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Short communication

Stevens–Johnson syndrome in childhood☆,☆☆

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ABSTRACT

Introduction: Stevens–Johnson syndrome and toxic epidermal necrolysis are two serious immune diseases within the context of bullous mucocutaneous syndrome. These have varying degrees of involvement of the skin and usually at least two mucous membranes.
Clinical cases: Three clinical cases are presented, two of them with significant ophthalmological sequelae, who had received drug treatment as a possible trigger, and another milder clinical case caused by Mycoplasma pneumoniae.
Discussion: The ophthalmologist plays a crucial role in the outcome and eye care of the patient in order to try to avoid the appearance of sequelae and subsequent loss of vision.

Síndrome de Stevens-Johnson en la infancia

Palabras clave:
Síndrome Stevens Johnson
Necrólisis epidérmica tóxica
Mycoplasma pneumoniae
Síndrome mucocutáneo ampolloso
Membranas mucosas

RESUMEN

Introducción: El síndrome de Stevens-Johnson y la necrólisis epidérmica tóxica son 2 graves enfermedades inmunológicas dentro del contexto de síndrome mucocutáneo ampolloso, con diferente grado de afectación cutánea y que suelen presentar afectación de al menos 2 membranas mucosas.
Casos clínicos: Presentamos 3 casos clínicos, 2 de ellos con importantes secuelas oftalmológicas que habían recibido tratamiento farmacológico como posible desencadenante, y otro cuadro más larvado causado por Mycoplasma pneumoniae.
Discusión: El oftalmólogo desempeña un papel crucial en la evolución y cuidados oculares del paciente para intentar evitar la aparición de secuelas y la consiguiente pérdida de visión.

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Introduction

The Stevens–Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are parts of a single clinic spectrum in the context of the bullous mucocutaneous syndrome, and are differentiated by the degree of cutaneous involvement, which is below 10% in SJS and above 30% in TEN. In addition, at least 2 mucous membrane are usually affected.[1–4]

Clinic case reports

An 8 year-old boy with laryngeal cough, conjunctivitis (Fig. 1), oral mucosa erythema (Fig. 2), peeling in the gland and fever, admitted to the pediatric intensive care unit (PICU) with suspected atypical SJS. Positive serology was obtained for Mycoplasma pneumoniae, which required the administration of clarithromycin and oral prednisone.

At the ophthalmological level, the patient was assessed daily and given intensive ocular treatment consisting in cleaning of pseudo-membranes, hourly hydration, broad range antibiotic every 8 h as a prophylactic measure due to corneal de-epithelization, topical corticoids every 4 h and autogenous serum.

Sixteen days after admission, the patient was released without ophthalmological or systemic sequels.

A 10-year-old girl who was administered ibuprofen due to fever and in the course of 10 days developed bilateral conjunctival erythema, oral mucosa erythema, macular exanthema in the torso (Fig. 3) and high fever. She was admitted to the PICU. The lesions extended progressively affecting 50% of bodily surface, requiring administration of corticoids and intravenous immunoglobulin.

Ocular involvement progressed to pseudomembranous conjunctivitis and corneal ulcers (Fig. 4). Accordingly, intensive ocular treatment was applied, subsequently requiring amniotic membrane graft in the left eye. One month after admission, the patient exhibited severe dry eye syndrome that progressed to keratinization with free edges, distichysiasis,

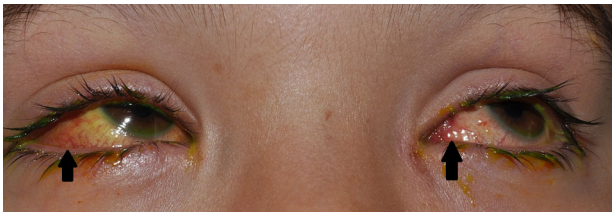

Fig. 1 – Ciliar injection (arrows) and pseudomembranous conjunctivitis in patient with atypical SJS after pneumonia due to Mycoplasma pneumoniae.

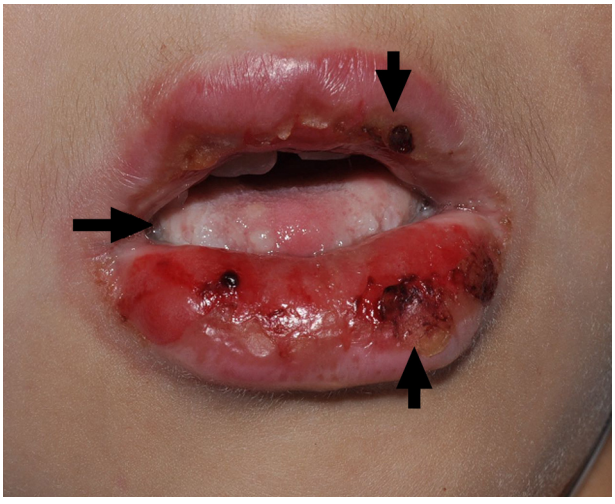

Fig. 2 – Oral mucosa involvement in patient with atypical SJS after pneumonia due to Mycoplasma pneumoniae.

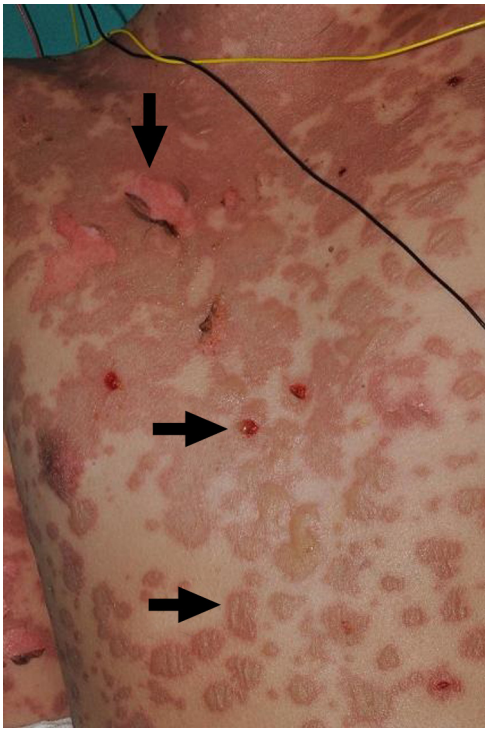

Fig. 3 – Generalized exanthema with de-epithelized areas and Nyckolsky + (upper arrow), crusts (middle arrow) and bullous areas (lower arrow).

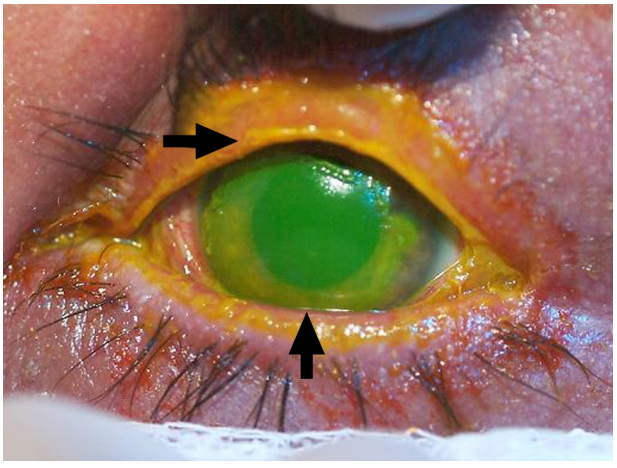

Fig. 4 – Corneal ulcer and formation of pseudomembranes in patient with TEN.