AUTHORS' REPLY

Dear Sir,

We would like to first thank Drs Lim and Teng for their interest in our article and for their comments.[1] Our study was a retrospective case series based on our experience in managing these patients.[2] Allopurinol is a widely-prescribed, efficacious and cost-effective urate-lowering drug and will likely remain the treatment of choice for gout. The majority of patients prescribed with allopurinol do not experience any adverse effects, while a minority (2%) may experience mild cutaneous reactions, and rarely (0.4%) do patients experience severe life-threatening cutaneous adverse drug reactions. Although we did not have a denominator in our study, it is likely to be large, in view of its widespread use.

Nonetheless, looking from the point of severe cutaneous adverse drug reactions (SCARs), such as Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN), allopurinol remains the most common putative drug in Europe, Israel, Taiwan[3] and also in Singapore.[4] Moreover, the incidence of allopurinol-associated SJS or TEN has also increased largely due to its increasing use.[3]

The aim of our study and recommendations was not to discourage the use of allopurinol, but to encourage the rational prescription of the drug, particularly in relation to the indications, as well as to highlight the morbidity associated with allopurinol hypersensitivity and the need for monitoring when the drug is initiated.

While we acknowledge the paucity of data in older literature with regard to the dosage and risk of SJS and TEN, recent data from the EuroSCAR workgroup (a multinational case-control surveillance of severe cutaneous adverse drug reactions) has shown that the use of 200 mg or more of allopurinol daily was associated with a higher risk of SJS or TEN (adjusted odds ratio (OR) 36, 95% confidence interval (CI) 17–76), compared with lower daily doses (adjusted OR 3.0, 95% CI 1.1–8.4), after having adjusted for gender, age, drug exposure and other non-drug risk factors. Stratified analyses were also performed for co-medications, and it showed that co-medications with diuretics did not increase the risk for SJS/TEN.[5]

Our recommendation for two months of monitoring following drug initiation is purely for SCARs. This has been the observed latency prior to the onset of SCARs, based on various multinational surveillance epidemiological studies.[5,6] We agree that continued surveillance is needed for other forms of drug toxicity and adverse reactions, particularly when there are changes in drug dosages, a potential for drug interactions as well as the presence of medical comorbidities.

Indeed, allopurinol is a necessary "evil", but the onus is on us to balance the risks and benefits in order to minimise exposure to this "evil", particularly when it is not indicated. We thank the authors for sharing their views and management approach, as well as to the editor for allowing us to clarify our views.

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