

Case Report

Pentazocine induced ulcers: a presentation of drug abuse

N Shah, R Paudel

Department of Dermatology & Venereology
BP Koirala Institute of Health Sciences, Dharan

Introduction

Pentazocine is an opioid analgesic introduced in 1967 which was purported to have no addictive potential. However, in the subsequent years, several reports have shown it to have abuse potential and cutaneous complications of pentazocine abuse have been reported.¹

We report a case of cutaneous complications of pentazocine abuse in a 32-year-old male presenting with multiple ulcers.

At the site of injection, there was itching, followed by formation of a nodule which would burst leading to thin serous yellow discharge with formation of ulcer in one to two weeks. The ulcers healed in a few weeks leaving hyperpigmented scars. Patient had been abstinent for 15 days at presentation following which he developed irritability, loss of appetite, disturbed sleep, low confidence and one episode of suicidal ideation. He was treated for deep

Case report

A 32 years old male restaurateur presented with the complaints of multiple ulcers over lower extremities for the last two years. He admitted to abusing a variety of drugs including pentazocine. He self-administered pentazocine injections over upper and lower extremities on a daily basis, intravenous as well as subcutaneous, usually in combination with buprenorphine, phenargan and diazepam for the last 5 years.

vein thrombosis due to the intravenous injections one year back.

On examination, there were multiple ulcers irregularly shaped, of varying size, with indurated hyperpigmented margins, oozing of serous fluid from some of the ulcers along with multiple hypopigmented/hyperpigmented macules and plaques symmetrically distributed over the thighs and legs at the sites of previous ulcers. In addition, there was a background of

Address for correspondence

Dr. Nidhi Shah
Department of Dermatology & Venereology
BP Koirala Institute of Health Sciences, Dharan
Email: nidhishah.md@gmail.com

ill-defined hyper-pigmentation with thickened skin distributed symmetrically over both legs (Fig 1). The patient was admitted, managed conservatively for ulcers and counseled regarding drug abuse.

The patient was motivated to overcome the addiction, hence a psychiatric consultation was sought and the patient was started on mirtazapine and zolpidem.



Figure 1: Multiple Ulcers and hyper-pigmented scars on lower extremities

His serology was negative for hepatitis B, C and HIV. Venous Doppler of the lower Limbs showed mild diffuse thickening of wall of distal part of left common femoral vein, the proximal part of superficial femoral vein and sapheno-femoral junctions with slight luminal narrowing possibly a sequel of previous thrombosis or thrombophlebitis and mild cellulitis around both legs.

Discussion:

The exact pathogenesis of cutaneous complications of pentazocine is not known. It has been suggested that if not rapidly absorbed, pentazocine may get precipitated, which may then initiate a chronic inflammatory response.² Clinical presentations may vary and include ulcers, sinus, nodules, puffy hand syndrome, thrombophlebitis, hyper-pigmentation and

induration of skin or scars along veins.³ Awareness of the complications of pentazocine and a forthcoming history of use of pentazocine will not pose much diagnostic difficulty. In our patient, the history was known and ulcers developed at the sites of injections, hence the diagnosis was not difficult. However, in cases where the patient is holding back the history, the ulcers may be misdiagnosed as vasculitis, panniculitis, pyoderma gangrenosum or cutaneous tuberculosis. Institution of treatment for these conditions may actually result in more harm, as for all the above conditions except tuberculosis, immunosuppressive treatments are used. Hence, the diagnosis in such cases requires high index of suspicion and exclusion of other commoner causes of leg ulcers such as vasculitis, pyoderma gangrenosum or cutaneous tuberculosis. Investigations to establish the presence of pentazocine in urine are very useful in making the diagnosis, but their limited availability is a disadvantage.¹

References:

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