Fatal vasculitis associated with ofloxacin

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Vasculitis is an adverse effect of numerous drugs. We report on a man who developed vasculitis and died after taking ofloxacin for a chest infection.

Case report

A 75 year old man was treated with bumetanide and spironolactone for cardiac failure. Two weeks later he was given ofloxacin 200 mg twice daily for five days for apparent bronchitis. Several haemorrhagic bullae and palpable purpuric rash developed on the feet and hands (figure). He was mildly jaundiced, and his liver was palpable 2 cm below the costal margin. Full blood count, differential white cell count, and results of coagulation studies were normal. A test for antinuclear factor yielded negative results. Microscopy of urine showed numerous red cells, and analysis showed a trace of protein. The plasma concentration of urea was 56 4 mmol/l, creatinine 400 mmol/l, and bilirubin 43 mmol/l; y-glutamyltransferase activity was 65 U/l and alanine transferase activity 56 U/l.

Twenty four hours later massive melaena with haematuria occurred. Haemorrhages were evident on the palate. Gastroscopy showed a bleeding prepyloric ulcer and nodular haemorrhagic lesions similar to those that had developed in the skin. Temporary improvement occurred with intensive care, but the patient died after a second massive gastrointestinal haemorrhage a few days later.

Haemorrhagic bullae on erythematous base

Problems in setting standards for hospital referrals: experience with warts

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After the publication of an article entitled ‘‘Dermatologists should not be concerned in routine treatment of warts’’ we sent a questionnaire to dermatologists to determine whether this was a generally accepted view. We report our results, which show some of the difficulties in defining standards for hospital referrals.

Methods and results

We sent a questionnaire to 144 randomly selected consultant dermatologists in England and Wales; 131 replies were received (92%). Once general practitioners were sure about the diagnosis of warts 46 dermatologists agreed that they should be able to refer any patient they wanted; 43 that they should be able to refer patients with multiple warts; 33 that they should be able to refer patients with single plantar warts; and 93 that they should be able to refer patients with warts resistant to three months’ topical treatment. Fifty six, 52, 59, and 17 respectively, however, disagreed that general practitioners should be able to refer under these conditions. Although several dermatologists did not fill in this part of the questionnaire, only three replied ‘‘don’t know’’ to these questions. A similar divergence of views was seen in the response to a general question about the appropriateness of a hospital based service for treating warts (table).

Wide ranging views were expressed in additional comments or letters, several of which were very detailed. Some consultants argued that warts were far from trivial and that wart clinics offer a valuable


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