Background: Fixed drug eruption (FDE) is a cutaneous adverse drug reaction characterized by erythematous or bullous lesions that heal with hyperpigmentation and typically recur in the same location with drug intake. Non-steroid anti-inflammatory drugs are the most frequent cause of FDE, followed by antibiotics.

Observation: A 54-year-old caucasian female with a history of 3 blistering outbreaks within the last 4 months presented to the consultation with a two-day evolution dermatosis characterized by tense, clear bulla located in the oral mucosa and perioral area, associated with reactivation of previously existing violet patches with tense blisters in the center. She reported taking sporadically: betahistine, bilastin, brotizolam, cyclobenzaprine chlorhydrate and ibuprofen. After asking several times, she admitted to have taken etoricoxib 3 days before for joint pain.

Cutaneous biopsies for histopathology and immunofluorescence were made and were consistent with the hypotheses of fixed drug eruption. She was submitted to patch testing with the Portuguese baseline series and personal medication in lesional and non-lesional skin (ibuprofen, cyclobenzaprine chlorhydrate, betahistine, brotizolam, bilastin and etoricoxib), as well as celecoxibe 10 % pet in lesional and non-lesional skin. Readings showed positivity for nickel and 2-hydroxyethyl methacrylate (past relevance), and positivity only in lesional skin for etoricoxib 10% pet, confirming the causative role of etoricoxib as the culprit drug.

Key message: Typical lesions, histopathology and patch testing confirmed the diagnosis of FDE induced by etoricoxib. This molecule is a cyclo-oxygenase 2 selective inhibitor, rarely described as the responsible drug in FDE. In etoricoxib-induced FDE usually it is safe to use other coxib with a different chemical structure, as we were able to demonstrate. Patch testing can be useful in the diagnosis of FDE, avoiding the need for oral provocation tests.