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Trazodone Induced Pruritus and Transient Skin Rash

Muhammed Emin Boylu[1]*, Onur Yılmaz[2]

[1] Council of Forensic Medicine, Psychiatry Department İstanbul, Turkey
[2] Doğuş University, Faculty of Psychology, İstanbul, Turkey

Address for correspondence: Muhammed Emin Boylu*, Fevzi Çakmak Mahallesi Sanayi, Caddesi Kımız Sokak No:1. Bahçelievler/İSTANBUL 34196. Email: me.boylu@hotmail.com

INTRODUCTION

Trazodone is a multifunctional drug with dose-dependent pharmacological effects. It has hypnotic effects at low doses due to 5-HT2A receptor blockade, H1 histamine receptor antagonism and blockade of α1 adrenergic receptors. At higher doses it causes serotonin transporter receptor (SERT) blockade and its antidepressant efficacy depends on this. Although trazodone has traditionally been used as a low-dose hypnotic, it can also be used as a multifunctional antidepressant at higher doses (1).

The most common side effects are nausea, vomiting, oedema, blurred vision, headache, dizziness, constipation, hypotension and dry mouth and may rarely cause priapism and seizures (2). One case study found that a skin rash may occur as a consequence of a drug reaction linked to low-dose trazodone (3). In addition, previous studies have reported that a generalized bullous fixed eruption, thought to be associated with trazodone, was observed in a patient with a history of demyelinating inflammatory polyneuropathy (4).

In our case report, it was observed that a patient who had not been admitted to a psychiatry outpatient clinic (*Bezmialem Vakıf University Hospital in Turkiye*) before but who used psychiatric drugs while being followed up in neurology had a skin rash after trazodone treatment and the existing rash regressed after the drug was discontinued. A 51-year-old male patient was admitted to the psychiatry outpatient clinic with the complaint of difficulty falling asleep. It was learned that he had been followed up for 7 years with various antidepressant drugs by the neurology outpatient clinic. The first presentation to the neurology outpatient clinic 7 years ago was bifrontal throbbing pain and escitalopram 10 mg/day was prescribed. Afterward, escitalopram was increased to 20 mg/day, and then sertraline was switched to 50 mg/day. In this period, it was learned that mirtazapine 15 mg/day was added to the treatment 3 years ago due to difficulty in falling asleep. It is known that the patient does not have any additional diseases. The patient applied to us for a prescription for the continuation of sertraline 50 mg/day and mirtazapine 15 mg/day treatment since the drug treatment was over. Although there was a significant regression in sleep-related complaints after starting mirtazapine, the patient did not want to continue the medication due to a slight weight gain, and his treatment was changed to sertraline 50 mg/day and trazodone 50 mg/day. The patient started to use the medication the next day and developed rash and itching in various parts of his body. It was learned that the patient continued to use this treatment for three days and discontinued the treatment on his own decision due to the persistence of itching and rashes. One week after stopping the drug, the patient came to the follow-up visit and stated that his pruritus continued to decrease and non-pigmented rashes in the form of mild redness, which were common on the arms and legs, disappeared. All values including RBC,

HCT, WBC, PLT, MPV, eosinophil count and percent, CRP, ferritin were within normal range. There was no rash or redness after the patient stopped trazodone. Pruritus, which was present, was observed to have decreased and disappeared. The last treatment was organized as sertraline 50 mg/day and mirtazapine 15 mg/day by joint decision with the patient.

If we evaluate the skin rash that occurred with the use of trazodone in our case, within the Naranjo Adverse Drug Reactions Measurement Scale (5), Our case, who got 6 points on the Naranjo Adverse Drug Reaction Measurement Scale, was evaluated in the probable-possible category. Naranjo ADRS score presents in Table 1.

While there have been reports of skin rash occurring due to the use of trazodone in the literature, there is a dearth of case reports on this particular topic (6,7). Our objective is to enhance the existing literature by reporting this unfavorable drug reaction.

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Tablo 1. Naranjo Adverse Drug Reaction Scale

Number	Question	Yes	No	Do not Know	Score
1	Are there previous conclusive reports on this reaction?	+1	0	0	+1
2	Did the Adverse event appear after the suspected drug was administered?	+2	-1	0	+2
3	Did the adverse event improve when the drug was discontinued or a specific antagonist was administered?	+1	0	0	+1
4	Did the adverse event reappear when the drug was readministered?	+2	-1	0	0
5	Are there alternative causes that could on their own have caused the reaction?	-1	+2	0	+2
6	Did the reaction reappear when a placebo was given?	-1	+1	0	0
7	Was the drug detected in blood or other fluids in concentrations known to be toxic?	+1	0	0	0
8	Was the reaction more severe when the dose was increased or less severe when the dose was decreased?	+1	0	0	0
9	Did the patient have a similar reaction to the same or similar drugs in any previous exposure?	+1	0	0	0
10	Was the adverse event confirmed by any objective evidence?	+1	0	0	0
Total Score					+6

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