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REVIEW ARTICLE

Dermatologic emergencies

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Angioedema/urticaria;
Meningococcemia;
Lyme disease;
Rocky Mountain spotted fever

Abstract Dermatologic emergencies represent about 8–20% of the diseases seen in the Emergency Department of hospitals. It is often a challenge for primary care physicians to differentiate mundane skin ailments from more serious, life threatening conditions that require immediate intervention. In this review we included the following conditions: Stevens-Johnson syndrome/toxic epidermal necrosis, pemphigus vulgaris, toxic shock syndrome, fasciitis necrotising, angioedema/urticaria, meningococcemia, Lyme disease and Rocky Mountain spotted fever.

PALABRAS CLAVE
Urgencias dermatológicas;
Síndrome de Stevens-Johnson (SSJ)/necrolisis epidérmica tóxica (NET);

Urgencias dermatológicas

Resumen Las enfermedades dermatológicas representan del 8% al 20% de la consulta en el Servicio de Urgencias de los hospitales. Para el médico de primer contacto constituye un reto el diferenciar enfermedades leves de aquellas que ponen en peligro la vida y requieren intervención inmediata. De estas existen múltiples que pueden ser potencialmente fatales y otras que requieren ser evaluadas por el especialista. En esta revisión se incluyen las siguientes

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Pénfigo vulgar;
Síndrome de choque tóxico (SST);
Fascitis necrotizante;
Angioedema/urticaria;
Meningococcemia;
Enfermedad de Lyme;
Fiebre Macular de las Montañas Rocosas

enfermedades: Síndrome de Stevens-Johnson (SSJ)/necrolisis epidérmica tóxica (NET), pénfigo vulgar (PV), síndrome de choque tóxico (SST), fascitis necrotizante (FN), angioedema/urticaria, meningococcemia, enfermedad de Lyme y Fiebre Macular de las Montañas Rocosas (FMMC).

Introduction

Between 8% and 20% of patients seen in hospital emergency departments present with dermatological diseases.[1,2] Differentiating between mild and life-threatening conditions that required immediate treatment can be challenging for doctors in charge of the preliminary assessment of the patient.[2] Many dermatological disease can be fatal and must be evaluated by a dermatologist, intensivist, surgeon, or other specialist.[3] In this review, we will focus on the following diseases: Stevens-Johnson Syndrome (SJS)/Toxic epidermal necrolysis (TEN), pemphigus vulgaris (PV), toxic shock syndrome (TSS), necrotising fasciitis (NF), angiooedema/urticaria, meningococcaemia, Lyme disease and Rocky Mountain spotted fever (RMSF). Some of these entities require aggressive hospital treatment and must be diagnosed immediately. Others should be referred to a specialist for watchful waiting to prevent potentially severe or incapacitating complications.

Stevens-Johnson Syndrome/Toxic epidermal necrolysis (SJS/TEN)

These are part of a spectrum of life-threatening, drug-induced mucocutaneous diseases. The drugs most frequently involved are allopurinol, aniconvulsants such as phenytoin and carbamazepine, non-steroidal anti-inflammatory drugs, sulphonamides and beta-lactams.[3] Incidence is estimated at between 0.4% and 7% per million inhabitants, irrespective of age group or sex. SJS/TEN is characterised by prodromal symptoms such as general malaise, rhinitis, odynophagia, conjuctivitis, myalgia and arthralgia, which can last up to 2 weeks. During this time, a macular rash with or without atypical target lesions appears, usually in truncal areas, and then extends to the extremities. Bullae also form, sometimes accompanied by denuded areas with a positive Nikolsky's sign (Toxic epidermal necrolysis).[3–6] (Figs. 1 and 2). Mucous membrane involvement is found in 70–100% of cases, with inflammation, pain and severe ulceration that can progress to involve the oesophageal and tracheal mucosa, thus increasing the risk of respiratory failure.[3,5] Nearly all patients have ocular and genital involvement. TEN is believed to be severe form of SJS, where severity is measured by the extent of body surface area (BSA) involvement. In SJS, <10% of total BSA is involved, while in TEN this increases to >30%. Between 10% and 30% of cases are considered to involve SJS/NET overlap.[3] NET is

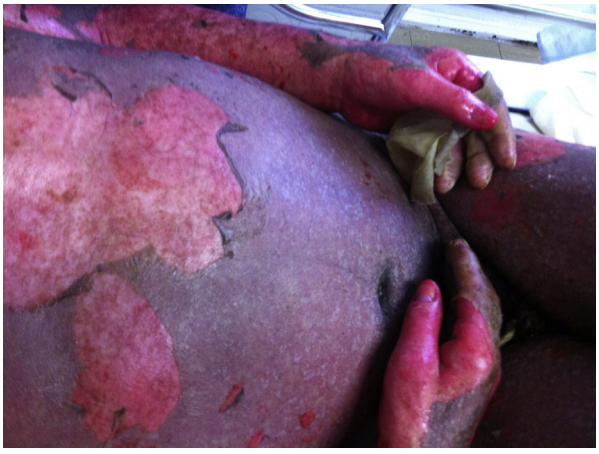

Figure 1 Toxic epidermal necrolysis.

characterised by ulceration of the skin, necrosis and severe systemic alterations affecting the lungs, the cardiovascular and gastrointestinal systems, the kidneys and blood. Patients can present with anaemia, leukopaenia, hepatitis,

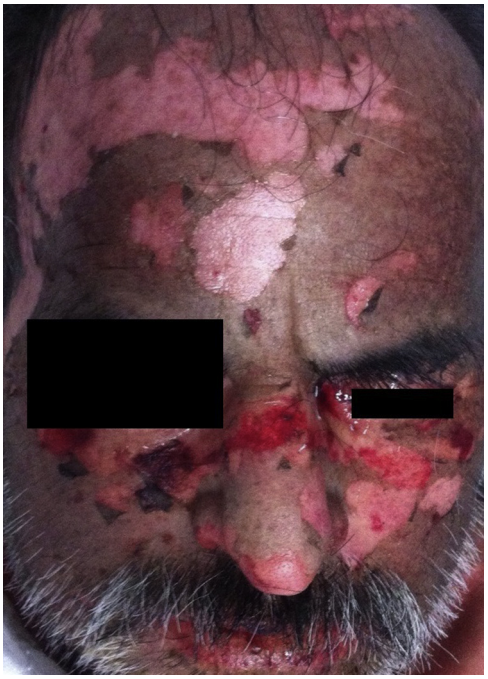

Figure 2 Toxic epidermal necrolysis.