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RESEARCH ARTICLE

DRUG INDUCED STEVEN JOHNSON SYNDROME

Gaddam Chandrika[1]., Nalluri Kranthi Koushik*[1]., Greeshma Musunuru[2]., Gummalla Pitchaiah[3] and Dhachinamoorthi D[4]

[1,3]Department of Pharmacy Practice, QIS College of Pharmacy, Ongole
[2]Doctor of Pharmacy, Department of Pharmacy Practice
[4] QIS College of Pharmacy, Ongole

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ABSTRACT

Stevens-Johnson syndrome is a rare, serious disorder of skin and mucous membranes. It's usually a reaction to a medication or an infection. Often, it begins with flu-like symptoms, followed by a painful red or purplish rash that spreads and blisters. Then the top layer of the affected skin dies, sheds and then heals. Stevens-Johnson Syndrome is a medical emergency that usually requires hospitalization. Treatment focuses on eliminating the underlying cause, controlling symptoms and minimizing complications as your skin regrows. Recovery after Stevens-Johnson syndrome can take weeks to months, depending on the severity of condition. If it was caused by a medication, permanently avoid that drug and others closely related to it.

INTRODUCTION

Steven Johnson syndrome (SJS) is a rare but severe dermatological condition, is considered a severe type of erythema with bullous and eroded lesions of skin and mucous membrane[1]. It typically occurs after ingestion of medication such as non steroidal drugs, antibiotics and anti convulsants, but it can also be due to infections, or more rarely due to cancers[2]. SJS may be caused by adverse effect of drugs vancomycin, allopurinol, valproate, carbamazepine, levofloxacin, isotretinoin, diclofenac, buproprion, nystatin [3] [4] [5] [6] [7]. Extra cutaneous manifestations of the syndrome may involve the conjunctiva, trachea, buccal mucosa, gastrointestinal tract and genitourinary tract. Treatment includes supportive and symptomatic management [8].

Case Report

A 56 years old male presented to the Secondary care hospital complaining of mouth ulcers in oral cavity, difficulty in swallowing, leg pain for 3 days and precipitating sort of pain for 1 year. Patient was apparently normal one year back after which he developed pricking sort of pain of both sides of feet. Three days back developed ulcers in oral cavity with difficulty in swallowing. No complaints of numbness and other complaints. He was known case of Diabetes (DM) for 1 year and on treatment with T.Metformin and T.Glibenclamide. Patient general and systemic examination was found to be normal. On oral examination desquamated ulcer patches were present. Laboratory investigations revealed an FBS of 132 mg/dl, RBS of 210 mg/dl and a slight decrease in lymphocyte, eosinophil, monocyte and albumin levels. Patient was prescribed T.Carbamazepine and T.Pregabalin for pain in another hospital. On taking those medications he developed oral ulcers.

DISCUSSION

Based on the chief complaints of patient, past medical and medication history, and oral examination patient was diagnosed as Steven Johnson syndrome secondary to carbamazepine therapy. His pain and oral ulcers were conservatively managed with T.Wysolone 30 mg, OD, T.Tryptomer 25 mg, OD and Syp Sucralfate 15 ml, TDS , an anti infective T.Azithromycin 500 mg, od was also prescribed in order to prevent infection of skin and soft tissue. T.Metformin 1000mg, BD was prescribed to control blood sugar levels. Symptomatically pt was prescribed with Inj.Fevastin 500mg, SOS, Inj.Pantoprazole 40 mg, OD. A repeated CBC was done which were within normal limit and during the course of hospital stay the patient developed hypotension and hypoglycemia hence iv fluids were given. He

was then discharged once he was symptomatically and clinically better. His discharge medications were T.Wysolone, Syp Sucralfate , T.Metformin, Zytee gel L/A and T.Tryptomer.

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