TOXIC EPIDERMAL NECROLYSIS

To the editor

Toxic epidermal necrolysis (TEN) is one of the serious conditions in dermatology. It can be fatal also at times. There is considerable controversy regarding the treatment of this condition, with some preferring steroids,[1] while the majority of the authors, not disposed favourably towards the use of this drug.[2-4] However we are of the opinion, that steroids administered judiciously and properly monitored can be of great use in treating this condition. We are

giving an example below.

A 12-year-old girl presented with generalized macular erythematous rash of 2 days duration. There were target lesions at places. There were also vesicular and bullous lesions in some places. Nikolsky's sign was positive. Oral mucosa was red and eroded. Conjunctiva was congested.

Patient was toxic and temperature was 101° F. There was no generalized lymphadenopathy dehydration or conspicuous hepatosplenomegaly.

Sensorium was normal, pulse 120/mt. and B.P. 90/60mm Hg. On interrogation we could get the history of sulpha intake for respiratory inflection, 2 days prior to the onset of the skin condition. On investigation there was nothing significant except W.B.C. count of 15000/cmm and E.S.R. of 22mm/Ist hour.

Taking all the factors into considerations, we made a diagnosis of TEN and initiated treatment. Patient was given for first seven days, injection dexamethasone 4mg, bid, inj. ampicillin 250mg bid, inj, gentamicin 40mg bid., and inj pheniramine maleate 22.5mg bid. all intramuscularly. She was also administered 5% dextrose saline 3 bottles (500ml each) for 7 days I.V. along with multivitamins. Local treatment consisted framycetin ointment application to skin, saline gargles and gentamicin eye drops. Two days after the initiation of treatment, there was generalized peeling of the skin and raw red areas were exposed on 90% of body surface. However patient became apyrexial and non toxic. After 7 days patient started taking oral fluids and re-epethelialization of skin started.

Following this we switched over to inj. cephataxime 250mg BD (I.M) in place of ampicillin and gentamicin, while the rest of the treatment remained as such.

After 12 days re-epithelialization of most of the body surface took place, and patient became almost normal. After this inj cephataxime was stopped and cortisone was tapered off.

Patient was discharged after 15 days, with an advice not to take any sulpha drugs in future. Subsequently patient did not have any recurrence and there were no complications.

We therefore feel that administration of steroids may play an important role in the treatment of TEN. In fact this is the third case of TEN, the senior author has treated with steroids and antibiotics and all of them recovered totally. However we do not recommend massive doses, or administration for prolonged periods. We prefer an optimum dose of 2mg of prednisolone or equivalent, per kg, of body weight I.M. to be tapered with the onset of amelioration. However we also feel, that denial of steroids to these patients altogether, will be detrimental.

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