UK guidelines for the management of Stevens-Johnson syndrome/toxic epidermal necrolysis in adults 2016 (print summary - full guidelines available at http://dx.doi.org/10.1016/j.bjps.2016.01.034)


Department of Dermatology, King’s College Hospital NHS Foundation Trust, London, SE5 9RS; *St Andrews Centre for Plastic Surgery and Burns, Mid Essex Hospital Services NHS Trust, Chelmsford, CM1 7ET; †British Association of Dermatologists, Willan House, 4 Fitzroy Square, London, W1T 5HQ; ‡Dermatology Unit, Singapore General Hospital, Singapore; §Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD; ¶Mucosa and Salivary Biology, Dental Institute, King’s College London, Guy’s Campus, Great Maze Pond, London, SE1 9RT; °University College Hospital, London, NW1 2BU; ††Clinical Experimental Sciences, Faculty of Medicine, University of Southampton, Southampton General Hospital, Southampton, SO16 6YD; †‡Department of Dermatology, Orpington Hospital, Orpington, Kent, BR6 9JU; †††Department of Dermatology, University Hospital of South Manchester NHS Foundation Trust, Manchester, M23 9LT; ‡‡Department of Histopathology, King’s College Hospital NHS Foundation Trust, London, SE5 9RS; ‡§Intensive Care Medicine, King’s College Hospital NHS Foundation Trust, London, SE5 9RS; ‡¶late of the Burns Centre, Chelsea and Westminster NHS Foundation Trust, London, SW10 9NH; ‡∥Department of Burns and Plastic Surgery, University Hospitals of South Manchester, Southmoor Road, Wythenshawe, Manchester, M23 9LT; ‡¶¶St John’s Institute of Dermatology, Guy’s and St Thomas NHS Foundation Trust, London, SE1 9RT;

Corresponding author: Daniel Creamer, daniel.creamer@nhs.net; guidelines@bad.org.uk

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Footnote:
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**Key words**: Stevens-Johnson syndrome, toxic epidermal necrolysis, drug hypersensitivity, management, guidelines
**Initial assessment on presentation**

- Take a detailed history from the patient and/or relatives
- Perform a full physical examination, including baseline body weight and record the vital signs, including oxygen saturation
- Order a set of investigations: FBC, U&E, LFT, glucose, magnesium, phosphate, bicarbonate, mycoplasma serology, CXR, skin biopsy and baseline body weight
- Initiate a primary management plan:
  1. establish peripheral venous access
  2. if patient cannot maintain adequate nutrition orally, insert a nasogastric tube and institute nasogastric feeding
  3. insert a urinary catheter if urogenital involvement is causing significant dysuria/retention

(Strength of recommendation D (GPP))

**Determination of drug causality**

- Identify causative agent and withdraw immediately

(Strength of recommendation D)

**Prognostic scoring**

- Calculate SCORTEN within the first 24 hours

(Strength of recommendation C)

**Care setting**

- A multi-disciplinary team should be convened, co-ordinated by a specialist in skin failure, usually dermatology and/or plastic surgery, and including clinicians from intensive care, ophthalmology and skin-care nursing
- Patients with greater than 10% BSA epidermal loss should be admitted without delay to a Burn Centre or ICU with experience of treating patients with SJS/TEN and facilities to manage the logistics of extensive skin loss wound care
- Patients must be barrier-nursed in a side room controlled for humidity, on a pressure-relieving mattress with the ambient temperature raised to between 25° and 28°C

(Strength of recommendation D (GPP))

**Skin management regimen 1**

*Applicable to all patients in all settings*

- Employ strict barrier nursing to reduce nosocomial infections
- Take swabs for bacterial and candidal culture from three areas of lesional skin, particularly sloughy or crusted areas, on alternate days throughout the acute phase
- Administer systemic antibiotics only if there are clinical signs of infection

(Strength of recommendation D (GPP))

**Skin management regimen 2**

*This may involve a conservative and/or surgical approach based on the specialist multi-disciplinary team’s daily review of the individual needs of the patient*

- Regularly cleanse wounds and intact skin by irrigating gently using warmed sterile water, saline or an antimicrobial such as chlorhexidine (1/5000)
- Apply a greasy emollient, such as 50% white soft paraffin with 50% liquid paraffin (50/50 WSP/LP), over the whole epidermis, including denuded areas
- Apply a topical antimicrobial agent to sloughy areas only (choice should be guided by local microbiological advice). Consider Ag-containing products/dressings.
- The detached, lesional epidermis may be left in situ to act as a biological dressing. Blisters should be decompressed by piercing and expression or aspiration of tissue fluid.
- Apply non-adherent dressings to denuded dermis (suitable dressings include Mepitel™ or Telfa™).
- A secondary foam or burn dressing should be used to collect exudate (suitable dressings include Exu-Dry®).

Institute a conservative approach in all patients as follows:

Consider transfer to a Burn Centre in patients with TEN (>30% BSA epidermal loss) and evidence of the following: clinical deterioration, extension of epidermal detachment, sub-epidermal pus, local sepsis, wound conversion and/or delayed healing. In a Burn Centre conservative measures may be supplemented with a surgical approach.
| **Fluid replacement regimen** | • Remove necrotic/loose infected epidermis and clean wounds using a topical antimicrobial agent (e.g. betadine or chlorhexidine) under general anaesthetic  
  • Consider debridement with Versajet™  
  • Physiological closure with Biobrane/ allograft/xenograft skin in patients with early presentation involving non-infected and large confluent areas  
  **(Strength of recommendation D (GPP))** |
| **Nutrition regimen** | • Site venous lines through non-lesional skin, whenever possible, and change peripheral venous cannulas every 48 hours  
  • Monitor fluid balance carefully: catheterize if appropriate/necessary  
  • Establish adequate intravenous fluid replacement initially. Fluid replacement can be guided by urine output and other endpoint measurements. Individualized fluid management should be adjusted on a daily basis.  
  • With improvement of SJS/TEN mouth involvement, oral administration of fluids should be progressively increased  
  **(Strength of recommendation D)** |
| **Analgesia** | • Provide continuous enteral nutrition throughout the acute phase  
  • Deliver up to 20 to 25 kcal/kg/day during the early, catabolic phase and 25 to 30 kcal/kg/day during the anabolic, recovery phase  
  **(Strength of recommendation C)** |
| **Supportive Therapeutic Measures** | • Use a patient appropriate validated pain tool to assess pain in all conscious patients at least once a day  
  • Patients should receive adequate analgesia to ensure comfort at rest, with the addition of supplementary opiates, as required  
  • Additional analgesia may be needed to address increased pain associated with patient handling, re-positioning and dressing changes  
  **(Strength of recommendation D (GPP))** |
| **Treatment of eye involvement** | • Immobile patients should receive low molecular weight heparin  
  • Patients in whom enteral nutrition cannot be established should receive a proton pump inhibitor to reduce the risk of stress-related gastro-intestinal ulceration  
  • Neutropenic patients may benefit from recombinant human G-CSF  
  **(Strength of recommendation C)** |
| **Treatment of mouth involvement** | • Daily ophthalmological review is necessary during the acute illness  
  • Apply an ocular lubricant (e.g. non-preserved hyaluronate or carbamollose eye drops) every two hours through the acute illness  
  • Ocular hygiene must be carried out each day by an ophthalmologist or ophthalmic-trained nurse  
  • Application of topical corticosteroid drops (e.g. non-preserved dexamethasone 0.1% twice a day) may reduce ocular surface damage  
  • Administer a broad-spectrum topical antibiotic as prophylaxis (e.g. moxifloxacin drops four times a day) in the presence of corneal fluorescein staining or frank ulceration  
  • In the unconscious patient, prevention of corneal exposure is essential  
  **(Strength of recommendation D (GPP))** |
Treatment of urogenital involvement

- Daily urogenital review is necessary during the acute illness
- Apply white soft paraffin ointment to the urogenital skin and mucosae every four hours through the acute illness
- Use a potent topical corticosteroid ointment once a day to the involved, but non-eroded, surfaces
- Use a silicone dressing (e.g., Mepitel™) to eroded areas

Treatment of airway involvement

- Respiratory symptoms and hypoxaemia on admission should prompt early discussion with an intensivist and rapid transfer to an ICU or Burn Centre, where fibre-optic bronchoscopy should be undertaken

Active therapy

- If active therapy is instituted it should be given, ideally, under the supervision of a specialist skin failure MDT in the context of clinical research and/or case registry

Discharge and follow-up

- Give the patient written information about drug(s) to avoid
- Encourage the patient to wear a MedicAlert bracelet
- Drug allergy should be documented in the patient’s notes; all doctors involved in the patient’s care should be informed
- Report the episode to the national pharmacovigilance authorities
- Organize an out-patient clinic appointment, and if required an ophthalmology out-patient appointment, within a few weeks of discharge
- Refer for review to unit with appropriate sub-speciality interest

Diagnostic testing

- Routine drug hypersensitivity testing is not recommended following an episode of SJS/TEN.
- Seek specialist advice on hypersensitivity testing where:
  1. the culprit drug is not known or
  2. medication avoidance is detrimental to the individual or
  3. accidental exposure is possible

SUPPORTING INFORMATION

Additional supporting information including the search strategy may be found in the full online version of this article here: http://dx.doi.org/10.1016/j.bjps.2016.01.034.

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