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Ulceration without Toxicity: A Case of Methotrexate Idiosyncrasy

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A 65-year-old male with chronic plaque psoriasis for 8 years, on methotrexate 15 mg/week for 3 months (cumulative 195 mg), presented with painful mucocutaneous erosions for 10–15 days, with fever, chills, malaise and cough. Examination showed haemorrhagic crusted erosions over psoriatic plaques on the abdomen, gluteal region, lower limbs and perianal area. Oral cavity examination revealed glossitis, whitish slough on buccal mucosa and superficial lip erosions [Figure 1]. Investigations revealed leucopenia, thrombocytopenia, hypoalbuminaemia and left lower lobe consolidation on chest imaging. Serum methotrexate level (<0.04 µmol/L, 8 days

Figure 1: Cutaneous examination showed haemorrhagic crusted erosions over psoriatic plaques on the (a) gluteal region, lower limbs and perianal area, and (b) abdomen. Oral cavity examination revealed (c) glossitis, whitish slough on buccal mucosa and (d) superficial lip erosions.

post-dose) was low, with normal renal and liver functions. A diagnosis of methotrexate-induced mucocutaneous ulcerations was made. Methotrexate was stopped, and the patient received oral folinic acid (15 mg Quater in die/four times a day [QID] for 7 days), followed by folic acid, protein supplementation, wound care and supportive oral care, with gradual recovery.

Mucocutaneous ulceration may indicate methotrexate toxicity even at therapeutic doses, requiring early recognition and folinic acid rescue.[1,2]

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