Images in Clinical Practice

Stevens Johnson Syndrome

A 7-year-old boy presented with skin lesions and purulent conjunctivitis of 4 days duration. He was treated for fever and cough with paracetamol, amoxycillin and phenyl-propanolamine. On examination he was febrile (104ºF) and dehydrated. The skin lesions were purpuric macules with blister formations and were present all over the trunk. There was cervical and axillary lymphadenopathy. But there was no hepatosplenomegaly. Apart from raised CRP levels and leukocytosis there were no other hematological and biochemical abnormalities. During the course of his hospitalization, the skin lesions spread to involve the limbs and face and the lesions on the trunk became confluent (*Figs. 1 and 2*). Later he developed oral ulcers and photo-phobia. He was provided with good supportive care and skillful nursing care which involved correction and maintenance of hydration, oral and ocular care, regular dressing of the skin lesions.

Stevens Johnson syndrome (SJS) is a rare disease of unknown etiopathogenesis. However *Mycoplasma pneumoniae* and certain drugs (antiepileptics, NSAIDS, antibiotics and anti HIV drugs) are found to be major precipitating factors. The peak incidence is in the second decade of life. It is usually preceded by prodromes such as URI or unexplained fever. The extent of skin eruption is variable and all affected children have two or more mucosal sites involved. It is to be differentiated from erythema multiforme and toxic epidermal necrolysis. It is a potentially severe illness but with adequate management, morbidity and sequelae are minimal. The treatment is essentially supportive. Prophylactic anti-

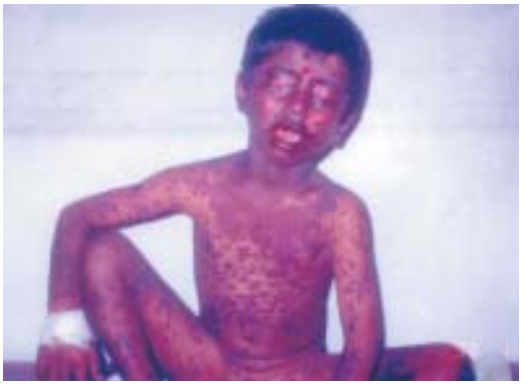

Fig. 1. Lesions of Stevens Johnson dyndrome - frontal profile.

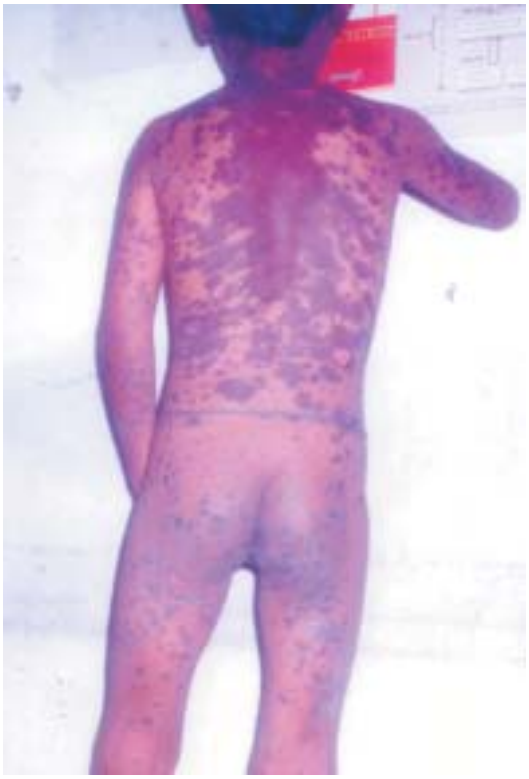

Fig. 2. Stevens Johnson syndrome - rear view.

biotics are needed only when *M. pneumoniae* is suspected.

The role of steroids is controversial and better avoided when infectious etiology is suspected. Encouraging results are being published recently with intravenous immunoglobulin therapy. Affected children are to be followed up regularly for sequelae like keratitis sicca, synechae, symblepharon and skin pigmentation.

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Giant Molluscum Contagiosum

A 10-year-old healthy girl presented with erythematous, broad based exuberant growth over medial aspect of left upper eyelid of one-month duration. Tip was umbilicated, with adjacent yellowish crust (*Fig. 1.*). Multiple pearly umbilicated lesions on both eyelids were present. She developed irritation in the left eye with redness and watering. Examination revealed chronic blepharitis, follicular conjunctivitis and multiple papules over lid margins. Extirpation of the papule led to expression of the curd like central core, which on gram stain showed pinkish, homogenously, staining molluscum bodies. Bacterial cultures of the crust grew staphylococcus aureus. A diagnosis of molluscum contagiosum of the eyelid was made. Serology for HIV was negative. Patient was prescribed oral cloxacillin and all lesions

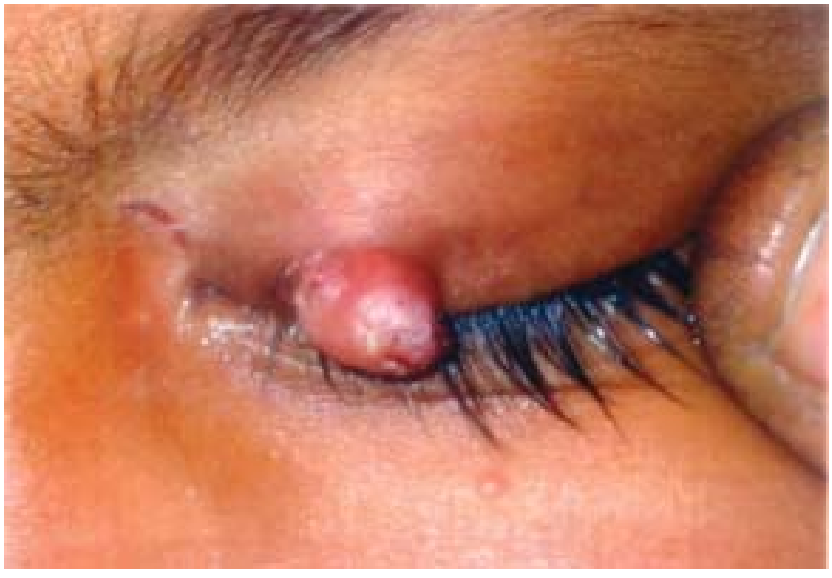

Fig. 1. Erythematous broad based umbilicated lesion over left upper eyelid. Note adjacent small pearly papules.