3) stated that they had seen three cases of dermatitis due to pyribenzamine and reported one severe instance in detail. This patient was able to tolerate benadryl and antistine without difficulty. Levin, Kelly and Schwartz (4) in evaluating neo-antergan stated that of 41 patients with hay-fever treated with neo-antergan, 11 developed a dermatitis. Details were not given. Strauss (5) reported a positive patch test in a case of dermatitis due to application of Pyribenzamine ointment.

From the foregoing it is obvious that the antihistaminic agents can produce cutaneous complications. It is doubtful if this is as unusual as the literature would lead us to believe. The following case report is presented because to the best of my knowledge this is the first such case in three respects, (1) a dermatitis due to Trimeton, (2) a dermatitis due to the intravenous injection of Benadryl thereby establishing the fact that none of the extraneous matter in the capsule caused the eruption in this case and (3) a positive skin test was obtained to an antihistaminic drug.

**REPORT OF CASE**

Mrs. L. H. L., 36 year-old, white, registered nurse, was referred to me on July 12, 1948 by Dr. Benjamin Woro of Antioch, California. The patient stated that for the past three years she had suffered with an eruption of her vulva and anal area that recurred each year. In 1947, she had taken Benadryl by mouth without difficulty. Her eruption had recurred about July 1, 1948. On July 6, Trimeton was prescribed for the dermatitis and the following day an eruption developed on her neck. On July 9, the Trimeton was discontinued and an intravenous injection of Benadryl was administered. Within one hour, a generalized eruption appeared. This was described as being "urticarial". On the following day this
developed into a severe pruritic, excoriated, coalescent, erythematous, maculopapular eruption. This dermatitis required about six weeks of local and x-ray therapy before clearing.

Patch and scratch tests were performed on August 6, 1948 with the following substances: Benadryl (capsule,) Pyribenzamine hydrochloride (tablet, 2% ointment and elixir,) Thenylene hydrochloride (tablet,) Trimeton (tablet,) Antistine hydrochloride (½% ophthalmic solution,) Hydryllin (tablets,) Neohetraniine (tablets,) Diatrin hydrochloride (tablets,) Neoantergan (tablets,) Histadyl hydrochloride (capsule, 2% ointment,) Decapryn succinate (tablet,) Thephorin (tablet,) Aminophyllin (solution) and Theamin (solution.) All tests were negative except for a sharply demarcated area of erythema and edema due to the Trimeton patch test. The performance of these tests was followed by an exacerbation of the eruption on the following day.

DISCUSSION

Eruptions due to antihistaminic agents usually appear six to twelve hours after ingestion of the exciting agent. There may be incubation period or the dermatitis may appear after the ingestion of the first dose. The eruption is usually generalized and explosive. The lesions may resemble any of the acute drug eruptions or commonly, may be eczematoid. Skin tests are of little value in these cases. The history of a dermatitis occurring within 12 hours after the introduction of one of these agents is very suggestive that the antihistaminic is the cause of this complication. Apparently, such dermatoses can be reproduced at will. Testing by re-administering the drug is justifiable in mild dermatoses only, certainly not in the here-in case.

The fact that the antihistaminic drugs can produce dermatitis medicamentosa and eczematoid eruptions makes one speculate whether histamine is really the cause of such cutaneous manifestations. The limited value of this group of therapeutic agents in most drug eruptions and in all types of eczema further strengthens this feeling.

SUMMARY

The development of an eruption on the neck due to Trimeton is described.
The eruption became explosively generalized after an intravenous injection of Benadryl.
Dermatoses due to antihistaminic agents are reviewed.

REFERENCES

3. **RATTNER,** HERBERT AND **GRAFFIN,** JACK: Dermatitis due to Pyribenzamine, American Praction. 2: 754 (July) 1948.