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A Unique Case of Stevens–Johnson Syndrome and Giant Cell Arteritis

Introduction: Stevens-Johnson Syndrome (SJS) is an inflammatory autoimmune disesease with clasic drug precipitants as well as genetic and ethnic predispositions. Giant Cell Arteritis (GCA) is classified as a separate disease and thought to be the most common form of vasculitis. These two autoimmune diseases are not known to occur concurrently. To our knowledge, this is the firs case of both SJS and GCA occuring simultaneously.

Case: 72-y-old female with a history of treated breast cancer who rapidly developed fever and a pruritic morbiliform rash after using multiple antibiotics to treat a toe ulcer. She initially completed 1-2 weeks of oral cephalexin, and then 3 days of ciprofloxacin and clindamycin before developing an erythematous pruritic rash(70% BSA) which developed into blistering and progressively involved her mucous membranes with bloody diarrhea. She had a BSA of detachable epidermis ≈10% with no sloughing, bulla, vesicles, or excoriations. She had a positive Nikolsky sign and SCORTEN Prognosis Score of 3, equivalent to 35.3% mortality rate. Of note, she complained of burning eyes with gritty sensations with no visual changes, in which ophtalmology ruled out pseudomembranes. Her bloodwork showed elevated CRP and ESR with an eosinophil count of 0.2.
On arrival to the ER, she received one dose ceftriaxone and azithromycin for possible pneumonia and sepsis. There was no history known rheumatologic or autoimmune diseases, including plymyalgia rheumatica (PMR). She was not on any anti-epileptics, allopurinol, or immunosuppressants and had been exposed to multiple different antibiotics for recurrent sinus infections when she was younger. She was diagnosed with evolving SJS/TEN (Toxic Epidermal Necrolysis) spectrum eruption, likely secondary to ciprofloxacin or clindamycin with cutaneous and systemic manifestations. When admitted, all of her antibiotics were discontinued and she was started on meropenem. In addition to supportive care, she was started on cuclosporine and etanercept, and second generation anti-histamines. A workup was sent to rule out mycoplasma, HSV, EBV, and CMV infection.
Six days after admission with ongoing eye burning, she developed new onset bilateral temporal headaches and scalp tenderness but no jaw claudication or PMR symptoms. She had new prominent palpable temporal arteries that were tender, beaded, and diminished palpable pulses with elevated inflammatory markers. She was empirically started on high-dose prednisone which improved her symptoms. Her temporal artery biopsy showed that she had bilateral superficial teporal arteries were positive for atypical variant of GCA. On outpatient follow-up rheumatology visits, attempts to taper were difficult with symptoms flares. She continues to improve with steroids.

Conclusion : This is the first case report diagnosing simultaneous SJS and atypical GCA, secondary to ciprofloxacin and clindamycin, which are both uncommon causes for SJS. This case outlines the management of this presentation While both SJS and GCA are theorized to be autoimmune mediated, there is no known association with SJS and GCA.