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Lamotrigine-Induced Rash and Facial Swelling in a 27-Year-Old Female: A Case Report

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Abstract

Lamotrigine, a widely used antiepileptic and mood stabilizer, is associated with a risk of dermatologic hypersensitivity reactions, which can range from mild rashes to severe cutaneous adverse reactions. We report the case of a 27-year-old female with recurrent depressive disorder who developed widespread rash and facial swelling following initiation of Lamonex SR (lamotrigine) 100 mg once daily without titration. Prompt recognition and discontinuation of the drug led to complete resolution of symptoms. This case highlights the importance of careful titration and early monitoring when initiating lamotrigine.

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Introduction

Lamotrigine is an antiepileptic drug commonly prescribed as a mood stabilizer in bipolar disorder and, less frequently, as an augmenting agent in treatment-resistant depression.

While effective, it carries a well-documented risk of dermatologic hypersensitivity reactions, which occur in up to 10% of patients, most frequently within the first two to eight weeks of therapy [1,2]. These rashes range from benign eruptions to potentially life-threatening conditions such as Stevens–Johnson Syndrome (SJS) and Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS).

The risk of rash is strongly influenced by dose and titration schedule. Since the introduction of a gradual dose-escalation regimen in 1994, the incidence of

severe rashes has declined significantly from approximately 1% to 0.1–0.01% [3]. However, benign rashes remain common, with a reported frequency between 8–11% [4]. Facial swelling is less frequently described but may represent an early warning sign of systemic hypersensitivity.

Here, we describe a case of lamotrigine-induced rash and facial edema in a young female with recurrent depressive disorder, occurring within the early phase of treatment and associated with initiation at a non-titrated dose.

Case Presentation

A 27-year-old married female, mother of two children, presented with persistent low mood. The patient described her mood as persistently low, with a sense of sadness and heaviness present throughout the day. She reported frequent tearfulness, feelings of hopelessness and helplessness, and expressed that her emotional state remained unchanged even when circumstances improved. She also described increased irritability leading to difficulty concentrating on household tasks. This was accompanied by excessive worry about daily responsibilities and her children's well-being, along with somatic tension such as palpitations and muscle tightness. These symptoms often worsened at night, interfering with her ability to fall asleep., disturbed sleep, inner restlessness ("uljhan"), anhedonia. She described difficulty deriving pleasure from previously enjoyable activities, fatigue, and decreased motivation. She described herself as emotionally numb, stating that even positive events failed to lift her mood. This led to social withdrawal, reluctance to participate in family gatherings, and feelings of guilt for not being able to engage with her family., and pervasive negative thoughts. She endorsed persistent negative thoughts about herself and her abilities. She described feeling like a burden to her family, with reduced self-confidence and worthlessness. She worried excessively about her inability to function as a good mother and wife, despite reassurances from her family. No suicidal thoughts or intent were reported at the time of assessment. She described difficulty deriving pleasure from previously enjoyable activities, fatigue, and decreased motivation.

She had a known history of Recurrent Depressive Disorder (unipolar, ICD-10: F33), with two prior depressive episodes occurring approximately three and two years earlier, both of which responded to pharmacological treatment.

At presentation, she was receiving fluoxetine 40 mg once daily, desvenlafaxine 50 mg at bedtime, and clonazepam 0.5 mg twice daily. Considering her recurrent course and partial response to antidepressant therapy, lamotrigine (Lamonex SR) 100 mg once at bedtime was initiated as an augmenting agent.

She had no past or family history of mania, hypomania, psychosis, substance use, or comorbid medical illness. Family history was non-contributory.

On the 10th day of lamotrigine therapy, she developed facial flushing, puffiness, and widespread erythematous, non-blanchable, maculopapular rashes involving bilateral upper limbs, trunk and back. The lesions were pruritic in nature. There was no mucosal involvement, lymphadenopathy, systemic symptoms, or features of anaphylaxis.

Mental status examination revealed a cooperative and appropriately dressed patient, with low and anxious mood and restricted affect. Thought content was characterized by negative cognitions without delusions or hallucinations. Speech was normal in rate and tone. Cognitive functions were intact, with preserved orientation and memory. Insight and judgment were intact.

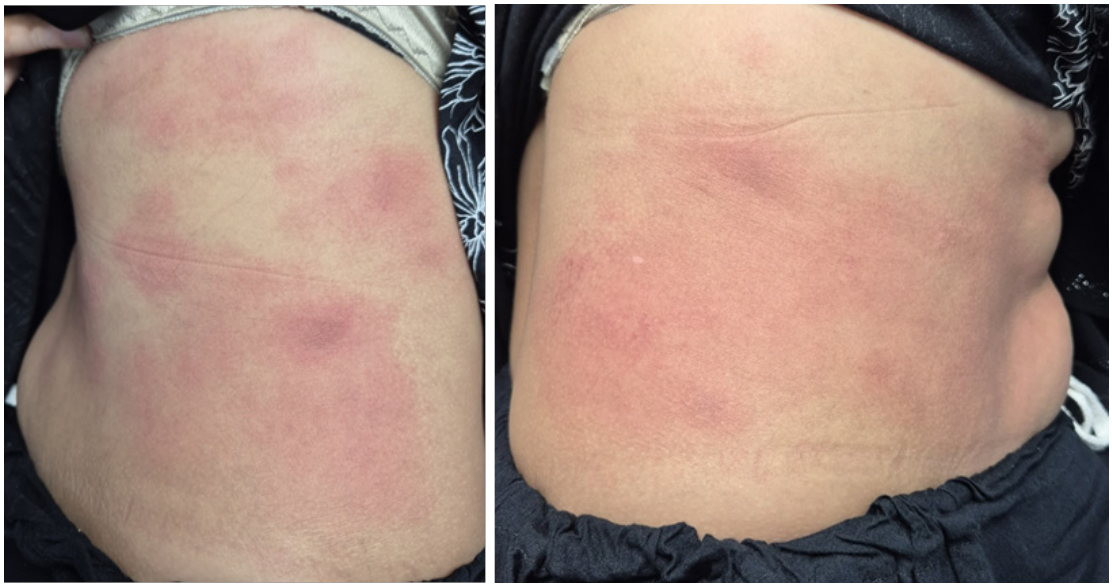

Figure 1: Non-Blanchable Erythematous Maculopapular Rash Present on Left and Right Sides of the Trunk.

Examination

Non-blanchable erythematous maculopapular rash on bilateral extremities trunk and back; mild facial puffiness; no airway compromise or angioedema. Systemic examination was normal.

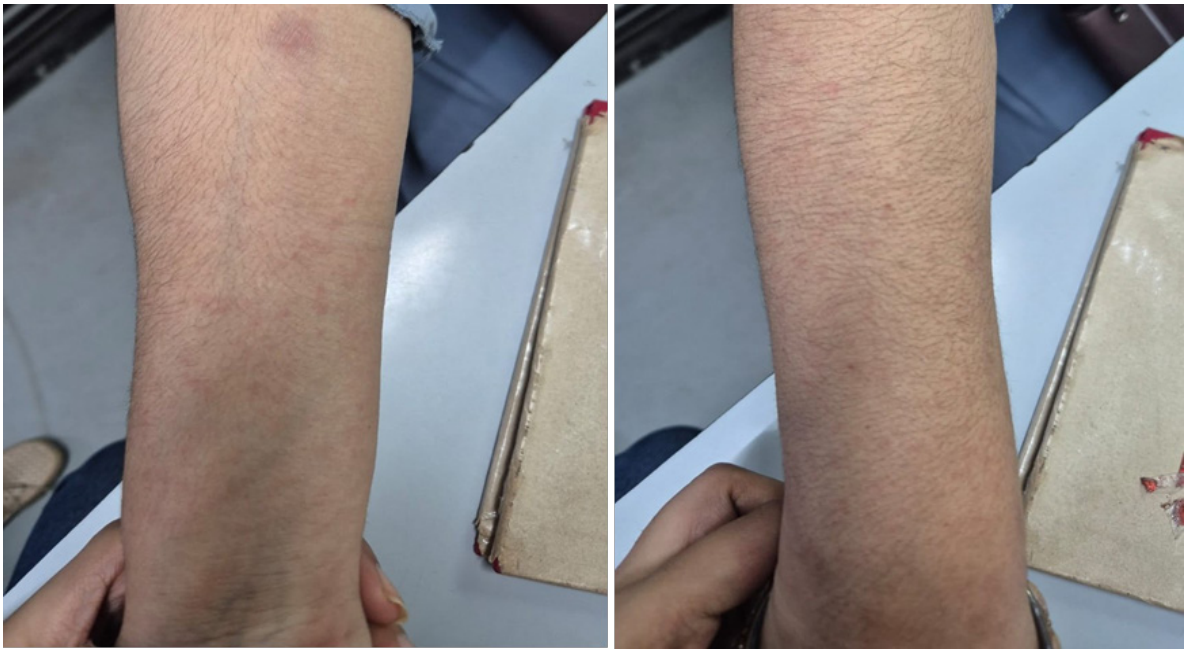

Figure 2: Presence Of Non-Blanchable Erythematous Maculopapular Rash on the Dorsal and Ventral Sides of the Right Hand.

Investigations: Complete blood count, liver, and renal function tests were within normal limits. No eosinophilia was detected.

Management and Outcome: Lamotrigine was immediately discontinued. She was managed with oral levocetirizine 5 mg once daily, topical emollients, and cold compresses. The patient was closely monitored for systemic features or mucosal involvement. Over the next 5–7 days, her rash and facial swelling gradually resolved, with no progression to severe cutaneous adverse reaction.

Discussion

This case illustrates a lamotrigine-induced hypersensitivity reaction presenting with rash and facial swelling within the first two weeks of therapy. The timing and clinical features are consistent with previously reported cutaneous adverse effects of lamotrigine [1,2].

Importantly, the patient was started directly on 100 mg once daily without titration, which likely precipitated the reaction. Current guidelines emphasize a slow dose-escalation schedule (starting at 25 mg once daily, increasing every 1–2 weeks) to minimize rash risk [3,4]. Concomitant use of valproic acid further increases risk, though this was not present in our case [2].

While the reaction in this patient remained limited to the skin and soft tissues, the presence of facial swelling is clinically significant, as it may herald progression to more severe systemic hypersensitivity. Prompt recognition, discontinuation of lamotrigine, and supportive management are essential to prevent complications.

This case underscores the importance of strict adherence to recommended titration schedules and close monitoring during the initial weeks of therapy, particularly in psychiatric populations where lamotrigine is increasingly used off-label as an augmenting agent.

Conclusion

Lamotrigine can cause hypersensitivity reactions ranging from mild rashes to severe cutaneous adverse reactions. In this case, rapid initiation at a non-titrated dose led to the development of rash and facial swelling within 10 days. Early identification and immediate discontinuation of lamotrigine resulted in complete recovery. This case highlights the critical importance of dose titration, patient education, and vigilance during the early treatment period.

Patient Consent

Verbal informed consent was obtained from the patient for publication of this case and associated clinical details

Conflict of Interest

None declared.

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