9/7/23 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter***: *Gabriel Lukban (@gbbylk0148)* ***Case Discussants***: *Rabih (@Rabihmgeha) and Kiara (@Kiaracamacho96)*

CC: 62yM w/ bl eye redness and purulent discharge.

HPI: 3d prior used otc eye drops, no improvement. Painful sores, fever 39.5C max. Diagnosed with acute gingivitis and bac conjunctivitis. Given tobra-dexamethasone eye drops. Could not tolerate solids which prompted presentation to ED. treated with piperacillin-bactam, cipro eye drops, magic mouthwash
Day 2 of admission, developed rash over chest and back, drooling and dyspnea

PMH: b/l nephrolithiasis, HTN on losartan, asthma, DM2 (dx 2 wks ago), hyperuricemia

Meds: potassium citrate, budesonide, metformin, allopurinol (stopped 3-4d ago due to itchiness)

Fam Hx: Unremarkable

Soc Hx: unremarkable

Health-Related Behaviors: None

Allergies: None

Vitals: BP 120/70 HR 85 RR 23 T 37.8C o2 sat 93%
Exam:
Gen: mod-severe distress, unable to speak due to pain, AxO x3
HEENT: matted eyelashes, purulent eye discharge and erythema. Eyes closed due to pain. No blurry vision.
Pulm: wheezing
Abd: soft nt nd
Extremities/skin: clustered erythematous circular lesions, purpuric on upper back and chest. Scattered erythematous to crusted lesions on forehead, glabella and perioral area. Erythematous patches over buccal mucosa and back of throat. 2x2 cm ulcer over scrotum

Notable Labs & Imaging:
Hematology:
WBC: 12.4 (neu 76%, lymph 15%) Hgb,Plt: unremarkable

Chemistry:
Na, K, Cl, BUN/Cr: wnl
AST: 63 (normal range 59) ALT: wnl
Bcx, oral swab -ve
CXR unremarkable
Flexible laryn: inflamm and erosion of pharynx, epiglottis. No obst

Treated with iv methylprednisolone. Condition improved

Final Dx: SJS due to allopurinol and suspected secondary bacterial infection

Problem Representation: 62yM w/ h/o hyperuricemia recently started on allopurinol p/w b/l eye redness and purulent discharge, sores, fever, dyspnea, and erythematous purpuric lesions on exam found to have allopurinol-induced SJS and suspected secondary bacterial infection

Teaching Points: Ayesha
- The approach to eye redness should mimic cellulitis (is it skin involvement or deeper?). Degree of discharge = determines level of inflammation
- Bilateral discharge = viral (which is not overtly purulent), the more discharge there is, the more likely it's a deeper surface issue. (This is too severe for conjunctivitis)
- Infections + drugs out of inflammatory would more likely cause these subacute symptoms
- Determine: Extent of devastation of rash on surface of body (how deep, and how wide), and how much has it evolved?
- Allopurinol → can cause hypersensitivity reaction.
- Superficial vs. deeper disease both give very different diagnosis. (Does dyspnea point to a more deeper issue?)
- Superficial rash (due to drugs most of time). Is it a systemic disease part of derm manifestation or just a superficial rash?
- **SJS & TEN** → causes skin lesions + mucosal = with no visceral disease → *labs might be **negative***. Airway stenosis + bronchiolitis could be due to the mucosal involvement of SJS. high fever, mucosal involvement first (devastating, severe, ulcerative), followed by skin involvement.
- **Drug induced hypersensitivity syndrome** - more visceral involvement compared to SJS. (visceral, renal and hepatic predominance insync with an erythrodermic rash)
- Delayed presentation of SJS /drug induced hypersensitivity → cardiomyopathy and thyroid disease
- HLAB51 test - helps to determine hypersensitivity to allopurinol