"CASE OF TOXIC EPIDERMAL NECROLYSIS OR SCALDED SKIN SYNDROME"

by

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Toxic Epidermal Necrolysis of Lyell is a non-specific reaction pattern of the skin consisting of bullous lesions, erythema and positive Nikolosky sign. The bullae appear on the face, neck and other intertriginous areas. Shortly thereafter the epidermis over large areas of the body separates at a single plane of cleavage, detaching from the skin in large sheets, like wetpaper sliding of a wall. The disease can occur at all ages.

Scalded skin syndrome was first described Dr. Neff. He described a bullous eruption complicating measles with later typical features of scalded skin syndrome.

The causes of scalded skin syndrome are very many. They can be classified as:— 1. Infections: 2. Drugs.

INFECTIONS

Available information leads us to believe that some cases of scalded skin syndrome are due to group 2 staphylococci.

Other Bacteria: It is surprising that we have not yet found cases of scalded skin syndrome associated with streptococcus infection except for one reported case

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from which streptococcus viridans was obtained. Viruses: Attempts have been made to isolate viruses from lesions of the scalded skin syndrome. Dr. Neff described a patient who initially had symptoms comparaible with measles, as well as Koplikspots Since then a number of cases of Morbillibullosi or Masernpemphigoid have been described. We do not know if these patients developed scalded skin syndrome as a manifestation of measles or if they were rendered more susceptible to bacterial infection by measles. It is also possible that the erythema preceding their appearance of bullae was misinterpreted as measles.

DRUGS

Drugs implicated in these cases are: Penicillin, sulfamethoxypyridazine, sulfanilamide, phenolphthalein, aspirin, barbiturates and Sulfones. Boric Acid toxicity:— A large proportion of accidental poisoning with boric acid developed a typical erythema followed by desquamation. A man agen 40 years Ramaswamy, was admitted with a history of red rashes and blisters all over body. Four days prior to that he had taken pills for headache – 4 tablets of Asprin 5 grain each as one single dose as the headache was severe.

Previous History:— He had similar attacks previously when he had taken asprin. This time he noticed severe headache. On admission he looked ill, temperature was normal, pulse 75, respiration 20. On physical examination

erythematous lesions and bullae are seen over trunk and limbs. The mouth was free. In many places the bullae have ruptured leaving raw areas of skin. The erythematous lesions are noticed more on the flexor surfaces and the bullae and peeling skin in large shreds seen on the trunk.

Respiration and cardiovescular system showed no abnormailty. His abdomen was difficult to examine because of the painful bullae on the surface and large raw areas.

Investigation: Blood count WBC 9500, Dc P69, L22, E9, RBC 5 million, HB Tolquist 75%

Fluid from the bullae sent for culture was sterille. Treatment given: The bullae were snipped and all raw areas were treated with warm saline bath and applied with Burrows; solution. Internal: Prednisolone 25 mgm daily for 5 days then gradually reduced. Improvement was noticed within two days and maintained and he was discharged from the hospital in 10 days.

REFERENCES

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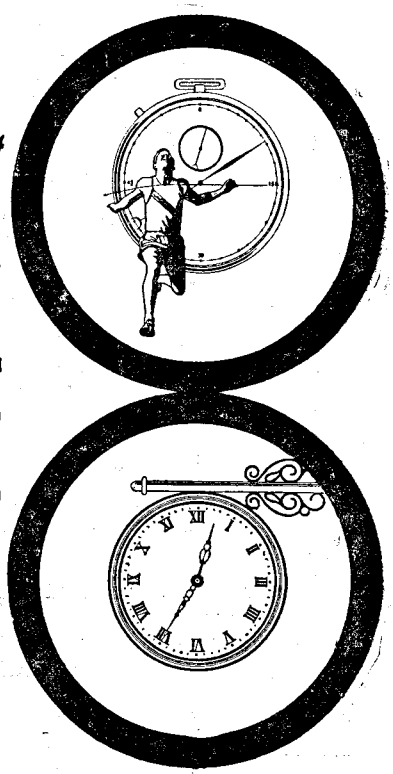
3 brothers

For rapid onset

HISTAPHENE

IN ALL ALLERGIC DISORDERS

and also for sustained effect



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