International Journal of Medical Science and Clinical Invention 5(01): 3465-3466, 2018
DOI:10.18535/ijmsci/v5i1.19 **ICV 2016: 77.2**
e-ISSN:2348-991X, p-ISSN: 2454-9576

Case Report

Drug induced Stevens Johnsons Syndrome : a case report

Dr Gargi.H. Pathak, Dr Anuya Chauhan**, Dr Dhriti Shukla****

***Professor
**Assistant Professor
*3rd Year Resident

Department Of Paediatrics ,B . J. Medical College, Ahmedabad

Abstract : Stevens Johnson syndrome is an acute self limited disease presenting with severe mucosal erosions with widespread erythematous, cutaneous macules or atypical targets .The majority of cases are drug induced affecting oral and perioral region.

A 3 year old male child presented with chief complaints of fever, cough, cold , breathlessness and extensive rashes on the skin of face , oral mucosa, neck, abdomen, erythema of conjunctiva , ulceration of eyelid and oral cavity. The reaction was evoked after consumption of tab oxcarbamezapine since 10 days . He was treated with corticosteroids , antimicrobial drugs and oral topical anesthetic agents. Health care providers must be careful regarding the adverse effects of drugs especially the allergic manifestations like anaphylaxis and Steven Johnson syndrome which are potentially fatal conditions. The most commonly and widely prescribed drug regimens should also be used judiciously and continuously monitored to prevent such a fatal adverse drug reaction.

INTRODUCTION

Adverse drug reactions although rare , still remains a major threat to patient welfare. Steven Johnsons syndrome (SJS) is one such fatal drug reactions.

"A new eruptive fever with stomatitis and ophthalmia" was described as a variant of erythema multiforme and was termed by Steven and Johnson in 1922.

SJS is rare with an incidence of .05 to 2 persons per 1 million population per year . It has significant impact on public health in view of its high morbidity and mortality.

SJS is severe hypersensitive reaction that can be precipitated by infection, vaccination, drugs, foods, physical agents. Our case of Steven Johnson Syndrome was secondary to oxcarabamazepine therapy instituted for focal seizures which is commonly and widely used

A 3year old male child reported to emergency department of pediatric ward, civil hospital Ahmedabad with chief complaints of fever, breathlessness and extensive rashes all over body since 2 days

Patient was in altered sensorium with impending respiratory failure.

The past history of the patient revealed that he had episode of focal convulsion fever , cough and cold for which he had been prescribed tab oxcarbamezapine tab amoxi-clav,tab paracetamol for 5 days, before 10 days following which he developed such type of reaction.

The patient was in altered sensorium and on examination there was hyperpyrexia, generalized maculopapular and bullous eruptions on neck, face, ear. The trunk and extremities were having well developed variable, sized target like lesions.

Intraoral examination revealed ulcerations of vermilion surface of lips, labile mucosa , tongue, palate

Hemorrhagic crusted erosions were also seen on both the upper & lower lips.

The oral ulcerations had developed one day prior to development of skin lesions.

Ophthalmic examination showed acute conjunctivitis, hyphema and subconjuctival hemorrhages.

Based on this our clinical diagnosis was Steven Johnson syndrome as the lesion noticed

His complete blood picture revealed Hb 12gm/dl , raised ESR-52 mm/1st hour TC 14,000 cells/mm3, platelets count was 3.2lac/mm3

Oxcarbamazepine was withheld and we treated him under expert guidance of dermatologist with systemic steroids Inj dexamethasone and Benzydyamine hydrochloride 0.15 % oral rinse for oral ulcers.

Patient was given ventilatory support for respiratory distress, however the patient left against medical advice after 12 hrs of admission.

DISCUSSION

Steven-Jonhson Syndrome is severe, episodic, muco-cutaneous intolerance reaction described by Hebra 1866 & Albert Mason Stevens and Frank Chambliss Johnson in 1922. SJS presents with epidermal detachment of < 10% of body surface area.

Specific drug hypersensitivity leads to major Histocompatibility class -1 restricted drug presentation & is followed by an expansion of cytotoxic T-lymphocytes , leading to an infiltration of skin lesion with T-cells & natural killer cells.

Granylysin level in the serum of patients with SJS/TEN are much higher than in patients with ordinary drug induced skin reaction.

Drug induced SJS presents with fever, flue like symptoms after taking drug. 1 to 3 days later signs begins in mucous membrane of eye , mucosa, of dermal-epidermal junction of skin, mucosa as seen in our patient.

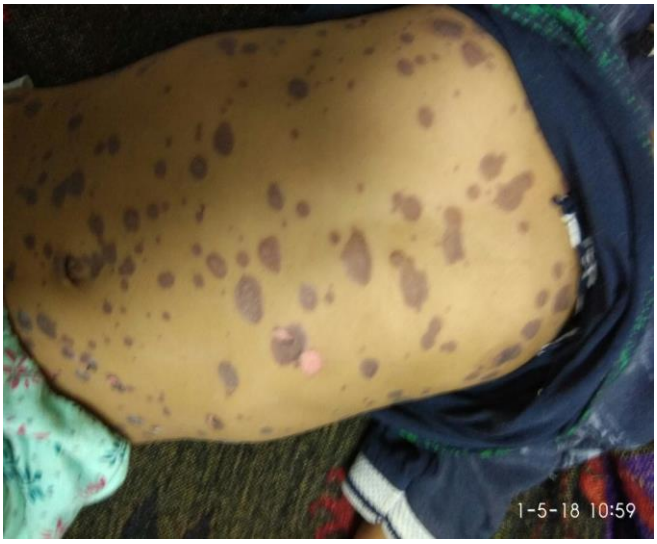
Clinically this can be detected by positive nikolsky sign.

Pulmonary edema & progressive respiratory failure develop within 2-3 days & large ulcerations & necrosis of bronchial epithelium.

Early diagnosis with prompt recognition and withdrawal of all potential causative drugs is essential for favourable outcome.

Common drugs associated with steven Johnson syndrome are sulfa drugs, vancomycin , allopurinol , valproate, phenytoin , oxcarbamazepine, sulfonamides,oseltamavir, penicillins ibuprofen, nevirapine ,diclofenac and nystatin.

Corticosteroids have been mainstay of therapy for SJS.



CONCLUSION

We would like to state that patients started with any common drug regimen may havea potential risk of developly SJS.

The oral ulcerations & erythema are usually the initial presenting complaint which the patient may ignore .There should be a high index of suspicion.

An early diagnosis of SJS could be made due to presence of oral lesions.

Increased clinical vigilance is required to identify hypersensitivity reactions like rash, vesiculobullous lesions and other symptoms like fever , nausea.

The offending drug should be discontinued and never be rechallanged.

REFERENCES

1. YAP FBB, wahiduzzamam, stevens Johnson syndrome (SJS) in Sarawak : A four years review egyrtian dermatology online journal 2008: 4(1)
2. AM stevens , FC Johnson A new eruptive fever associated with stomatitis & opthalmia Amer J DIs child 1922: 24(6)
3. Roujeau JC, Huyph TN, Braeq c. et al. genetic susceptibility to toxic epidermal necrolysisarch dermatol 1987;123 (9)
4. Powell N, Munru JM, Rowbotvam D. colonic Involvement in stevens Johnson syndrome. Postgrad med J 2006; 82