We describe a clinical case of presumable Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) in a 61-year-old patient with multiple possible etiological factors involved described in the literature, including the use of antibiotics causing: dyspnea, erythema multiforme, in relation to the dose and the indicated treatment time. It is estimated that approximately 1% of patients treated with this drug have some type of these reactions.

INTRODUCTION

A 61-year-old women with a diagnosis of facial sagging and orthohyperkeratosis. Go for assessment due to the presence of deformation in the particularly periauricular as well as bilateral submandibular face with a history of facial surgery 15 years ago. (Fig. 1)

In the medical history denies allergies. Normocephalic skull, there is no presence of subsidence or exostosis, at the level of eyelids, with the presence of previous surgery scar. Laboratory tests: Glucose 104, Urea 19.3, Creatinine 0.5, Tp 13.8 86.9%, INR 1.19, TPT 30.4, Bh Leukocytes 8.00, HB 14, and Platelets 264,000. Vital signs: TA 130/80, FC 67x, FR 18x. Temp 36.7 °C, Sat 98%. Internal medicine reported: Cardiovascular risk Goldman I, Asa I, without contraindications to the use of general or regional anesthesia.

In the immediate surgical post, preventive cefotaxime is applied to infection and presents dyspnea, significant edema as well as peribucal ecchymosis, so the bandage is removed to reduce dyspnoea. (Fig. 2)

The allergic reaction to cefotaxime is established as a diagnosis (Immune response type: IgE. Clinical symptoms: Anaphylactic shock, angioedema, urticaria, bronchospasm. Typical reaction chronology: Within 1 to 6 hours after the last intake of the drug) Therefore, it was discontinued and management was initiated

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for angioedema based on methylprednisolone, chlorotrimeton, ranitidine (H1 and H2 blockers), close monitoring and nebulisations.

At 24 hours the patient presented persistent dyspnoea. Vital signs: TA 130/85, FC 95 x FR 28 x and Sat 98%. The edema and ecchymosis on the face is more intense, in the surgical wound leaving blood material through the drain probes.

At 72 hours, the patient reported facial discomfort with inability to swallow due to edema. Vital signs: TA 130/80 FC 88 x FR 24 x Temp 7C oC Sat 98%. Facial edema, peribucal ecchymosis, right periorbital region and anterior chest, right retroauricular hematoma, (Fig. 3)

(Fig.3)
edema in upper and lower limbs. Better tolerate bandage compression, has not presented dyspnea. (Fig. 4)

(Fig.4)

At one week, the patient presents seroma, decreasing the expense progressively for six days, with the total closure of the surgical wounds after the last expense. He also presented dehiscence of the right retroauricular wound for seven days. (Fig. 5)

(Fig.5)

One month later, she is asymptomatic, with a scarred wound, completely reversed areas of necrosis and with the patient's satisfaction of the aesthetic result.

Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are rare but serious allergic reactions to substances, often drugs, that result in serious disorders of the skin and mucous membranes. Antibiotics such as sulfonamides, penicillins, cephalosporins and fluoroquinolones can cause SJS and TEN.1;2;3;4.

The SJS and TEN are two entities that potentially constitute a threat to life; both are part of the same clinical spectrum, whose initial manifestations are nonspecific; the main characteristic to differentiate them is the extent and severity of skin lesions, same as in TEN; It is usually greater than 30%, although overlapping tables have been described between the SJS and the TEN.

The SJS and the TEN are conditions whose exact annual incidence in the world is unknown, although it is estimated that 1-2 cases / million occur each year, but 4.3-10 cases / million inhabitants have also been cited. SJS and TEN can cause skin rash, peeling and sores on mucous membranes.

The SJS is idiopathic in less than 5% of cases, and between 5-20% can be triggered by infections, several drugs, some vaccines although these in a smaller number of reports.

In the physiopathogeny, an acute inflammatory process has been identified, following the action of immune complexes mediated by hypersensitivity, and it turns out to be the most notable clinical form, known as typical SJS; This includes lesions on the skin and mucous membranes, and may involve ocular conjunctiva, oral mucosa, nasal, vaginal, urethral and perianal area; in the most severe manifestations respiratory tract is affected, with tracheobronchial epithelial lesion and less frequently of the interstitial epithelium; The variant known as TEN, which is the most severe expression of the same SJS and constitutes the most severe form, with evolution to areas of necrosis in both skin and respiratory epithelium, and is associated with mortality of up to 30%.

Clinical manifestations
The SJS / TEN is an acute inflammatory process, with a prodromal period of 1-14 days, accompanied by fever, malaise with dermal lesions of variable severity characterized by reddish maculopapulae, which sometimes adopts atypical lesions considered as' shot at white "may involve oral mucosa and evolve with periorificial lesions that bleed; There are also coalescent lesions with generalized erythema, phytaten and blas with necrotic roof, epidermal denudation zones, alternating with erythema areas. It usually has purulent conjunctivitis; in more severe cases, such as TEN, nostrils, pharynx, esophagus and respiratory tract are affected; There will be other signs in case of renal, hepatic or hematological condition. Recently, all the expressed signs and symptoms have tried to consider them distinguishing three phases:

First phase (acute phase). It includes nonspecific signs and symptoms, including fever, ocular congestion with pruritus, discomfort to swallowing, then early skin lesions on the face and trunk, palm of the hand, erythema and erosion of oral and genital mucosa are added, in addition to eyelid edema, conjunctivitis with secretion and pseudomembranes; this occurs in 90% of patients; in some of the cases during this phase respiratory and gastrointestinal manifestations may appear.

Second stage. There are long epidermal detachment areas; if detachment is not observed, a more detailed exploration of the skin should be done and tangential mechanical pressure can be exerted on various areas of erythema; with this the Nikolsky sign is obtained, and it is positive if the mechanical pressure
induces epidermal detachment, although this sign is not only specific for SJS / TEN.

Third phase. This phase includes the sequels; It is more frequent to find sequels in patients who were cataloged with NET, and the signs are of hyper or hypopigmentation of the skin, atrophy in nails, dry eyes, symphophagine, entropion, lagophthalmia, corneal ulcer, keratoconjunctivitis, decreased visual acuity, sequela of lesions in oral, esophageal mucous membranes; Some adult patients have manifested pluriglandular exocrine insufficiency and pancreatic dysfunction. 6,7,8,9,10

The areas of peribucal and oral necrosis progressively decrease after 21 days. (Fig. 6)

One month later, the patient is asymptomatic, with wounded wounds, areas of necrosis completely reversed and with the patient's satisfaction of the aesthetic result (Fig. 7).

DISCUSSION

With an incidence of 1 to 6 cases per million per year and 0.4 to 1.2 cases per million per year, the SJS and TEN, respectively, constitute two infrequent pathologies in the population. In addition, it is worth mentioning the multiple etiological factors involved in these entities and in particular in this case where their combination and synergism define their complexity.

The evolution of skin healing after the onset of SJS / TEN was approximately 7-10 days. Epithelization was completed in approximately 30 days. Fortunately, due to the diagnosis and intensive care in time, the patient in this case did not present sequelae of the third phase of the SJS and the TEN.

CONCLUSION

Antibiotics are the most common cause of life-mediated immune-mediated pharmacological reactions that are considered off-target, including anaphylaxis, and organ-specific severe skin adverse reactions. However, many documented antibiotic reactions such as allergies were unknown or not remembered by the patient, skin reactions not related to drug hypersensitivity, drug infection interactions or drug intolerances. Although such reactions represent an insignificant risk to patients, they currently represent a global threat to public health. Antibiotic allergy labels cause the displacement of first-line therapies for prophylaxis and antibiotic treatment. 5

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