DRUG OR DISEASE ?

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Acknowledgements:

- KKCTH

  Dr. Ramkumar – Consultant Dermatologist

  Dr. Ramprakash – Consultant Ophthalmologist

  Dr. Prasad Manne – Consultant Cardiologist

  Dr. V.K.Sairam – Consultant Nephrologist

  Dr. BalaRamachandran – PICU team

- Southern Railway hospital

  Dr. Kannan – Head of the Department and his team

HISTORY

- 16 year, adolescent girl
- Previously well

<u>4 weeks back:</u>

- Generalised maculopapular rash
- Swelling and pain involving multiple joints
- Fever

EVALUATED ELSEWHERE

High uric acid - ?Gout – started on allopurinol

- Arthritis settled: Rash persisted

Suspected connective tissue disorder

- Started on hydroxy chloroquine
- Received 2 doses of steroid in between

COURSE OF EVENTS

- Sudden increase in severity of rash for 3 days
- Associated involvement of eye and oral mucosa
- ?Steven Johnson syndrome
- Referred to us for further evaluation

ON EXAMINATION

- Febrile ,sick looking
- Facial rash
- Diffuse violaceous maculopapular rash involving palms and soles
- Severe mucositis (eye & oral mucosa involved)
- Joints – normal
- Vitals, BP – normal
- Systems – NAD

DIAGNOSIS

INVESTIGATIONS

- Normal counts.
- Anemia (Hb-9.6 gm/dl)
- DCT 2+
- ESR – 90 mm/hr
- Urine microscopy – albumin 2+, 15-20 RBC's/HPF
- Serum creatinine – 1 mg/dl
- ECHO – mild pericardial effusion

- ANA, dsDNA, complement C3 – samples sent

CONSULT

Dermatologist

- Probable SLE / allopurinol induced SJS – suggested skin biopsy

Ophthalmologist

- Probable SJS

TREATMENT

- Supportive care

- IV Fluids
- Skin care
- Oral hygiene
- Eye care

COURSE IN THE HOSPITAL

- Developed large painful blisters over face
- Surgical consult
- Fluid aspirated
- Started on IV clindamycin

COURSE IN THE HOSPITAL

- ANA - 4+ speckled
- anti ds – DNA – positive
- C3 and C4 – low

} confirmed SLE

- Started on pulse methylprednisolone
- Nephrology consult – 24hrs urinary protein and proceed

SLE – 1997 REVISED CRITERIA

Malar rash
Discoid rash
Photosensitivity
Oral or nasal ulcers
Arthritis: Nonerosive, affecting 2 or more joints

Serositis: Pleuritis, pericarditis, peritonitis

Renal manifestations: Persistent proteinuria or cellular casts
Consistent renal biopsy

Seizure or psychosis
Hematologic manifestations: Hemolytic anemia
Leukopenia (<4,000 leukocytes/mm^3)
Lymphopenia (<1,500 leukocytes/mm^3)
Thrombocytopenia (<100,000 thrombocytes/mm^3)

Immunologic abnormalities: Positive anti–double-stranded DNA or anti-Smith antibody test result
False-positive rapid plasma regain RPR test result, positive lupus anticoagulant test result, or elevated anticardiolipin immunoglobulin (Ig) G or IgM antibody
Positive antinuclear antibody test result

DAY 4

- Incidentally detected Bradycardia
- HR – 38/min
- ECG – AV dissociation

- Shifted to PICU

IN THE PICU

- Started on isoprenaline infusion
- Developed tachycardia with chest discomfort
- Isoprenaline infusion stopped

- Shifted to Southern Railway hospital for further care

FOLLOW UP:

- Responded to steroid – bradycardia improved
- Had a setback - seizures - controlled with fosphenytoin
- Discharged

DIAGNOSTIC POSSIBILITIES

Allopurinol induced SJS in Juvenile SLE

- Most likely

SLE presenting as SJS

- Less likely

References:

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  Lee HY, Tey HL, Pang SM, Thirumoorthy T

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- Second-degree atrioventricular block as an early manifestation of adult systemic lupus erythematosus.

  J Microbiol Immunol Infect 2005 Aug;38(4):296-9.

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THANK YOU