Rapid progression to toxic epidermal necrolysis following initially reassuring presentations

Abstract

A 31-year-old female presented to a primary care service with a 2-day history of a spreading rash, fever (40°C), and malaise, three weeks after commencing lamotrigine, within the known high-risk period for SJS/TEN.

Examination revealed a blanching maculopapular rash affecting the upper limbs and trunk, without blistering or mucosal involvement. Differential diagnoses included viral exanthem and drug eruption. In the absence of features suggestive of Stevens–Johnson syndrome (SJS), the patient was managed conservatively with advice for monitoring and symptom management.

Two days later, the patient presented to an emergency department, where reassessment again demonstrated no mucocutaneous features concerning for SJS/TEN, and she was discharged. Within hours of discharge, she re-presented with rapid deterioration, including fever (39.9°C), severe skin pain, blistering, and mucosal involvement affecting the oral cavity and eyes.

She was admitted with suspected SJS progressing to SJS/TEN overlap, later confirmed as toxic epidermal necrolysis (TEN), requiring intensive care admission for management of widespread epidermal loss and systemic compromise.

This case highlights that SJS/TEN may evolve rapidly despite multiple reassuring clinical assessments. Early presentations may lack hallmark features, creating diagnostic uncertainty.

For dermatology nursing practice, this case emphasises the importance of maintaining a high index of suspicion in patients recently commenced on high-risk medications, particularly within the first few weeks of therapy. Clear safety-netting, patient education, and a low threshold for escalation are critical to support timely recognition and intervention.

Fiona Kimber