

**Scribing (Seeme)**  
**CC:** 78 y old M with worsening of whole body rash with mucosal involvement and SOB  
**HPI:** 7 months ago the patient experienced worsening psoriasis on the dorsal aspects of both feet following immunotherapy, which was believed to be the trigger, leading his oncologist to stop immunotherapy subsequently. In December 2024, he developed a pulmonary embolism and was started on apixaban. He was doing well with improvement of psoriasis and no symptoms secondary to the PE, until three weeks ago, when he noticed progressive spreading of red macular lesions, erythema with skin pain and oral ulcers, that began in bilateral legs, until reaching the torso and oral mucosa. He was evaluated by dermatology and a skin biopsy at that time revealed chronic interface dermatitis with hyperkeratosis and spongiosis, concerning for a drug eruption. He was started on prednisone 40 mg daily and topical triamcinolone. At the same time multiple medications (allopurinol, colchicine, tamulosin, Eliquis, and Bactrim) were recommended to be stopped by dermatology. He reconsulted again, the ED exam noted worsening or stable skin erythema compared to earlier photos, with continued oral ulcerations but no systemic symptoms (e.g., no fever, conjunctival injection, hematuria, hematochezia, or eye pain). Due to not improving in the prednisone 40mg, dermatology recommended to do 60mg and do triamcinolone wet wraps. He never went up on the medications. He had SOB and was given pentamidine this morning and was using home inhalers. Started on BIPAP and IM epi was not improving.

**PMH:**  
 Psoriasis, atopy,  
 Lung cancer  
 DM, HTN, CAD with stents (20 y ago), COPD,  
 HFrEF, Peripheral neuropathy, BPH  
**Med:**  
 Stelara  
 Gabapentin  
 Ramipril  
 Metformin  
 Radiation, pentamidine  
 Apixaban, inhalers  
 Chemo, nivolumab, prednisone (3 weeks)

**Fam Hx:**  
 Not significant  
**Social Hx:**  
 Not significant  
**Health-Related Behaviors:**  
 smoking  
**Allergies:** NKDA

**Vitals:** T: BP: 140/70 HR: 110 RR: 26 Sat: 91 BMI: nl  
**Exam:** Gen: nl  
 HEENT: nl CV: nl  
**Pulm:** wheezing throughout lungs  
**Abd:** nl; **Neuro:** nl  
**MSK:** diffuse macular erythema with red lesions over the torso, arms and bilateral dorsum of feet with scaling and tenderness, small ulcers in roof of mouth



**Notable Labs & Imaging:**  
**Hematology:**  
 WBC: 18k leukocytosis (neutrophilic predominance) Hgb: nl  
 Plt: nl MCV: nl  
**Chemistry**  
 Na: nl K: nl Cr: nl BUN: nl Ca: nl Ph: nl Mg: nl Glu: nl Cl: nl  
 HCO3: nl AG: nl ph: 7.35 HCO3: nl  
**Imaging:**  
 EKG:  
 CXR:  
 Dermatology was consulted again and biopsy was done.

Biopsy results: spongiosis and hyperkeratosis- suggestive of drug reaction  
**Dx :** Pentamidine related bronchospasm

**Problem Representation:** 78 y old M PMHx of lung cancer on immunotherapy, psoriasis and multiple comorbidities presenting with fever, tachycardia, wheezing and a diffuse erythematous rash with mucosal ulcers following recent drug exposure.

**Teaching Points (Anmolpreet):**  
**I] Rash:** History and exam → important to know-length and depth of rash; blanching/non-blanching; time-course; External issue vs Internal issue (systemic)- generally a more diffuse rash indicates a systemic involvement rather than a local external reaction to an allergen.  
 DDx categories:- Infections (in an immunocompromised host), Autoimmune; Get stat vitals!  
 Look for *alarm features*-painful, quick spread, hemodynamics, fever  
**Mucocutaneous involvement:** Stevens Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN) are no-miss causes → expected a hyperacute course.  
 R/O drug reactions: Allopurinol can potentially lead to SJS. (Pentamidine too)  
**DDx:** Immunotherapy adverse effect, Paraneoplastic pemphigus vulgaris, Mucous membrane pemphigoid, VEXAS, Castleman's disease, Paraproteinemia associated disorders, IBD  
**II] SOB:** issues with oxygenation, CO2, anemia; dyspnea pyramid-heart, lungs, blood (anemia, acid-base disorders); Broad DDx: ++cardiovascular risk factors; COPD; PJP 2/2 immunocompromise  
**III] Psoriasis:** imp. how it was diagnosed and if it is truly psoriasis.  
**IV] COPD:** important how it was diagnosed and if it is truly COPD.  
**V] Wheeze:** anaphylaxis (bronchoconstriction), COPD exacerbation  
**VI] Erythroderma:** generalized redness and scaling involving >90% of body surface area → life-threatening; could have pre-existing skin conditions like psoriasis and even drug reactions.