

## Issues about diagnosis and treatment of toxic epidermal necrolysis

Sir,

We would like to make the following comments regarding the case recently published in your journal “Carbamazepine-induced toxic epidermal necrolysis.”<sup>[1]</sup>

The authors describe a clinical picture, clearly suggestive of toxic epidermal necrolysis (TEN), with compatible mucocutaneous lesions and positive Nikolsky’s sign, which is characteristic but not specific to this disease.<sup>[2]</sup> The clinical picture begins less than three weeks after initiating carbamazepine, a drug, that is clearly related to TEN.<sup>[3]</sup> However, confirmation of the diagnosis requires a cutaneous biopsy for conventional histopathology and immunohistochemistry to rule out other conditions that may be clinically similar to or even completely indistinguishable from TEN (staphylococcal toxic shock syndrome, linear IgA dermatosis, bullous pemphigus, etc.).<sup>[2]</sup>

TEN is known to be a drug reaction based on clinical experience. Recently, the term “Acute Syndrome of Apoptotic Pan-Epidermolysis” (ASAP)<sup>[4]</sup> was proposed to include all clinical situations of massive and acute epidermal cleavage resulting from apoptotic injury. ASAP includes conditions such as drug-induced TEN, TEN-like lupus erythematosus, TEN-like pseudoporphyria, and graft versus host disease. Even with histopathology and immunohistochemistry, differential diagnosis may be impossible, and the clinical course may vary.<sup>[4]</sup>

As the authors themselves point out, treatment of TEN with corticosteroids is still an unresolved issue. Although the use of corticosteroids used to be widespread, the lack of clinical evidence regarding their efficacy and the fact that they have been linked, in

some studies, with increased infections and mortality, makes their use in these patients inadvisable.<sup>[5]</sup> However, data from a European retrospective study suggest that corticosteroid treatment may have a beneficial effect, although a uniform dose-dependent benefit was not observed.<sup>[5]</sup> Similarly, the results from a small single-center retrospective study suggest that treatment with “pulses” of high doses of dexamethasone may be beneficial.<sup>[6]</sup> A randomized controlled study is needed to clarify this issue.

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### References

1. Chowta NK, Chowta MN, Ramapuram J, Kumar P, Fazil A. Carbamazepine-induced toxic epidermal necrolysis. *Indian J Crit Care Med* 2011;15:123-5.
2. Harr T, French LE. Severe cutaneous adverse reactions: Acute generalized exanthematous pustulosis, toxic epidermal necrolysis and Stevens-Johnson syndrome. *Med Clin North Am* 2010;94:727-42.
3. Mockenhaupt M, Viboud C, Dunant A, Naldi L, Halevy S, Bavineck JN, *et al.* Stevens-Johnson syndrome and toxic epidermal necrolysis: Assessment of medication risks with emphasis on recently marketed drugs. The EuroSCAR-study. *J Invest Dermatol* 2008;128:35-44.
4. Cisneros CG, Romiti R, Santi CG, Aoki V, Valente NY, Nico MM. Toxic epidermal necrolysis-like cutaneous lupus erythematosus: A series of three patients. *Aeta Derm Venereol* 2010;90:175-8.
5. Schneck J, Fagot JP, Sekula P, Sassolas B, Roujeau JC, Mockenhaupt M. Effects of treatments on the mortality of Stevens-Johnson syndrome and toxic epidermal necrolysis: A retrospective study on patients included in the prospective EuroSCAR Study. *J Am Acad Dermatol* 2008;58:33-40.
6. Kardaun SH, Jonkman MF. Dexamethasone pulse therapy for Stevens-Johnson syndrome/toxic epidermal necrolysis. *Aeta Derm Venereol* 2007;87:144-8.

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