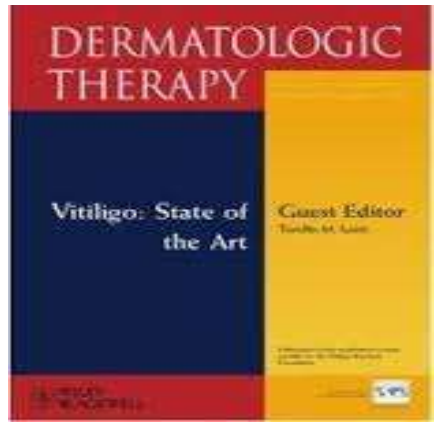
ĐIỂM BÁO DA LIỄU THÁNG 7/2020

TS.BS. Nguyễn Trọng Hào

Ngày 10/7/2020



Treatment of recalcitrant viral warts using a 1064 nm Nd:YAG laser

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Background and Objectives

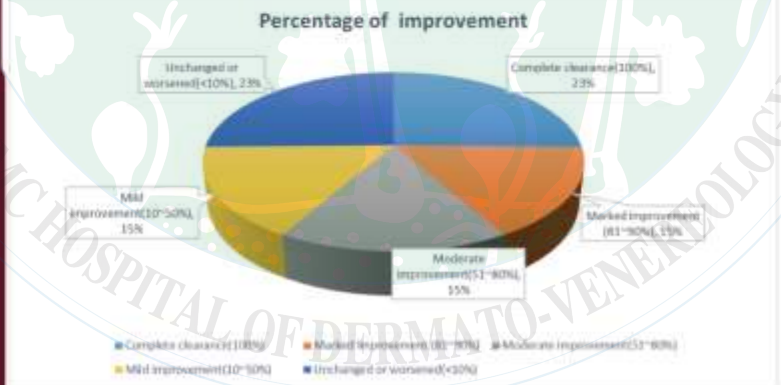
- Viral warts are benign proliferations of epithelial cells caused by infection by human papilloma virus (HPV) types 1, 2, 4 and 57. The best approach to treatment-refractory warts is unclear.
- There is a variable treatment modalities regarding the therapies of recalcitrant warts, Laser therapy is considered a promising treatment method for recalcitrant warts.
- Different types of lasers have been used for treatment of warts. long-pulsed Nd:YAG laser is considered a good treatment modality in resistant plantar warts.
- We evaluated the clinical improvement of 13 patients with a recalcitrant viral wart who were treated with a long pulsed ND:YAG laser

Study Design and Methods

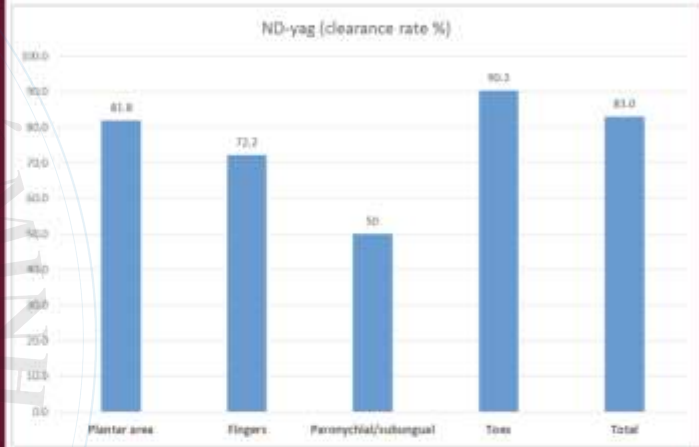
- We defined recalcitrant warts as those not responding to other treatments and being present for longer than 6 months.
- This study included 13 patients with single or multiple recalcitrant viral warts that persisted for more than 6 months.
- 13 patients with 206 recalcitrant plantar warts who were treated by 1064 Nd:YAG laser.
- The diagnosis of plantar warts was made by clinical examination.

Results and Conclusion

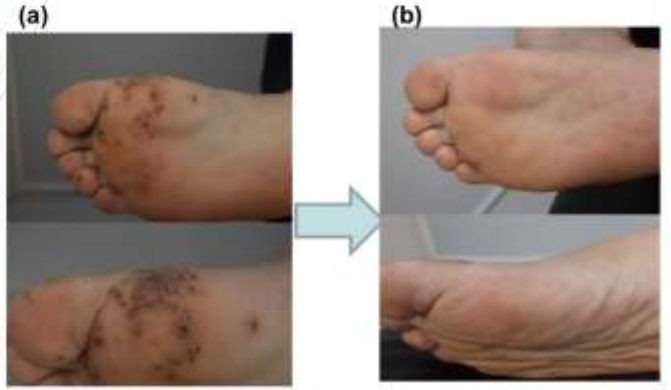
- 3 patients (23%) were completely cleared of their warts with long-pulsed Nd:YAG laser.
- 205 recalcitrant viral warts were decreased to 35 lesions; total clearance rate are 83%.
- There are no significant adverse effect.
- Nd:YAG laser emits microwaves with a wavelength of 1064 nm.
- This is the ideal wavelength to destroy the HPV virus.
- Long-pulsed Nd:YAG laser for to treat recalcitrant viral wart is safety and efficiency therapeutic modality.



* Percentage of improvement after Nd:YAG laser treatment at the final follow-up visit.



* Percentage of improvement observed in warts by location



* Treatment progression at various time points in subject 10. (a) Baseline, (b) post-final treatment

J Korean Med Sci 2009; 24: 889-93
ISSN 1011-8934
DOI: 10.3346/jkms.2009.24.5.889

Long-Pulsed Nd:YAG Laser Treatment of Warts: Report on a Series of 369 Cases

Various treatment methods have been adopted in the management of warts; however, there is still no consensus on first-line treatment. This study was designed to evaluate the efficacy of long-pulsed Nd:YAG laser in the treatment of warts. Over the course of 1 yr, 369 patients with recalcitrant or untreated warts were exposed to a long-pulsed Nd:YAG laser. The following parameters were used: spot size, 5 mm; pulse duration, 20 msec; and fluence, 200 J/cm^2. No concomitant topical treatment was used. In all, 21 patients were lost during follow up; hence, the data for 348 patients were evaluated. The clearance rate was 96% (336 of the 348 treated warts were eradicated). The clearance rate of verruca vulgaris after the first treatment was very high (72.6%), whereas the clearance rate of deep palmopantar warts after the first treatment was low (44.1%). During a median follow-up period of 2.24 months (range, 2-10 months), 11 relapses were seen (recurrence rate, 3.27%). In conclusion, long-pulsed Nd:YAG laser is safe and effective for the removal or reduction of warts and is less dependent on patient compliance than are other treatment options.

Key Words : *Lasers; Warts*

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Received : 15 April 2008
Accepted : 25 October 2008

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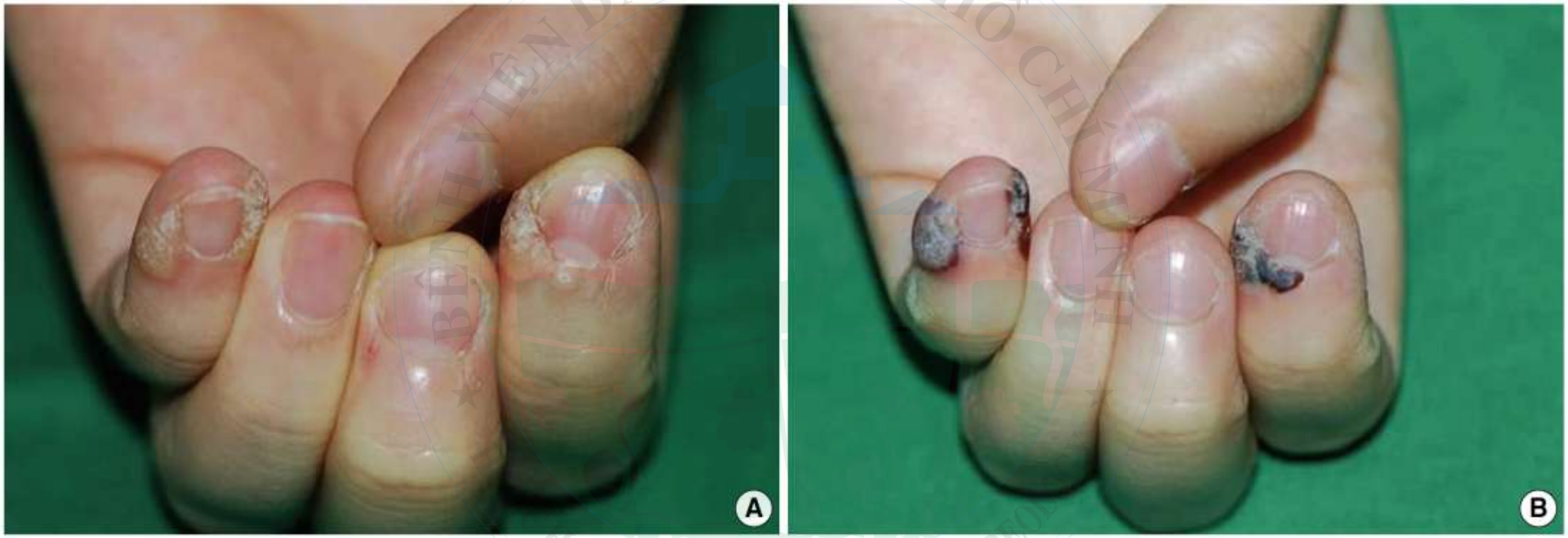

Fig. 5. (A) Periungual wart. (B) Crusts were formed three days after treatment.

Han TY et al. J Korean Med Sci. 2009 Oct;24(5):889-93

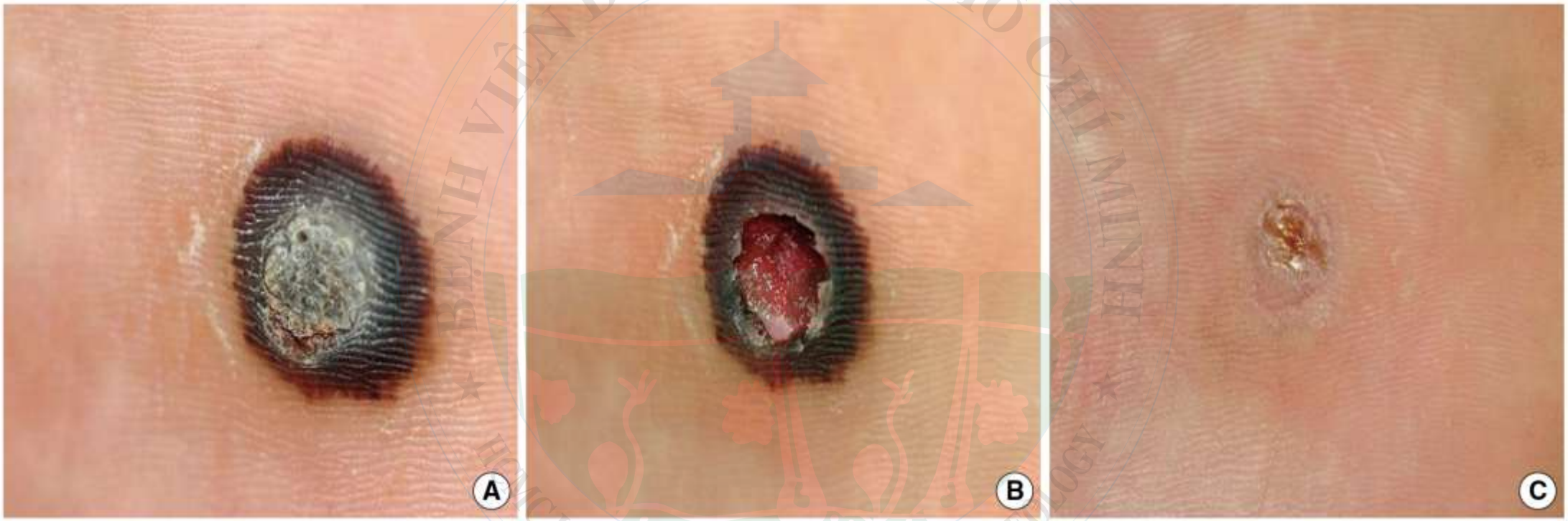

Fig. 6. (A) Deep palmoplantar wart three days after treatment. (B) After one week. (C) After two weeks.

Han TY et al. J Korean Med Sci. 2009 Oct;24(5):889-93

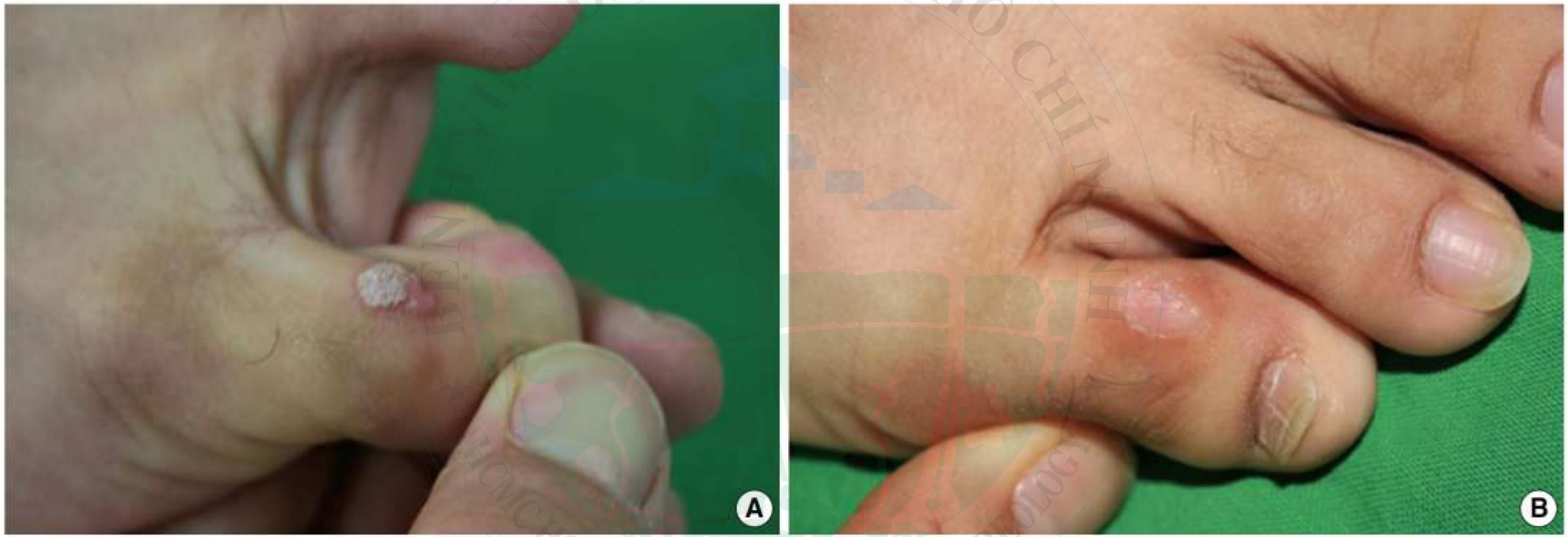

Fig. 7. (A) Verruca vulgaris on the toe. (B) Complete clearance after only one treatment session.

Han TY et al. J Korean Med Sci. 2009 Oct;24(5):889-93

The effect of silymarin on liver enzymes in patients taking isotretinoin: A randomized clinical trial

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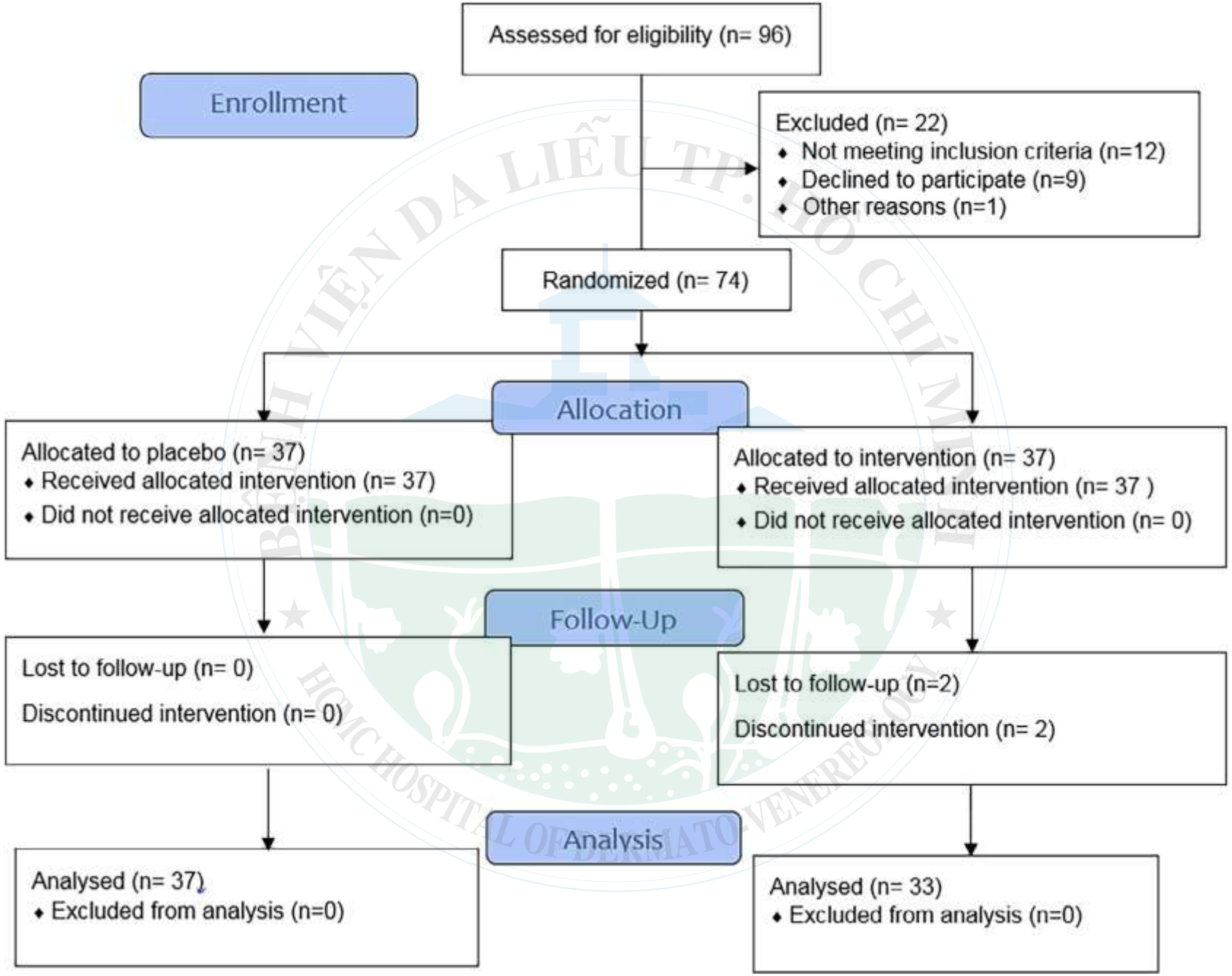
Funding information
Arak University of Medical Sciences, Grant/

Abstract

The aim of the present study was to investigate the effect of silymarin (Livergol) on liver enzymes in patients taking isotretinoin (Roaccutane). In this double-blind clinical trial, 74 patients with acne and taking isotretinoin were randomly assigned into intervention (N = 37) and control (N = 37) groups. The intervention group received a 140 mg Livergol capsule per day for 30 days. The control group received a starch-containing capsule as a placebo once a day for 30 days. Liver enzyme levels were measured before and after the intervention. The data were analyzed using chi-square test, Independent t test, paired sample t test and analysis of covariance (ANCOVA). The results showed no statistically significant difference between the intervention and control groups at the beginning of study in levels of aspartate aminotransferase (AST), alanine aminotransferase (ALT) and alkaline phosphatase (ALP) ($p > .05$). At the end of the study, a statistically significant difference was observed between the two groups in levels of AST and ALT ($p < .05$). Livergol prevented liver enzymes from increasing, so it can be used as an effective, low-cost, and low-complication treatment for the problem of increased levels of liver enzymes following the use of isotretinoin.

Mirnezami M et al. Dermatol Ther. 2020 Mar;33(2):e13236. doi: 10.1111/dth.13236



Mirnezami M et al. Dermatol Ther. 2020 Mar;33(2):e13236. doi: 10.1111/dth.13236

Variables		Groups		
		Intervention (mean ± *SD*)	Control (mean ± *SD*)	*p*-value[a]
AST	Before	21.20 ± 6.47	19.90 ± 4.41	.340
	After	19.33 ± 4.55	23.81 ± 5.73	.001
	p-value[b]	$p < .001$	$p = .009$	
ALT	Before	19.09 ± 8.67	18.94 ± 5.13	.930
	After	16.36 ± 6.33	21.35 ± 7.65	.004
	p-value[b]	$p < .001$	$p = .008$	
ALP	Before	199.12 ± 71.19	202.78 ± 58.62	.814
	After	193.75 ± 59.99	213.56 ± 65.46	.193
	p-value[b]	$p < .001$	$p < .001$	

Mirnezami M et al. Dermatol Ther. 2020 Mar;33(2):e13236. doi: 10.1111/dth.13236

Management of granulomatous foreign body reaction to fillers with methotrexate

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Abstract

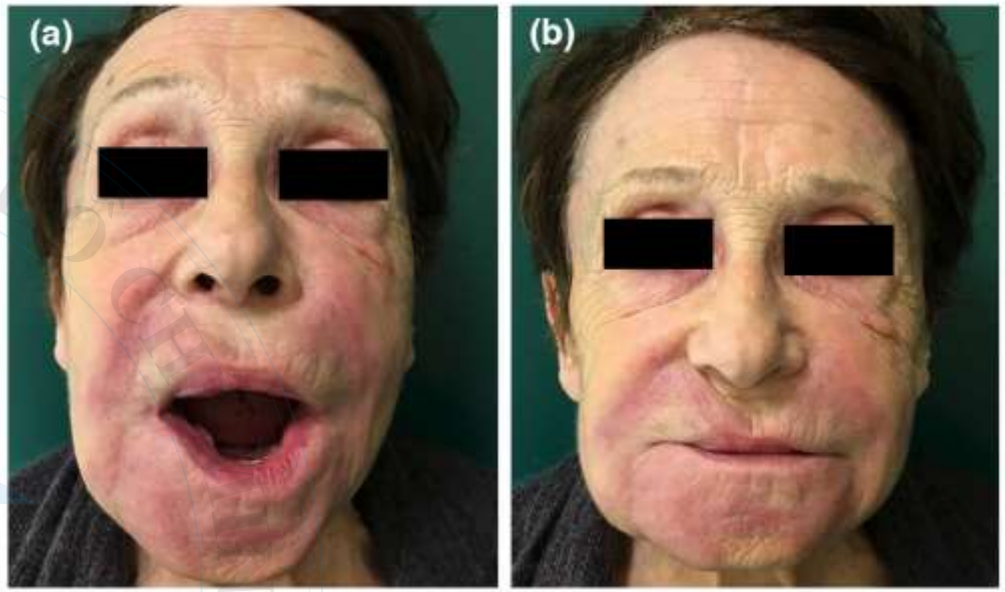
Background Granulomatous foreign body reactions (GFBR) have been reported after injection with almost every soft tissue fillers, more commonly with non-biodegradable ones. Such granulomatosis is rare but can cause significant discomfort owing to their aesthetic and functional repercussions.

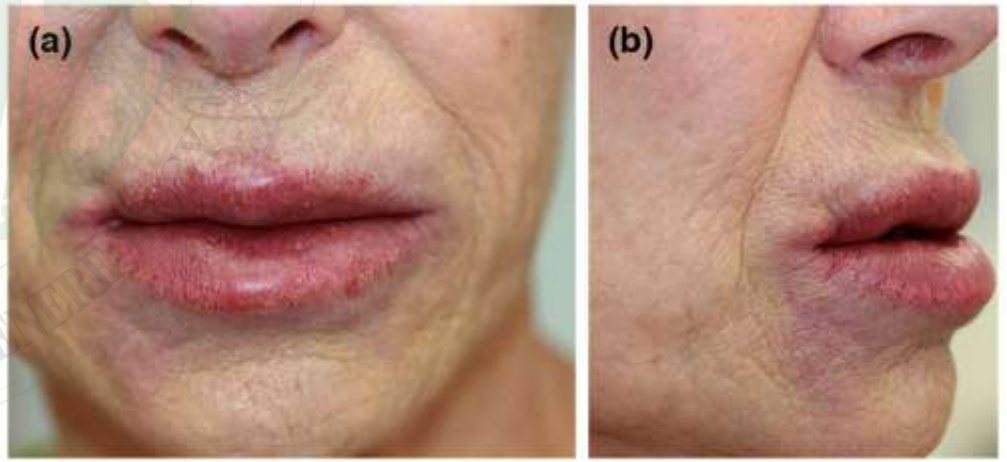
Objective To determine whether immunomodulation with low doses of methotrexate is effective in the treatment of GFBR to filler material.

Methods Clinical case series of four patients with severe, treatment-resistant GFBR to non-biodegradable fillers in the Department of Dermatology of Bordeaux University Hospital, Bordeaux, France, successfully treated with oral or subcutaneous methotrexate, 10–15 mg weekly during 6 months. Adverse events were monitored throughout the treatment once weekly the first month then once monthly the remaining 5 months.

Results Four women with a mean age of 73.7 years (66–85 years) and nodularity of the face were included and treated up to 6 months. Histological findings were consistent with GFBR to liquid injectable silicone in 2 cases, polymethylmethacrylate in 1 case and hydroxyethylmethacrylate in the last case. The delay after injection of the filler material was from 17 to 30 years. In one patient, inflammatory lesions followed dental care. After 6 months of treatment with 10–15 mg once weekly, all patients were cleared. Three patients developed a mild hepatic cytolysis (grade 1 or 2). Methotrexate could be maintained in those 3 cases and was discontinuated after 6 months in all cases. Two patients developed recurrence of lesions, 28 and 9 months, respectively, after treatment stops, requiring reintroduction of treatment. The two other patients remained cleared after 6 months of follow-up.

Conclusion Low doses of methotrexate appear to offer a low-risk therapeutic alternative in resistant and severe GFBR to fillers. A prospective study with long-term follow-up is required to confirm these preliminary observations.

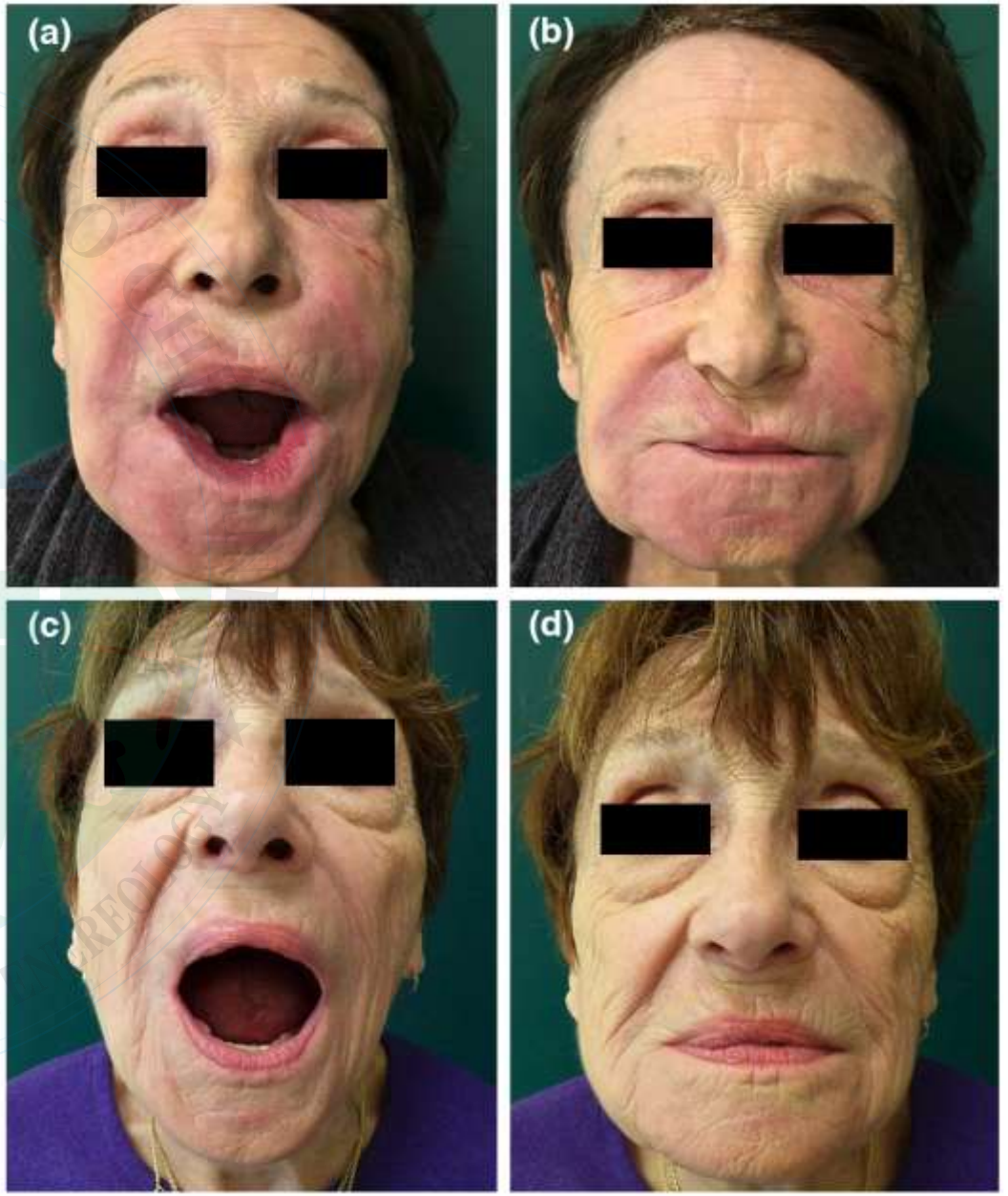




Broly M et al. J Eur Acad Dermatol Venereol. 2020 Apr;34(4):817-820.

Case 1

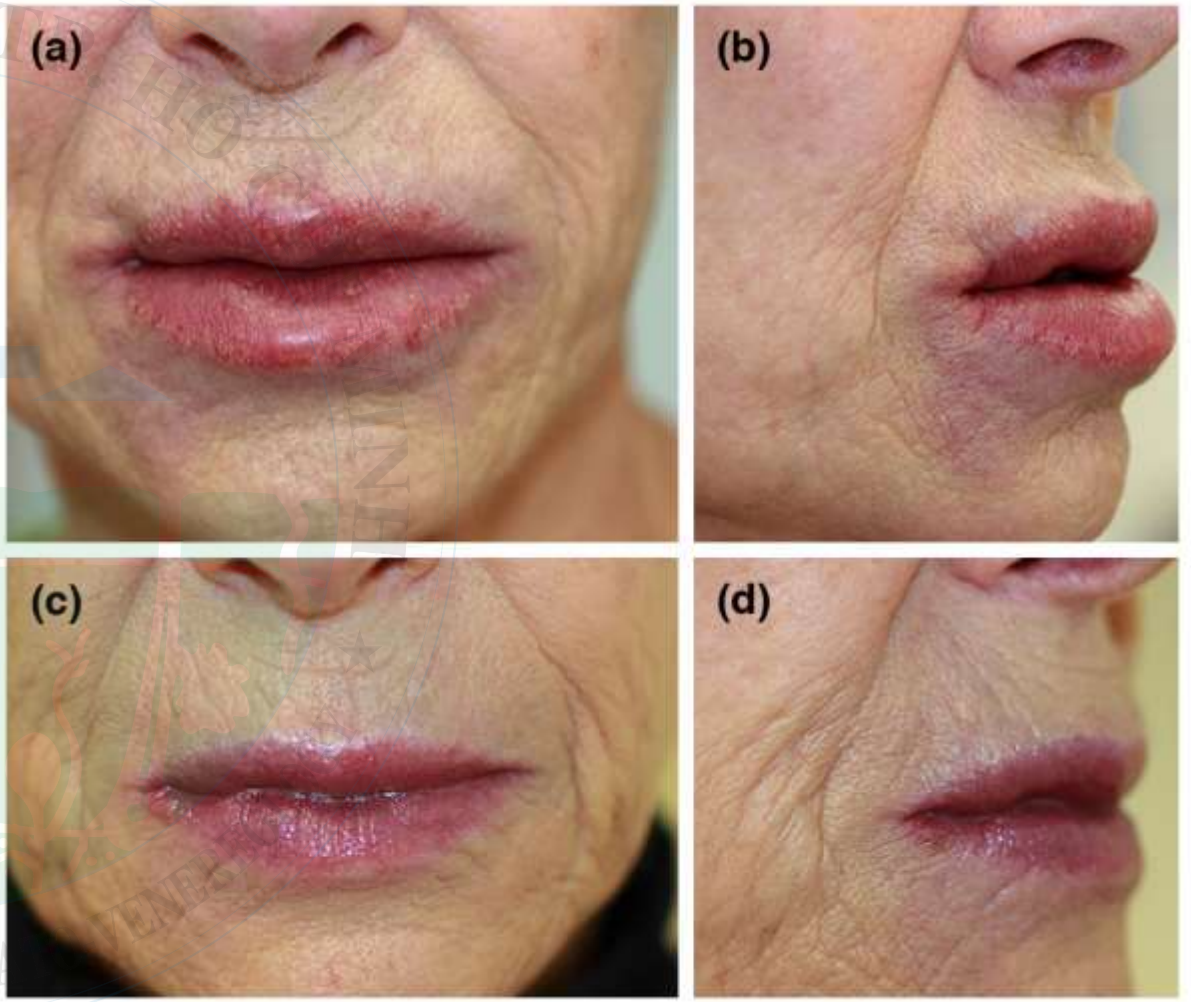
- An 85 y.o woman, progressive firmness and nodules in the perioral region of 3 years duration.
- Lips and nasolabial folds injected with permanent fillers 20 years earlier.
- The lesions were initially noticed following a dental procedure (titanium implants).
- MRI: a subcutaneous facial soft tissue infiltration in the perioral and submandibular region.
- Histological findings: a delayed reaction to liquid injectable silicone (LIS), showing diffuse dermal granulomatous reaction with shaped and clear vacuoles, both extracellular and within giant cells or macrophages likened to ‘swiss cheese’.
- A once weekly 10 mg dose of subcutaneous methotrexate, for 6 months with a good tolerance.



Broly M et al. J Eur Acad Dermatol Venereol. 2020 Apr;34(4):817-820.

Case 2

- A 71 y.o woman, lip chronic oedema 18 years after an intralabial injection of polymethylmethacrylate (PMMA)
- A skin biopsy: histiocytic granulomatous reaction with giant cells surrounding optically round vacant vacuoles consistent with a delayed reaction to PMMA.
- Methotrexate was administered subcutaneously 10 mg weekly for 6 months, leading to a complete regression of the swelling and infiltration

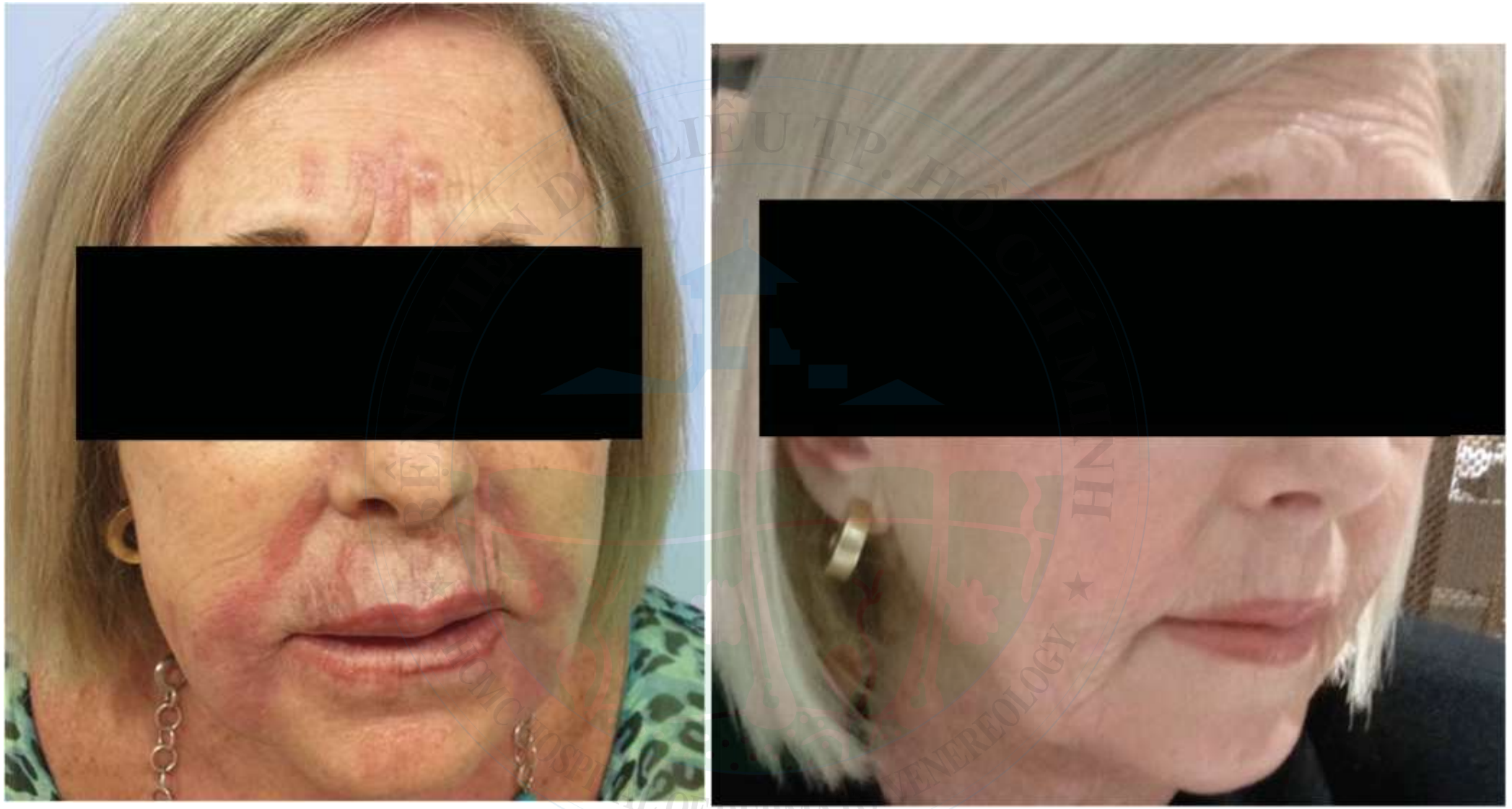


Broly M et al. J Eur Acad Dermatol Venereol. 2020 Apr;34(4):817-820.

Discussions

- Rare, incidence: 0.02–2.8%
- Usually delayed (up to 20 years) mainly with nonbiodegradable filling materials (PMMA, HEMA, LIS, polyacrylamide gel or polyalkylimide gel), unusual with HA.
- Risk factors: recurrent dental or sinus infections, trauma, polyallergy, treatment with interferon alpha or omalizumab or chronic systemic inflammatory diseases
- Prolonged administration of antibiotics
- Oral and/or intralesional corticosteroids
- intralesional 5-FU
- Allopurinol, minocycline, colchicine, ciclosporine, etanercept,
- topical imiquimod or tacrolimus
- intralesional diode laser
- CO2 laser
- Surgical excision

Broly M et al. J Eur Acad Dermatol Venereol. 2020 Apr;34(4):817-820.



Methotrexate: 15mg/week

3 months

Carmen P´erez-Ruiz et al. Dermatol Surg. 2019 Mar;45(3):489-492

Contents lists available at ScienceDirect

American Journal of Ophthalmology Case Reports

journal homepage: www.elsevier.com/locate/ajoc

Case report

Disseminated silicone granulomatosis in the face and orbit

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ARTICLE INFO

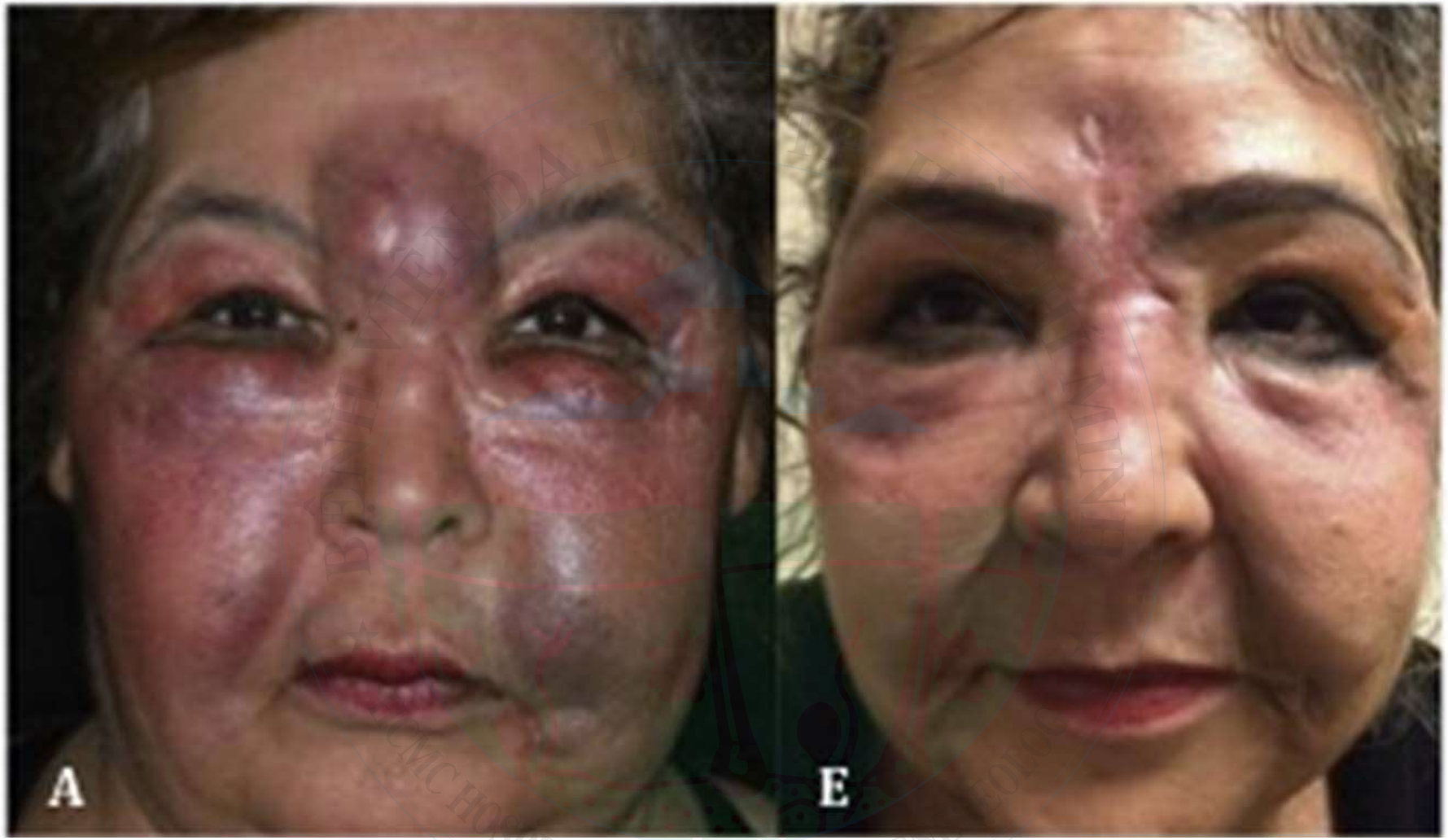
Keywords:
Silicone
Disseminated
Silicone granulomatosis
Orbit
Breast implants
Autoimmune/inflammatory syndrome

ABSTRACT

Purpose: To report a case of disseminated silicone granulomatosis presenting with ptosis, proptosis and vision loss.

Observations: A 56-year-old female presented with ptosis, proptosis, and vision loss and was noted to have palpable, erythematous masses involving the orbit, face, trunk, and body. She had a history of bilateral silicone breast implants and cosmetic facial filler injections. Orbital biopsy demonstrated non-caseating granulomas with foreign-body giant cells and vacuoles containing material consistent with silicone. Removal of the patient's breast implants and systemic immunosuppression led to dramatic granuloma regression.

Conclusions: Silicone can induce a severe, systemic inflammatory response and should be considered in the differential for facial and periorbital granulomas in patients with a history of silicone breast implants. Management of disseminated silicone granulomatosis is challenging and requires multimodal treatment with silicone removal and systemic immunomodulation.



doxycycline + methotrexate

Chen TA et al. Am J Ophthalmol Case Rep. 2018 Feb 4;10:32-34.

Observation on the effects of 595- nm pulsed dye laser and 755- nm long-pulsed alexandrite laser on sequential therapy of infantile hemangioma

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ABSTRACT

Background: Infantile hemangioma (IH) can lead to severe complications. The 595-nm pulsed dye laser is poorly effective on thick and deep IH. Long-pulsed alexandrite laser has the proper wavelength of 755 nm and a relatively deep penetration. Thus, this may be a safe and effective treatment method for relatively deep or thick IH.

Aims and objectives: This study aims to determine whether 595-nm pulsed dye laser and 755-nm long-pulsed alexandrite laser in sequential therapy are safer and more effective for relatively deep or thick hemangioma.

Materials and Methods: This was a prospective study. A total of 194 infantile IH patients (thickness greater than 2 mm and less than 8 mm) were randomly divided into two groups: control group (treated using 595-nm pulsed dye laser) and experimental group (treated by sequential therapy with 755-nm long-pulsed alexandrite laser and 595-nm dye laser).

Results: The control group had a total effective rate of 36.1%, while the experimental group had a total effective rate of 76.3%. Enumeration data were compared by X^2-test. The results were considered statistically significant at $P < .05$.

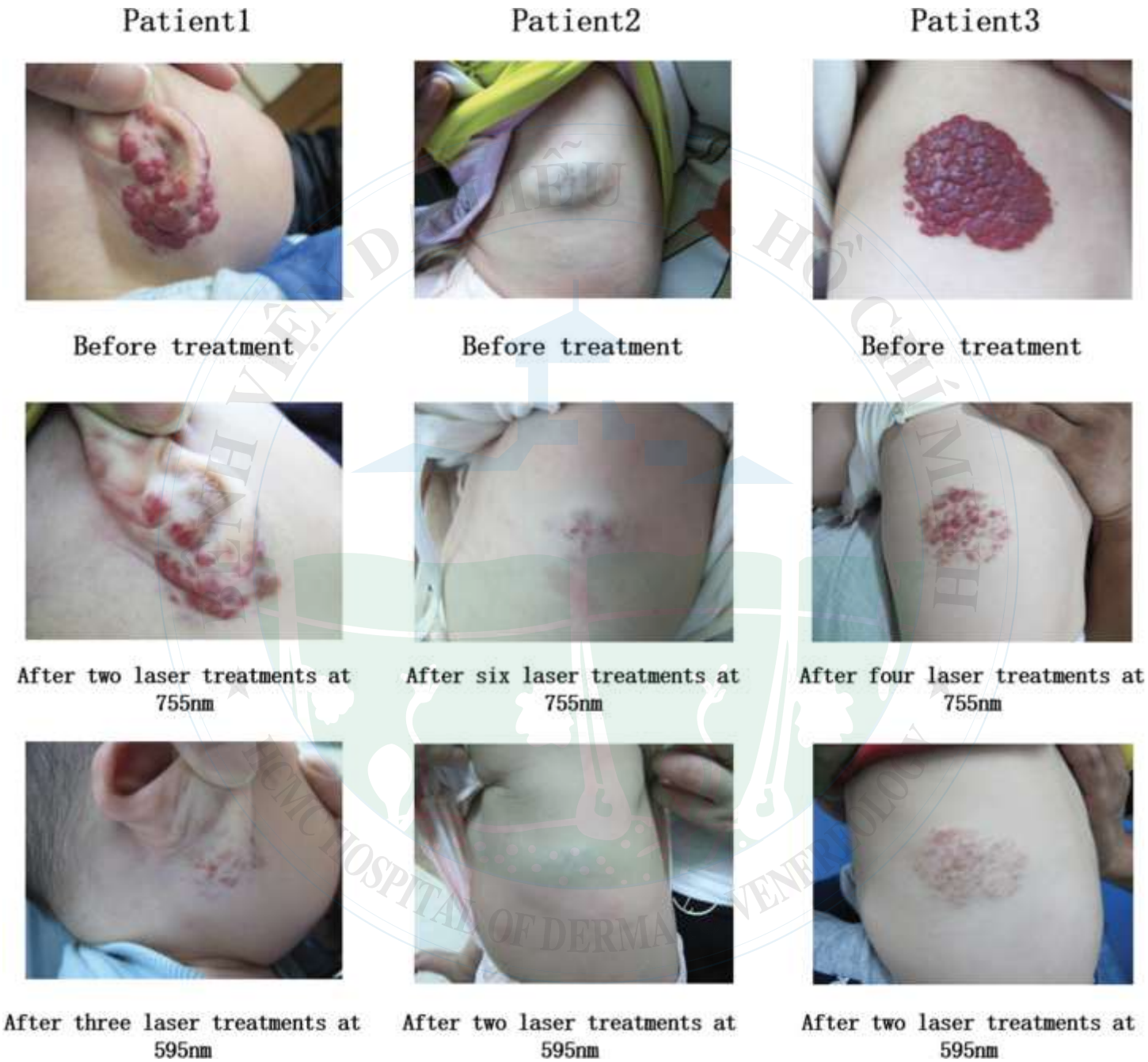
Conclusion: Sequential therapy with 755-nm pulsed dye laser and 595-nm long-pulsed alexandrite laser is a safe and effective treatment approach for relatively deep or thick hemangioma.

ARTICLE HISTORY

Received 9 January 2019
Revised 24 April 2020
Accepted 12 June 2020

KEYWORDS

Hemangioma; 755-nm long-pulsed alexandrite laser; 595-nm pulsed dye laser



Jin WW et al. J Cost Laser Ther. 2020 Jun 26;1-6. doi: 10.1080/14764172.2020.1783452

Topical 5% tranexamic acid for acne-related postinflammatory erythema

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Delhi, India

Key words: acne; postinflammatory erythema; tranexamic acid.

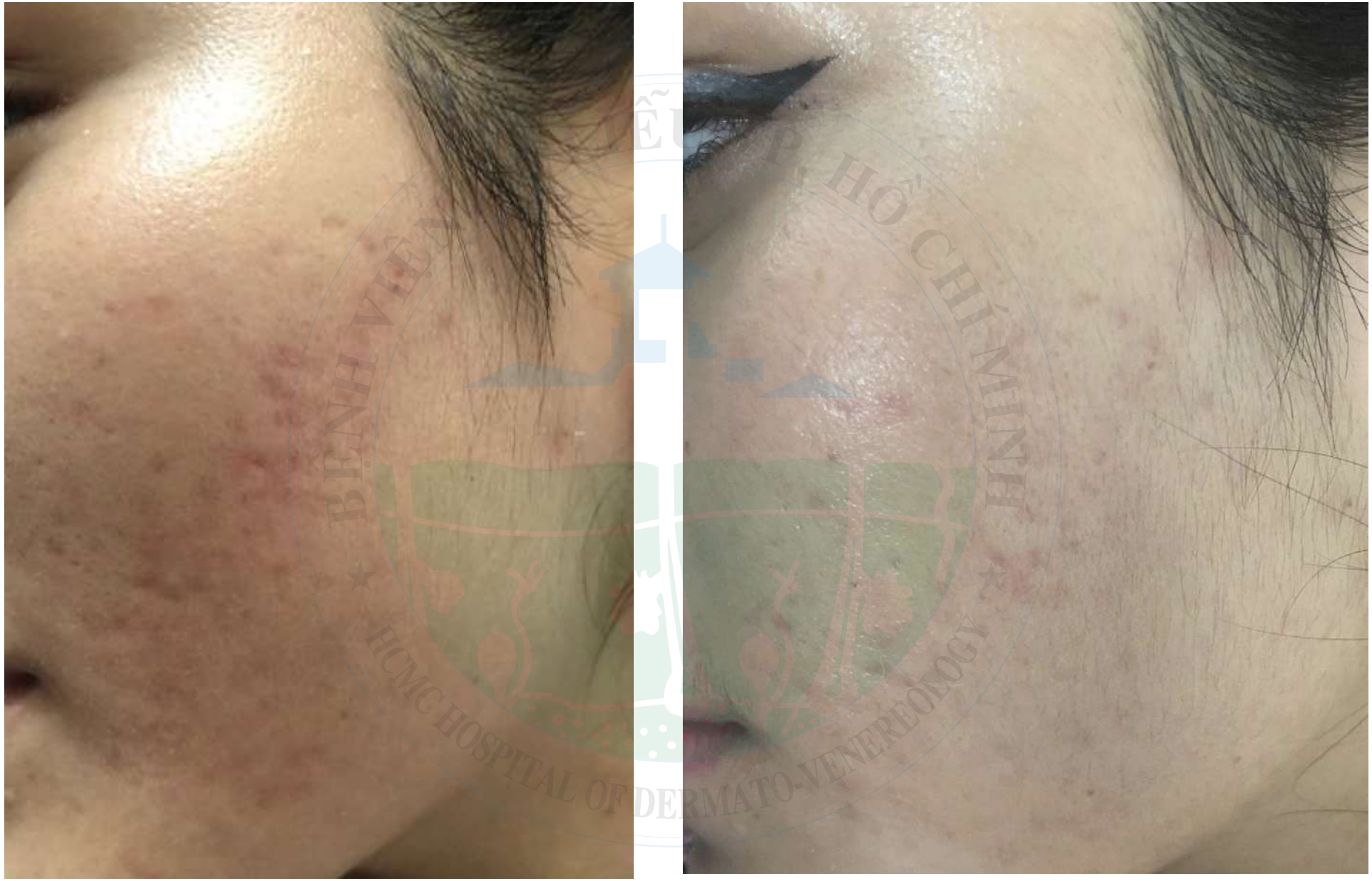
Abbreviations used:

PIE: postinflammatory erythema
TXA: tranexamic acid

THERAPEUTIC CHALLENGE

Postinflammatory erythema (PIE) is a common sequala of acne inflammation (Fig 1); it is cosmetically unacceptable and remains a therapeutic challenge. Pulse-dye laser and fractional microneedling radiofrequency have been used for the treatment of PIE.[1]

Jakhar D, Kaur I. J Am Acad Dermatol 2020;82:e187-8



Jakhar D, Kaur I. J Am Acad Dermatol 2020;82:e187-8

Solution

- Topical TXA has to be formulated from the injectable TXA (500 mg/5 mL).
- Diluted with 0.9% sodium chloride solution to give a 5% TXA solution.
- Stored in an ethylene/propylene copolymer plastic container.
- Stored away from light at room temperature, retain 98% of initial potency through 90 days.
- Given as a daily nighttime application, 5% topical TXA reduces erythema in 6 to 8 weeks.

Jakhar D, Kaur I. J Am Acad Dermatol 2020;82:e187-8

Journal Pre-proof

Topical timolol in chronic, recalcitrant fissures and erosions of hand eczema

Manoj Pawar, MD

PII: S0190-9622(20)30685-X

DOI: https://doi.org/10.1016/j.jaad.2020.04.070

Reference: YMJD 14500

To appear in: *Journal of the American Academy of Dermatology*

Received Date: 1 April 2020

Revised Date: 10 April 2020

Accepted Date: 15 April 2020

Pawar M. [published online April 22, 2020]. *J Am Acad Dermatol*. doi: 10.1016/j.jaad.2020.04.070

- timolol 0.5% ophthalmic solution
- 2-3 drops over each fissure/erosion at bedtime

Pawar M. [published online April 22, 2020]. *J Am Acad Dermatol*. doi: 10.1016/j.jaad.2020.04.070

Using Hypodermic Needle as Suture Needle in Emergency

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Abstract

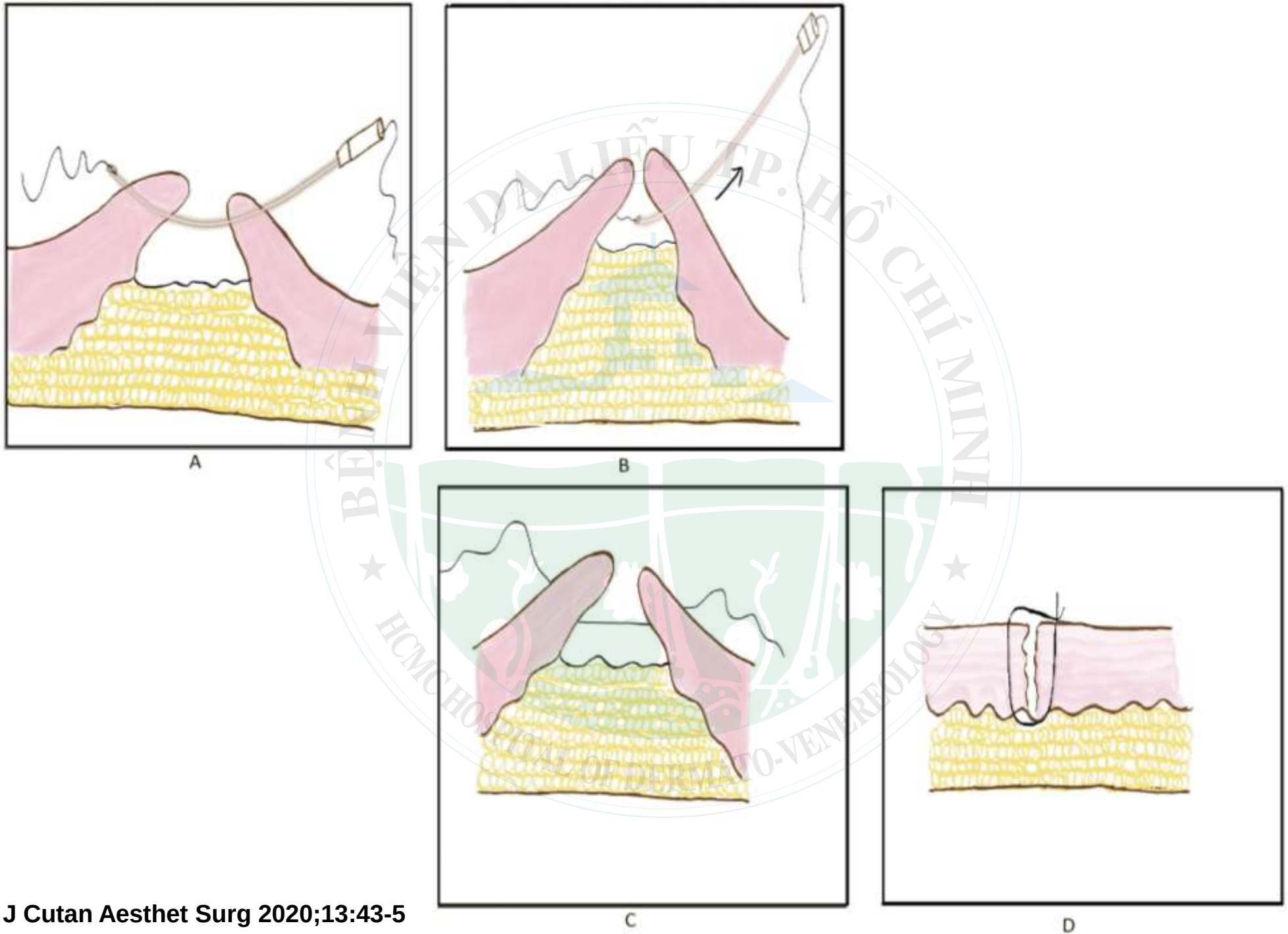
Sometimes, suture thread detaches from needle while suturing. This leads to wastage of left over thread and we have to repeat whole process of suturing as the extra suture needles are not easily available. The present article highlights the use of hypodermic needle as suture needle in such emergencies.

Keywords: Hypodermic needle, dermatosurgery, suturing, emergency, innovation, make shift

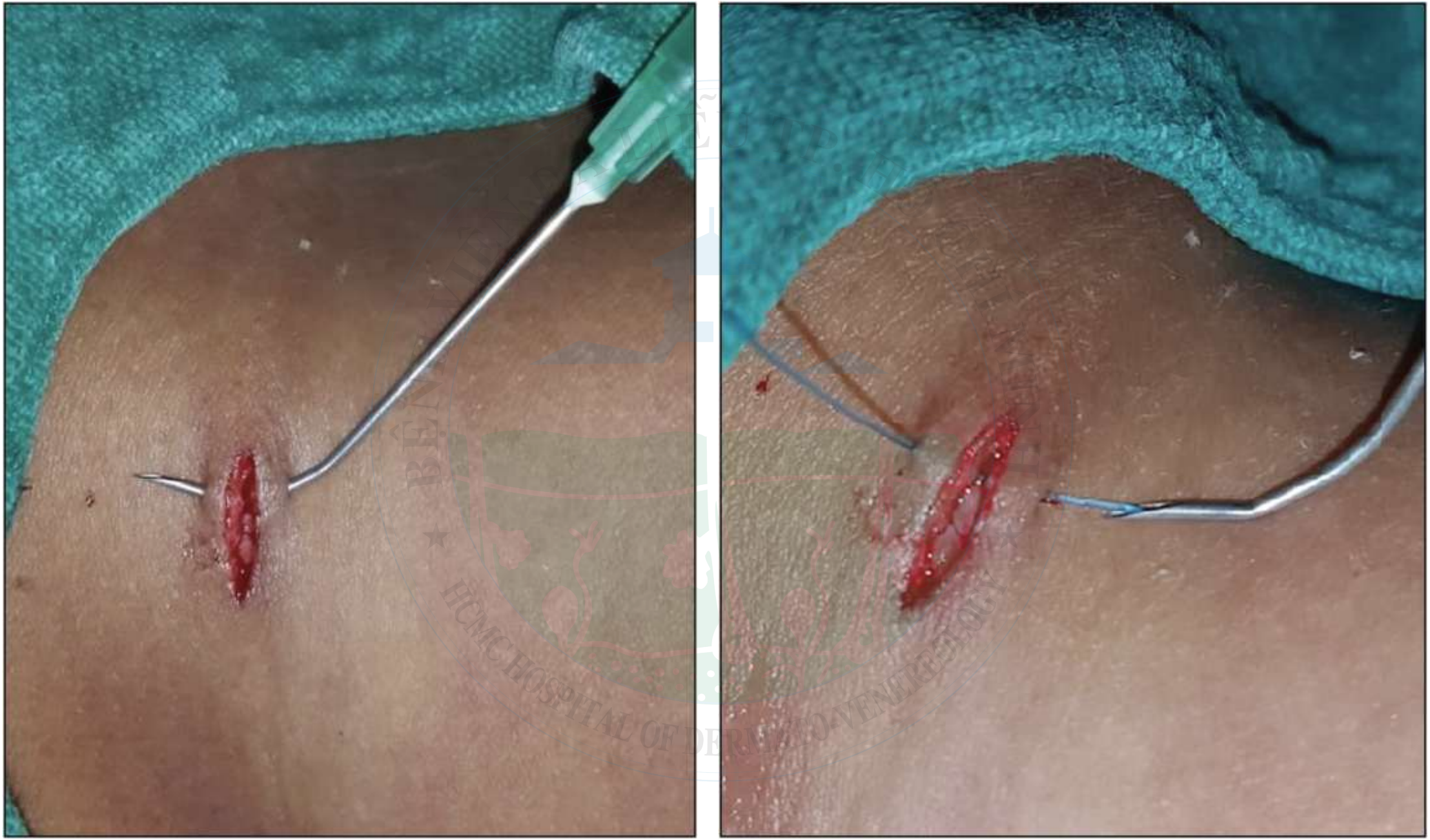
Surgical Challenge

Most of suture materials available in market are with swaged needle. The swaged needle is supposed to be less traumatic. Unfortunately, sometimes the suture thread detaches from the needle or even breaks, particularly when suturing is carried out on physiologically thick skin such as feet and upper back or pathologically hyperkeratotic, acanthotic, or fibrosed skin. Moreover, extra suture needles (with eye) of appropriate sizes are not easily available. This leads to repetition of whole of suturing process in continuous suturing or wastage of suture thread in interrupted suturing.[1]

needle while suturing as the needle may get weakened because of repeated compressions to secure the suture thread. To overcome these limitations, we recommend using an intact hypodermic needle after gently curving it with a sterile artery forceps or needle holder. The needle is then passed through the wound edges [Figure 1A] followed by passing of desired suture thread through any end of the needle. The suture is then taken out from the other end of needle and knot is tied after withdrawing the needle [Figures 1–3]. The gauge of hypodermic needle is chosen according to site of the wound as the different monofilament suture threads, for example, number 0, 2-0, 3-0, 4-0, 5-0 can pass through hypodermic needles of 21, 22, 23, 24, and 26 G, respectively.



Gupta S et al.. J Cutan Aesthet Surg 2020;13:43-5



Gupta S et al.. J Cutan Aesthet Surg 2020;13:43-5

Chemical cautery pen

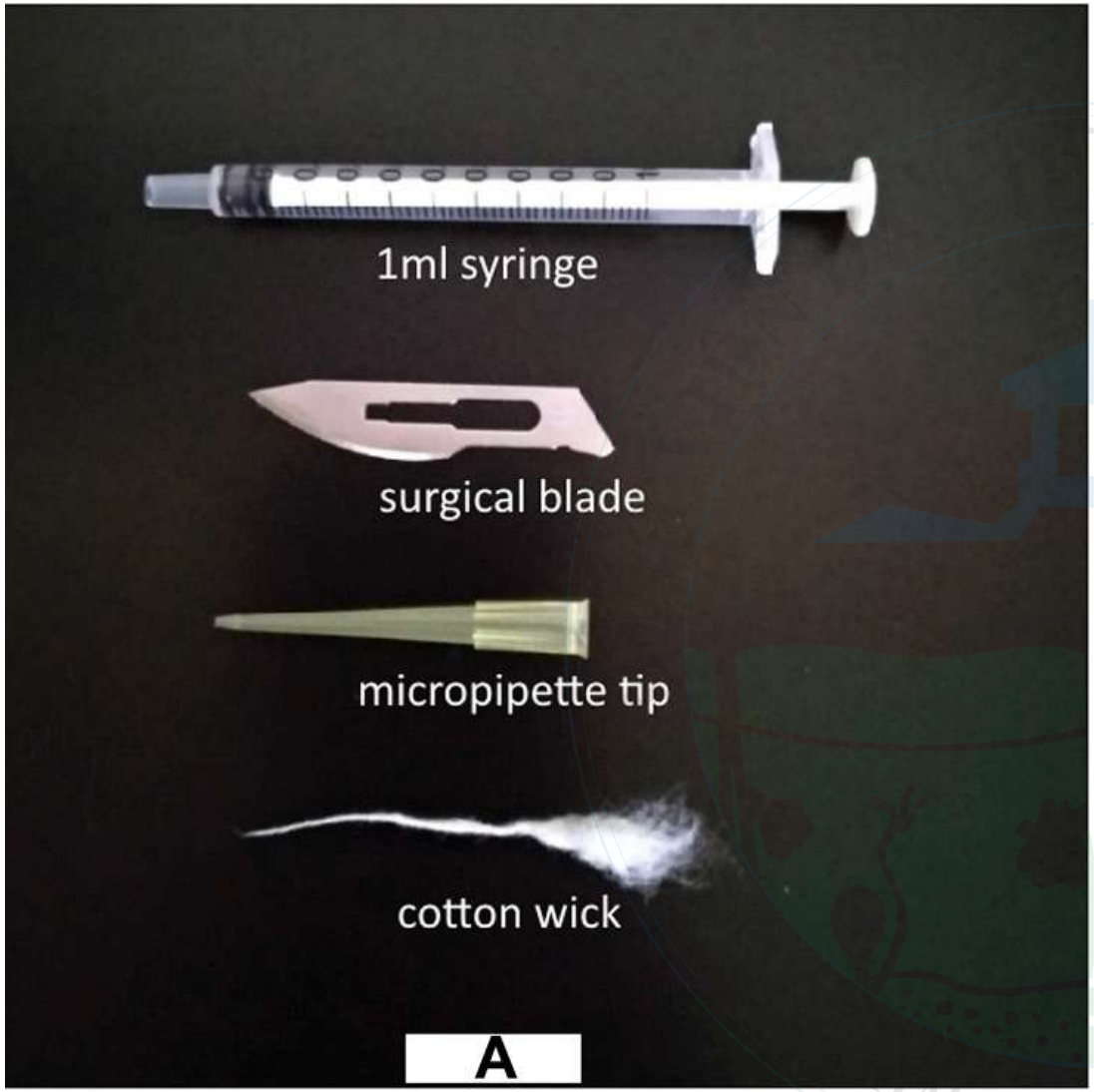
Ravi Shankar Jangra, MD,[a] Sanjeev Gupta, MD, DNB,[a] Somesh Gupta, MD,[b] and Anu Dr, MBBS[c]
Mullana, Ambala, India; New Delhi, India; and Budhera, Gurgaon, India

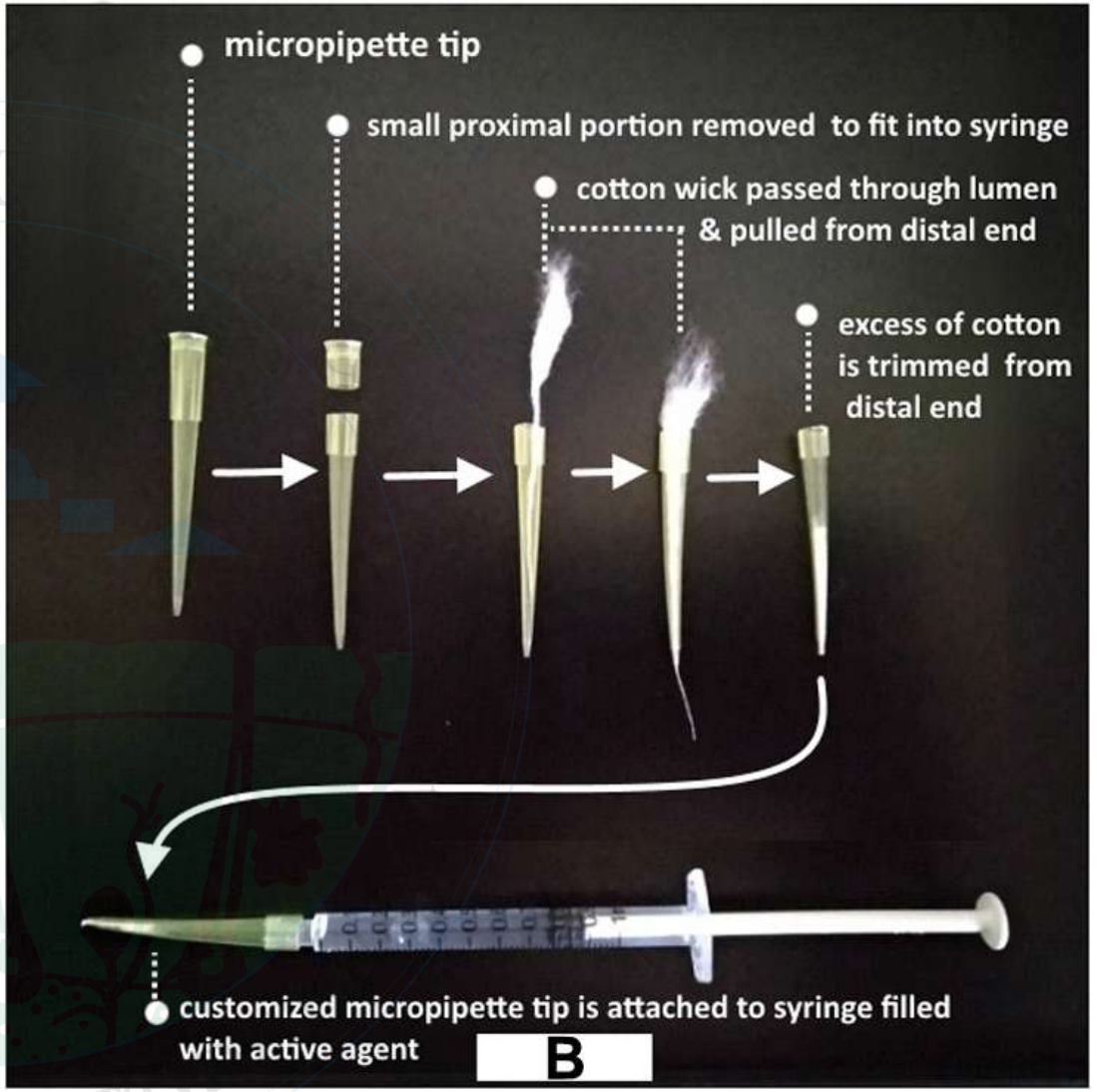
Key words: chemical cautery; dermatosurgery; disposable; innovation; pen.

SURGICAL CHALLENGE

Chemical cauterization is an office procedure in dermatology that is commonly used for destruction of diseased tissue. The conventional method of chemical cauterization involves immersing a pointed stick of wood (toothpick) into an active chemical agent and applying it on the lesion. A small amount of liquid is transferred to the skin lesion, producing the desired effect. This crude procedure has several limitations. The excess liquid may trickle from the toothpick and may cause damage to surrounding normal-appearing skin, resulting in pigmentation and/or scarring. If the lesions are numerous, it is cumbersome to repeatedly dip the toothpick into the liquid. Moreover, there is a chance of spillage of the liquid with disastrous consequences if the lesion is close to delicate structures such as the eyes.[1] To overcome this, the use of an insulin syringe filled with liquid agent has been proposed.[2] However, this does not eliminate the risk of spillage and has the added risk of needle prick injury.

Jangra RS et al. J Am Acad Dermatol 2020;82:e193-4.





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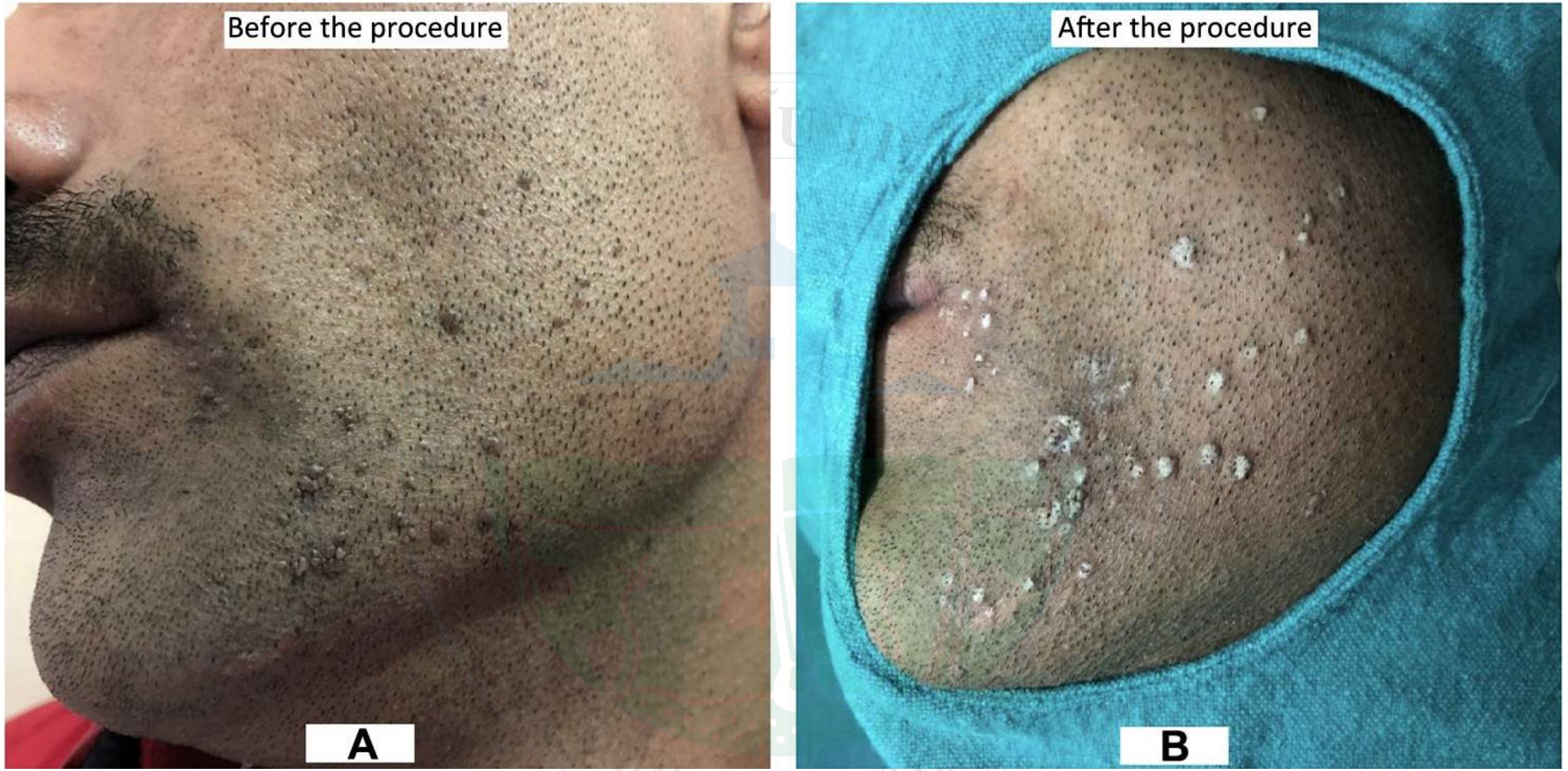

- A, A patient with common warts. B, Chemical cauterization with trichloroacetic acid using a chemical cautery pen

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Society of Dermatology Hospitalists supportive care guidelines for the management of Stevens-Johnson syndrome/ toxic epidermal necrolysis in adults

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Tampa, Florida; Boston, Massachusetts; Milwaukee, Wisconsin; New York and New Hyde Park, New York; Bethesda, Maryland; Columbus, Ohio; Birmingham, Alabama; Dallas and San Antonio, Texas; Rochester, Minnesota; Durham and Wake Forest, North Carolina; Los Angeles and San Francisco, California; Seattle, Washington; Mexico City, Mexico; Portland, Oregon; Louisville, Kentucky; Washington, DC; Indianapolis, Indiana; Sydney, New South Wales, Australia; Hyderabad, India; Chicago, Illinois; and Philadelphia, Pennsylvania

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What supportive care treatment strategies are safe and effective for adult patients with SJS, SJS-TEN overlap, or TEN?

1. Hospital setting and care team
2. Wound care
3. Ocular care
4. Oral care
5. Urogenital care
6. Pain management
7. Infection surveillance
8. Fluid and electrolyte management
9. Nutrition and stress ulcer prophylaxis
10. Airway management
11. Anticoagulation

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Hospital setting and care team

Management of patients with SJS/TEN requires a multidisciplinary team that may include dermatology, intensive care, pulmonology, ophthalmology, otorhinolaryngology, gynecology, urology, nephrology, plastic surgery, nutrition, nursing, psychology/psychiatry, and other fields.

Dermatologists are experts in the disease state of SJS/TEN and should directly participate in the management of such patients.

Staff should have specific training in the care of patients with SJS/TEN.

Chronic conditions and comorbidities play a significant role in the mortality of patients with SJS/TEN and the need for specialized care, and hospital transfers should take into account these comorbidities.

Medical or burn intensive care unit settings of care for SJS/TEN patients are recommended.

SJS/TEN patients must be cared for in a private room.

Patient rooms should be controlled for humidity.

Sterile sheets should be obtained and used for patient bedding, where available.

At least 1 nurse should take care of 1 patient with SJS/TEN (at least 1:1 ratio).

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Wound care

Determine % BSA of epidermal detachment (only skin that is already necrotic, detached, or skin with positive Nikolsky sign).
Avoid unnecessary wound manipulation by limiting the number of dressing changes.
Use an air-fluidized bed to minimize friction.
Gently cleanse all areas with sterile water, normal saline, or dilute chlorhexidine (0.05%) solution with dressing changes.
The detached and detachable epidermis should be left in place as a biologic dressing.
Lyse large or painful bullae for comfort only.
Wound débridement of necrotic skin is not recommended.
Apply topical emollients such as petroleum jelly on the entire epidermis.
Apply nonadherent sterile dressings to denuded skin.
Select nonadherent silver-impregnated primary dressings for optimal moisture retention and antibacterial properties.
Apply secondary dressing to absorb exudate.

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Oral care

The mouth should be examined as part of the initial assessment of a patient with SJS/TEN.

Daily oral examination is required during acute illness.

Have a low threshold for HSV PCR, bacterial, and fungal cultures if infection is suspected.

Petrolatum ointment should be applied on the lips immediately and then every 2 hours throughout the acute illness.

Viscous lidocaine 2%, 15 mL per application, can be used every 3 hours (and before cleanses) as an oral rinse to control pain.

Clean the mouth daily with warm saline mouthwashes or an oral sponge, sweeping the sponge gently in the labial and buccal sulci to reduce the risk of fibrotic scars and prevent buildup of hemorrhagic crust.

An antiseptic oral rinse should be used twice daily to reduce bacterial colonization of the mucosa.

A topical steroid (ultrapotent) ointment can be applied up to 4 times a day during the acute phase.

Consider diluted chlorhexidine digluconate mouthwash (2-3 times daily).

Consider the use of oral coating agents for pain reduction in patients with oral mucosal involvement.

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Pain management

Evaluation and treatment of pain is a priority in the acute phase, especially during wound management.

Pain should be evaluated every 4 hours.

A validated pain tool should be used to assess pain in all conscious patients at least once a day.

If the score is mild, pain control with acetaminophen should be introduced.

If acetaminophen is not enough, oral synthetic opiates, such as tramadol, should be considered.

If the pain score is moderate to severe, then morphine or fentanyl should be delivered enterally, by PCA, or by infusion.

Procedures such as dressing changes and bathing may require additional pain control.

Consider adding low-dose ketamine infusions.

Consider adding gabapentin or pregabalin.

NSAIDs should be avoided due to renal or gastric injury.

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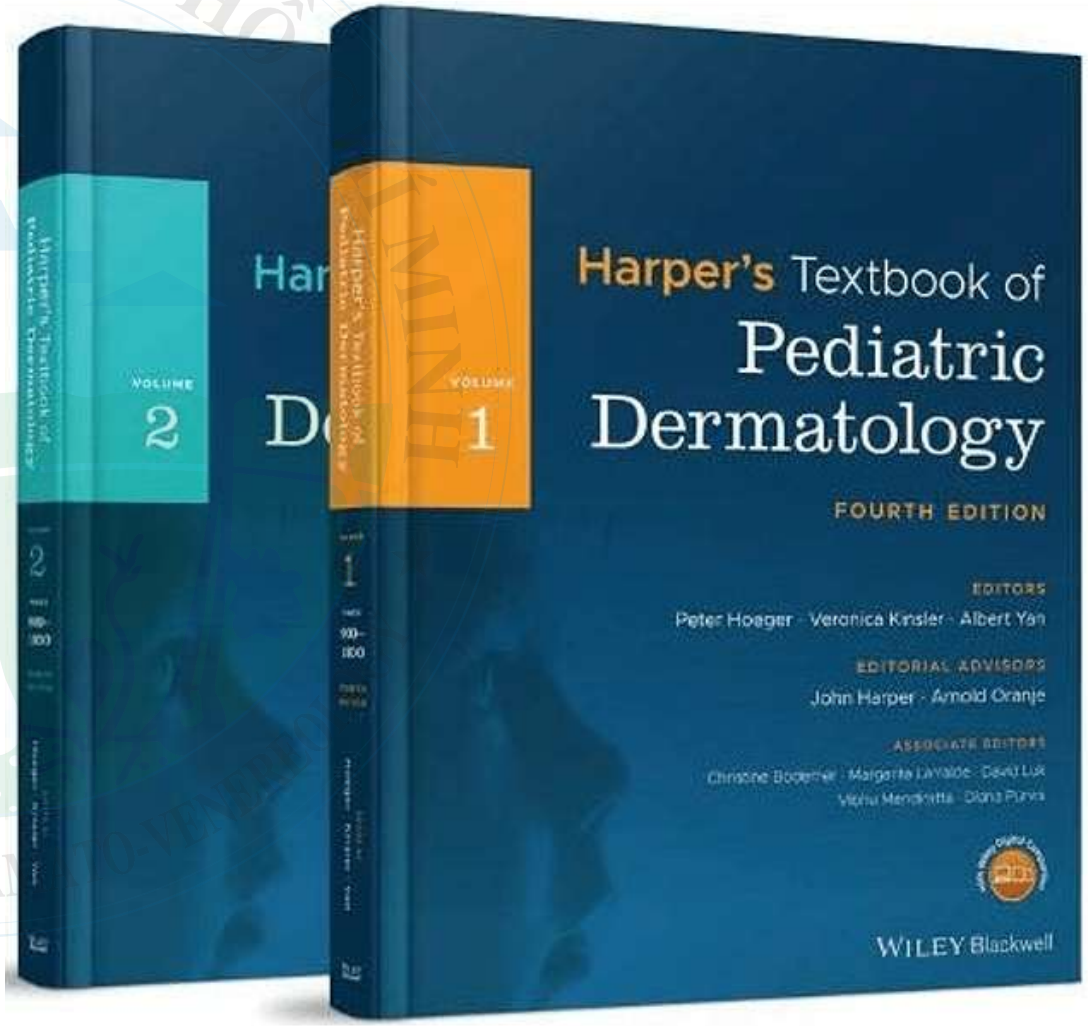
Harper's Textbook of Pediatric Dermatology

- Year: 2020 (4th edition)
- Pages: 2511
- 40 sections, 177 chapters



Summary

1. Treatment of recalcitrant viral warts using 1064 nm Nd:YAG laser
2. The effect of silymarin on liver enzymes in patients taking isotretinoin: A randomized clinical trial
3. Management of granulomatous foreign body reaction to fillers with methotrexate
4. Observation on the effects of 595- nm pulsed dye laser and 755- nm long-pulsed alexandrite laser on sequential therapy of infantile hemangioma
5. Topical 5% tranexamic acid for acne-related postinflammatory erythema
6. Topical timolol in chronic, recalcitrant fissures and erosions of hand eczema
7. Using Hypodermic Needle as Suture Needle in Emergency
8. Chemical cautery pen
9. Society of Dermatology Hospitalists supportive care guidelines for the management of Stevens-Johnson syndrome/toxic epidermal necrolysis in adults
10. Book review: Harper’s Textbook of Pediatric Dermatology