Erythema Multiforme
Sorafenib-Induced Eruption Mimicking Erythema Multiforme

Sorafenib tosylate is an orally administered small-molecule multikinase inhibitor that targets vascular endothelial growth factor receptors (VEGFR)-2 and -3, platelet-derived growth factor receptor (PDGFR), rearranged during transfection (RET), FMS-like tyrosine kinase 3 (FLT3), c-KIT, and C- and B-Raf. This drug is approved by the US Food and Drug Administration for the treatment of advanced renal cell carcinoma, unresectable hepatocellular carcinoma, and radioactive iodine–resistant, advanced, differentiated thyroid carcinoma. Cutaneous adverse effects of this drug affect up to 91% of patients. Commonly reported eruptions include nonspecific rash and hand-foot skin reactions, which can be dose-limiting toxic reactions. Erythema multiforme (EM) has also been described.3-6

Report of a Case | A man in his 70s was enrolled in a clinical trial of sorafenib for patients with metastatic androgen-independent prostate cancer. He had a remote history of genital, but not oral, mucositis and simplex virus infection. His baseline dermatologic examination was unremarkable. Ten days after initiation of sorafenib therapy, 400 mg twice a day, the patient developed no adverse events. The eruption first appeared on the trunk. He complained of fatigue but had no other systemic symptoms. Sorafenib treatment was withheld. Histologic examination of a punch biopsy specimen demonstrated a mild superficial perivascular and periadnexal lymphohistiocytic infiltrate with numerous eosinophils.

Two days later, the patient returned to the clinic with progression of the eruption. Numerous targetoid lesions with dusky centers, surrounding white rings, and peripheral erythematous rings were present on the trunk (Figure 1) and extremities. Several lesions had pseudovesicles or vesicles centrally. His oral mucosa showed several pinpoint white papules with an erythematous base without evidence of erosions. He denied systemic symptoms. Test results were positive for serum herpes simplex virus-2 IgG and negative for IgM.

Additional Contributions: We are indebted to our consultant pathologist, Nicholas Francis, FRCPath, Imperial College Healthcare NHS Trust, Charing Cross Hospital, London, England; our consultant urologist, Michael Dinneen, MD, FRCSI, Chelsea and Westminster Hospital, London, England; and our consultant dermatopathologist, Florence Derodie, FRCPath, Royal Free Hospital, London, England. We are also grateful to our colleagues at various health care centers for bringing these patients to our attention and providing knowledge and expertise in the individual cases. These persons were not compensated for their contributions.

Conflict of Interest Disclosures: Drs Turnbull, Shim, Patel, Mazzaon, and Bunker have served as consultants to Chelsea and Westminster Hospital NHS Foundation Trust and East and North Hertfordshire NHS Trust. Dr Turnbull is employed by the Waitemata District Health Board, New Zealand.

Funding/Support: This study was supported in part by the National Health Service (NHS) in that patients were seen in the public sector.

Role of the Funder/Sponsor: The NHS had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

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and sorafenib therapy was restarted without further sequelae. Unlike other cases reported in the literature, the patient described herein and the one described by Bilaç et al had clinically EM-like eruptions with targetoid lesions, nondiagnostic histopathologic findings, and successful reinitiation of sorafenib treatment. Thus, we recommend biopsy of targetoid eruptions during sorafenib therapy to differentiate between a diagnosis of EM and EM-like sorafenib reaction to minimize discontinuation of an antineoplastic agent shown to prolong progression-free survival.

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Conflict of Interest Disclosures: None reported.

Funding/Support: This study was supported by the Intramural Research Program of the National Institutes of Health, Center for Cancer Research, National Cancer Institute.

Role of the Funder/Sponsor: The funding institutions had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Additional Contributions: The authors would like to acknowledge Edward W. Cowen, MD, MHSc, and Mark C. Udey, MD, PhD, for helpful comments regarding this article.


BRAF Inhibition in a Lung Transplant Recipient With Metastatic Melanoma

New treatment options like the BRAF inhibitors have been established for immunocompetent patients with metastatic melanoma, but experience in organ transplant recipients is lacking.

Report of a Case | A female double lung transplant recipient in her 60s with a standard triple immunosuppressive regimen (cyclosporine, mycophenolate mofetil, prednisolone) and chronic lung allograft dysfunction was diagnosed with metastatic melanoma and pulmonary (Figure 1A), mediastinal, hepatic, osseous, subcutaneous, and cerebral metastases (Figure 2A). A primary tumor could not be detected, and tumor cells harbored