

LETTERS TO THE EDITOR

STEVENS-JOHNSON SYNDROME TRANSFORMING INTO TOXIC EPIDERMAL NECROLYSIS

It has been written in a standard textbook of Dermatology¹ that there is a close overlap between Stevens-Johnson syndrome and toxic epidermal necrolysis. We observed a similar case recently. A 70-year-old woman was admitted with multiple erythematous macular lesions on her trunk and extremities, ulcerations in her mouth and conjunctivitis. She had taken metamizole (analgin) in the morning and noticed the eruption by night. There was no history of intake of any other drug. She was febrile with hemorrhagic crusts over lips and conjunctivitis; typical iris lesions on trunk, palms and soles and haemorrhagic bullae on the trunk. She was diagnosed as a case of Stevens-Johnson syndrome and given 80 mg of prednisolone per day. In the next four days her lesions increased and changed to large blotchy erythematous areas which peeled off (Fig. 1). It was now suggestive of toxic

epidermal necrolysis (TEN) and later evolved into widespread areas of necrolytic skin. By the 7th day, the clinical picture evolved into a typical case of TEN, with large sheets of peeling skin. Skin biopsy showed features of toxic epidermal necrolysis. Routine haematological investigations, urine and skiagram of the chest were normal.

This case represents transition of Stevens-Johnson syndrome into toxic epidermal necrolysis, which we have noticed in a few earlier cases also. We believe that these are part of a spectrum which extends from erythema multiforme to TEN through Stevens-Johnson syndrome and a severe case of Stevens-Johnson syndrome many a time resembles or changes into toxic epidermal necrolysis. Conversely, it is also possible that TEN in its early stages is misdiagnosed as Stevens-Johnson syndrome in these cases.

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References

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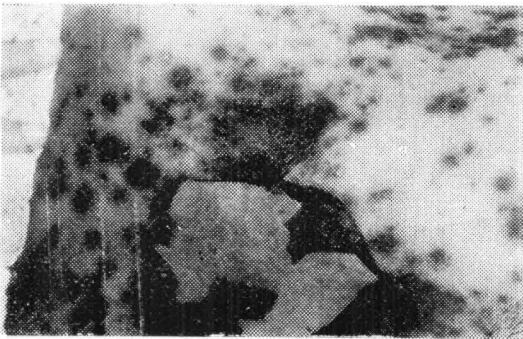


Fig. 1. Iris lesions and necrolytic skin lesions on the trunk.