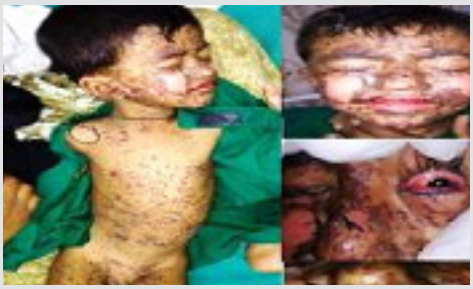

SKIN DISEASE

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Spot Diagnosis

Stevens-Johnson syndrome {SJS} is an immune-complex-mediated hypersensitivity disorder caused by drugs, viral infections, and malignancies {1}. The incidence is 1 to 6 cases per million people per years {2}. It is characterized by extensive necrosis and detachment of epidermis. Drugs particularly sulfonamides, NSAIDS, anticonvulsants are the common offenders {3}. After the drug exposure SJS clinically appears within 8 weeks {4 to 30 days}. The initial skin lesions are dusky erythematous macules which progressively coalesce on erythematous base. The lesions evolve to flaccid blisters and break easily. At pressure points the necrotic epidermis gets detachment exposing the red dermis. Nikolsky's sign will be positive. Usually epithelial detachment occurs for 5-7 days followed by re-epithelization. In 90 percent of the cases mucous membrane involement occurs and atleast two or more mucosal surfaces will be involved. {2}. In SJS pain from mucosal ulceration is severe and skin tenderness is absent in contrast to toxic epidermal necrolysis {TEN} {3}. Individual lesions typically should heal within 1-2 weeks, unless secondary infection occurs. The commonest complication is sepsis due to epithelial loss. The mortality rate for TEN is 30 percent and 5-12.5 percent for SJS {1-3}. Treatment is primarily supportive. Prompt withdrawal of the offending drug is very important. Fluid and electrolyte balance is the first priority, along with nutrition support. Some have advocated corticosteroids, cyclophosphamide, plasmapheresis, hemodialysis, and immunoglobulin. The use of steroids is still controversial {4-6}. However, the prevailing consensus seems to be that systemic glucocorticoids are justified in the early and evolving disease preferably within the first 72 hours of onset. {6}

REFERENCES

1} Parrillo SJ, Parrillo CV. Stevens-Johnson Syndrome. Available at website:www.emedicine.com. Updated: May 25, 2010
2} Valeyrie-Allanore L, Jaean-cLaude R. Epidermal Necrolysis. In: Wolff K, Goldsmith LA, Katz SI, Gilchrest BA, Paller AS, Leffell DJ {eds}. In: Fitzpatrick`s Dermatology in General Medicine. 7th edn. New York. Mc Graw Hill Medical. 2008: 349-354
3} Moreli JG. Vesicobullous disorders. In: Kliegman RM, Jenson HB, Behrman RE, Stanton BF {eds}. In: Nelson Text Book of Pediatrics. 18th edn. Philadelphia. W B Saunders. 2008: 2685-2688
4} Ginsburg CM. Stevens-Johnson syndrome in children. Pediatr Infect Dis. 1982; 1: 155-158
5} Cheriyan S, Patterson R, Greenberger PA, Grammer LC, Latall J. The outcome of Stevens-Johnson syndrome treated with corticosteroids. Allergy Proc. 1995; 16: 151-155
6} Sharma VK, Sethuraman G, Minz A. Stevens Johnson syndrome, toxic epidermal necrolysis and SJS-TEN overlap: a retrospective study of causative drugs and clinical outcome. Indian J Dermatol Venereol Leprol. 2008; 74: 238-240

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