Toxic Epidermal Necrolysis

Dear Editor,

It is indeed commendable for the authors of the case report titled, "Toxic Epidermal Necrolysis: A case report" [MJAFI 2006; 62: 271-2] for having successfully managed this rare and potentially fatal disease. Some points deserve to be mentioned.

Toxic Epidermal Necrosis (TEN) has been reported to develop in spite of treatment with corticosteroids [1,2]. So the authors contention that the onset of TEN was delayed because of prior steroids may not be really tenable. A more plausible cause of this delayed onset could be the type of the drug incriminated, a fact the authors have mentioned elsewhere in their report.

Fluid replacement regimen advised in patients with TEN is lower than (two thirds to three-fourths) and not the same as advised for burn patients; since tissue destruction, underlying vascular injury and subcutaneous oedema is milder in TEN [3]. The dose of cyclosporine for treatment of TEN reportedly ranges from 3-5 mg/kg body weight [4]. The high dose given in the case reported is worthy of highlighting in view of the successful outcome.

A challenge test by reinstitution of potentially incriminating drugs is fraught with danger, as it could bring on such a potentially

fatal disease process once again. It must be emphasized that such a test should be undertaken, with extreme caution, under controlled conditions and after obtaining informed consent.

References

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Reply

Dear Editor,

The authors wish to thank the reader for the keen interest shown in the article and for his compliments. We would like to clarify the issues raised by him.

Toxic Epidermal Necrolysis (TEN) has been reported to develop due to corticosteroids as well as in spite of steroid therapy [1]. The authors of the reference cited by the respondent concluded in their study that long-term steroid therapy may delay the onset of TEN, but it does not halt its progression [2]. The time from first administration of the likely culprit drug to the onset of TEN was significantly delayed from 13 days in the comparison group to 24 days in the steroid group in the cited study. In our case the delayed onset could be similarly attributed to the short course of steroid therapy. However, as this is a single case report our conjecture though in concurrence with earlier studies remains a matter of postulation.

The essential management of a TEN patient is in a burns unit with the same principles of hypovolemia, electrolyte, and sepsis and thermoregulation management [3]. However, TEN and burn patients are not identical; burns happen in a very short time period (a few seconds) and do not spread thereafter, the TEN-SJS progress occurs during several days. Cutaneous necrosis is more variable and often deeper in burns than in TEN. Conversely, in TEN the mucous membrane involvement reduces fluid intake and worsens the fluid deficit, the systemic involvement leads to haemodynamic instability and progression of cutaneous lesions enhances the risk of infection and sepsis. Therefore, overall the fluids requirements are invariably lower than in burns patients as mentioned by the respondent. Any fixed formula is only for initiation of fluid replacement (first 24 hours) and not for the entire duration of illness [4].

The high dose of oral cyclosporine (though higher than the usual dose for dermatological conditions) was administered in view of its poor absorption and to achieve a high therapeutic serum concentration in accordance with standard pharmacological

recommendations [5]. The good clinical response in a shorter duration of therapy seems to justify the dosage schedule.

A challenge test was forced upon us in this case as the patient was suffering from tuberculous meningitis, a potentially fatal condition. It was thus imperative that ATT (EHRZ) should be readministered at the earliest. Rechallenge followed by readministration of the drugs was carried out in accordance with standard guidelines on the subject. Rechallenge with phenytoin are known incriminating drug was not done, as alternatives were available if necessary.

References

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