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Photo-induced Stevens-Johnson syndrome

To the Editor: A 19-year-old woman with no past medical history developed a phototoxic rash with progression to Stevens-Johnson Syndrome (SJS) due to ciprofloxacin therapy for a recent vaginal infection. The patient completed a 10-day course of ciprofloxacin and received a 1-time dose of fluconazole on the 10th day of treatment; she was on no other medications and no other risk factors for SJS were present. The day after treatment completion, a red rash concentrated on her chest developed. She complained of difficulty and painful swallowing, which prompted her to visit our emergency department (ED). No facial swelling was present, and she was discharged from the ED and given an oral prednisone taper, famotidine, and diphenhydramine. She took 60 mg prednisone for 2 days and 40 mg prednisone for 1 day; her rash progressed and became more severe. She again presented to the ED for evaluation of her worsening skin condition. On physical examination, the patient had well demarcated dusky violaceous patches confined to sun-exposed areas on her chest, back, arms, and legs, sparing her bikini swimsuit area and watch distribution, as well as other dependent surfaces not exposed to sunlight (Fig 1). Scattered vesiculation was present on her upper back, chest, and upper arms, sparing her face and ears; skin pain was present. She also had white vesicles and erosions on the lips and ulcers of the oral mucosa accompanied by erythematous patches within the labia. There were no target lesions, and palms and soles were not involved. The patient stated she had gone to the beach 2 days before development of the initial rash; she did not apply sunscreen. Skin biopsy showed intact stratum corneum with interface dermatitis and full thickness epidermal necrosis compatible with SJS (Fig 2). Prednisone 60 mg/day was started, and she completed a 7-day course without taper. Her skin lesions and associated pain improved, and skin sloughing occurred on less than 5% her body surface.

This case is characterized by two different patterns of adverse cutaneous drug reaction: phototoxicity and SJS, also known as photo-induced SJS. The observed reaction to ciprofloxacin was deemed phototoxic because the lesions appeared as an exaggerated burnlike rash in areas of sun-exposed skin, noticeably sparing areas protected from the sun. These lesions progressed to include dusky patches with vesiculation and desquamation consistent with photo-induced SJS. While multiple cases of photosensitivity,

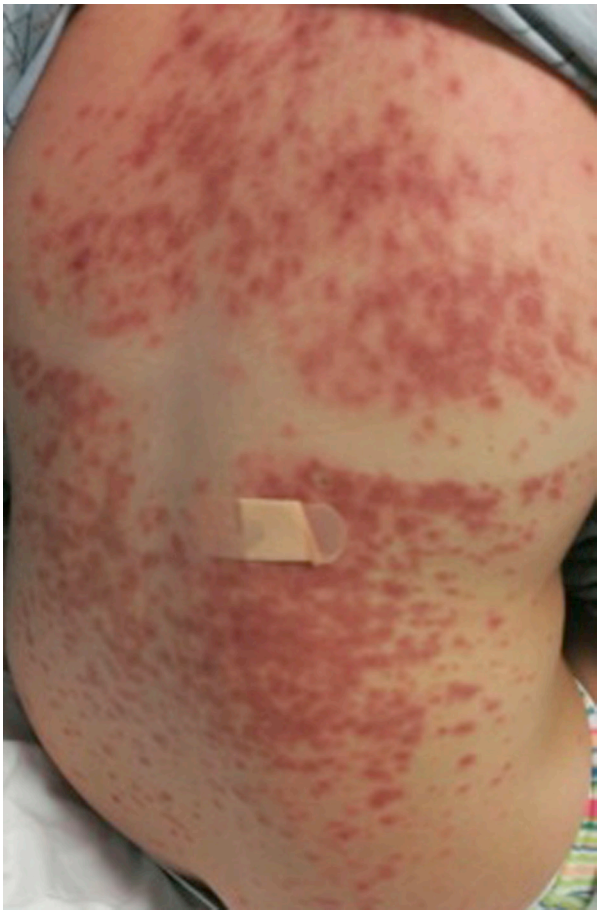

Fig 1. Photo-induced Stevens-Johnson syndrome in a patient treated with ciprofloxacin. The rash spares her bikini swimsuit distribution.

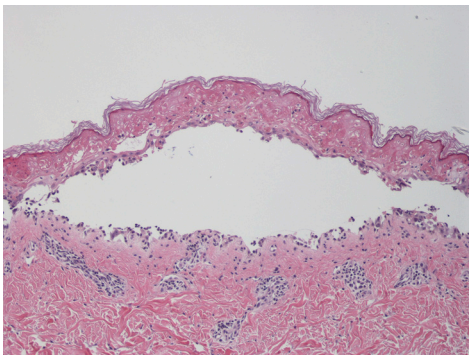

Fig 2. Photo-induced Stevens-Johnson syndrome in a patient treated with ciprofloxacin. Acute stratum corneum full-thickness necrosis of the epidermis and mild inflammatory infiltrate of lymphocytes. (Hematoxylin-eosin stain.)

phototoxicity, and SJS have been reported with ciprofloxacin therapy,[1] to our knowledge no case of photo-induced SJS has been reported with ciprofloxacin therapy. Few other cases of photo-induced SJS have been documented and the mechanism behind this reaction remains elusive. Reported cases have been associated with a sulfasalazine, clobazam, hydroxychloroquine, and naproxen.[2-5] One mechanism proposed is that UVB induces cytokines that recruit cytotoxic T lymphocytes to the epidermis, resulting in the epidermal damage.[4] It is also possible that the phototoxic effects of ciprofloxacin may represent a Koebner phenomenon in which lesions of SJS are confined to the sun-exposed areas.

Photo-induced SJS is an extremely rare entity. Only a few cases exist in the literature. This is a report of photo-induced SJS due to ciprofloxacin. If SJS associated with ciprofloxacin therapy is suspected, treatment should be discontinued immediately.

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Pili multigemini/trichofolliculoma-like organoid nevus

To the Editor: We introduce a distinctive form of epidermal nevus of the "organoid" type that we refer to as "pili multigemini/trichofolliculoma-like organoid nevus." Our patient is a healthy 6-year-old Latino girl born with a large, discrete patch of scalp alopecia that has remained unchanged, except for proportionate scalp growth. Her history and physical examination reveals normal findings, without cutaneous or dental abnormalities. The family history is unremarkable.

The lesion was an approximately 6- × 14-cm zone of partial alopecia (Fig 1). Within it, the hair was sparse and short, with individual hair shafts of variable length and spacing. Much of the alopecia could be attributed to hair shaft length rather than just decreased density. The scalp surface showed mild, patchy erythema, but was otherwise normal. Staged excisions were performed with excellent cosmetic result.

Microscopically, the overall density of follicles was slightly reduced (Fig 1), and some follicles had undergone destruction. The spacing and size of follicles varied considerably. Most follicles were structurally abnormal in several ways

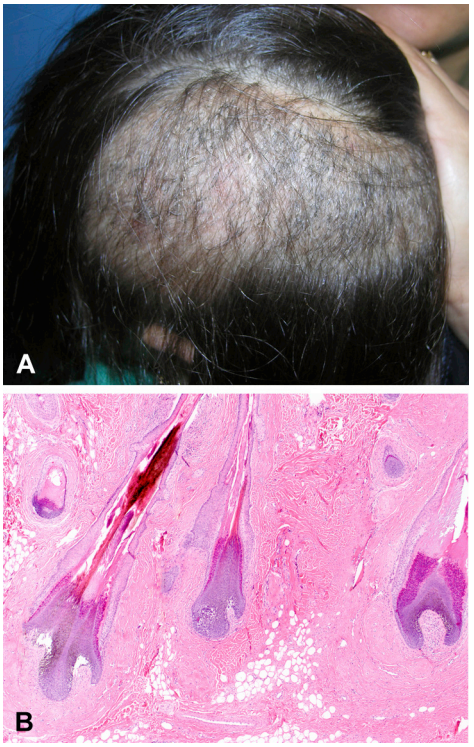

Fig 1. Pili multigemini/trichofolliculoma-like organoid nevus. Clinical appearance before surgical interventions (**A**). Vertical histologic sections showing several follicular structures (**B**). (Original magnification: ×100.)