Adverse cutaneous reactions to drugs are frequent, affecting 2% to 3% of all hospitalized patients. Fortunately, only about 2% of adverse cutaneous reactions are severe and very few are fatal. The clinical pattern of the individual skin lesion is classified into 4 types:

1. **Typical targets:** individual lesions less than 3 cm in diameter with a regular round shape, well-defined border, and at least 3 different zones, that is, 2 concentric rings around a central disk. One ring consists of palpable edema, paler than the center disk.

2. **Raised atypical targets:** round, edematous, palpable lesions, similar to EM but with only 2 zones and/or a poorly defined border.

3. **Flat atypical targets:** round lesions characteristic of EM but with only 2 zones and/or a poorly defined and often confluent. Blisters often occur on all or part of the macule.

4. **Bullous erythema multiforme:** detachment less than 10% of BSA, localized typical targets or raised atypical targets.

Sulfonamides are the most strongly associated with TEN.

**Classification of TEN:**

- **Stevens Johnson Syndrome:** detachment less than 10% of BSA, widespread erythematous or purpuric macules of flat atypical targets.

- **Overlap Stevens Johnson Syndrome / toxic epidermal necrolysis:** detachment greater than 30% of BSA, widespread purpuric macules or flat atypical targets.

- **Toxic epidermal necrolysis with spots:** detachment greater than 10% of BSA, large epidermal sheets and no purpuric macules.

The involved BSA should measure the extent of detached and detachable epidermis (which is often much less than the area of erythema) at the worst stage of the disease.

**Cautiously medications:**

- More than 100 drugs have been associated with the development of SJS/TEN. Sulfonamides are the most strongly associated with TEN followed by antibiotic drugs (in descending order of frequency: cephalosporins, quinolones, aminopenicillins, tetracyclines, macrolides, imidazole antifungals, anticonvulsants). Nonsteroidal anti-inflammatory drugs (especially oxicam), allopurinol, and others are also associated.

- The risk for developing TEN is largely confined to the start of antiepileptic therapy, that is, within the first 8 weeks, after which it was not associated with an increased risk. The incubation time for all other drugs varies from a few days to 2 to 3 weeks, but may be up to 1 month.

- Both SJS and TEN are life-threatening diseases, and so the management of patients must be prompt. Early diagnosis with the early recognition and withdrawal of all potential causative drugs is essential to a favorable outcome.

- The initial symptoms of TEN, that is, before the appearance of frank mucocutaneous sloughing, include:
  - (i) fever (all cases),
  - (ii) conjunctivitis (32% of cases),
  - (iii) pharyngitis (25% of cases), and
  - (iv) pruritus (28% of cases).

- The cutaneous lesions begin with a burning and painful eruption. This eruption extends symmetrically from the face and upper part of the body to the entire body, predominantly on the trunk and proximal limbs. The initial lesions are poorly defined macules with darker centers. Maximal extension of lesions usually occurs in 2 or 3 days, but can be manifested in a few hours. There is a sheet like loss of epidermis and the appearance of faccid blisters that spread with pressure in TEN.

- Corticosteroids have for years been the mainstay therapy for TEN and SJS. There are no randomized clinical trials on the use of corticosteroids in the treatment of these life-threatening diseases.

- IVIG has been used.