examination of non-eroded skin on the forearm showed changes compatible with erythema multiforme. Her skin condition deteriorated rapidly. Antibiotics were stopped and she was given i.v. hydrocortisone, but she died from shock only 10 days after admission.

DISCUSSION

Two cases of fatal TEN are reported. Case 1 received intensive i.v. therapy with ceftazidine and vancomycin prior to the development of TEN, while case 2 received only ceftazidine and acyclovir. It is not possible with certainty to establish which compound elicited the drug rash as drugs with a possible cross-reactivity were given after the rash occurred. In case 1 ceftazidine and vancomycin may have had an additive effect. The patient was also uremic, which is a complicating factor when intensive i.v. therapy is given. In case 2 only ceftazidine was given prior to the development of TEN, apart from aciclovir, which is a highly atoxic drug.

A Medline search gave 1.522 articles on TEN (November 22, 1999). The combination of TEN and ceftazidine yielded 0 articles, TEN and cephalosporins 22 articles, TEN and vancomycin 3 articles, and TEN and gentamycin 7 articles. This shows that TEN is rarely seen after these compounds, and fatal TEN has not been reported. Ceftazidine (3) and vancomycin (4, 5) have been associated with pustuloderma and TEN, respectively.

A recent study has documented that short-term therapy with phenytoin, phenobarbital and carbamazepine is associated with TEN or Stevens–Johnson syndrome among 16% of patients (6). TEN occurs during the first 8 weeks of treatment. Vancomycin is known to induce a number of side-effects, and it could have been the eliciting drug in case 1, who had uremia with impaired drug excretion (7). Severely ill patients undergoing multiple i.v. medications are at high risk for complications, as confirmed in this report. In addition, patients after bone-marrow transplantation and HIV/AIDS patients have an increased risk of TEN (1).

The immunosuppressive therapy in our patients was of no value, corresponding to a double-blind study of immunosuppression in patients with severe bullous erythema multiforme or TEN (8). Patients given intensive i.v. drug therapy in whom skin rashes develop should be evaluated acutely, and if TEN is diagnosed, only life-saving medication should be used.

REFERENCES

1. Revuz JE, Roujeau JC. Advances in toxic epidermal necrolysis. Sem Cutan Med Surg 1996; 15: 258–266.
2. Becker DS. Toxic epidermal necrolysis. Lancet 2000; 351: 1417–1420.
3. Rustin MH, Robinson RW, Dowd PM. Toxic pustuloderma: a self-limiting eruption. Br J Dermatol 1990; 123: 119–124.
4. Hannah BA, Kimmel PL, Dosa S, Turner ML. Vancomycin-induced toxic epidermal necrolysis. South Med J 1990; 83: 720–722.
5. Vidal C, Gonzalez Quintela A, Fuente R. Toxic eidermal necrolysis due to vancomycin. Ann Allergy 1992; 68: 345–347.
6. Rzany B, Correia O, Kelly JP, Naldi L, Auquier A, Stern R. Risk of Stevens–Johnson syndrome and toxic epidermal necrolysis during first weeks of antiepileptic therapy: a case–control study. Lancet 1999; 353: 2190–2194.
7. Elting LS, Rubenstein EB, Kurtin D, Rolston KVI, Fangtang J, Martin CG, et al. Mississippi mud in the 1990s. Risks and outcomes of vancomycin-associated toxicity in general oncology practice. Cancer 2000; 83: 2597–2607.
8. Guibal F, Bastuji-Garin S, Chosidow O, Saiag P, Revuz J, Roujeau JC. Characteristics of toxic epidermal necrolysis in patients undergoing long-term glucocorticoid therapy. Arch Dermatol 1995; 131: 669–672.

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Randomized Double-blind Comparison of Short-term Itraconazole and Terbinafine Therapy for Toenail Onychomycosis

Sir,

I read with interest a recent study in Acta Dermato-Venereologica (1) comparing itraconazole and terbinafine in the treatment of onychomycosis. Several comments come to mind.

1. In previous studies (2) the duration of follow-up was 46 weeks and the mycological cure rates for itraconazole declined after week 36 as those of terbinafine increased.
2. There is no "black-box" warning in the package insert with terbinafine as compared to itraconazole. In addition, the alleged "rare cases of serious hepatotoxicity..." are not included in the terbinafine package insert of terbinafine, presumably because of the remote likelihood of such an occurrence.
3. Terbinafine is the only fungicidal agent in the treatment of dermatophytosis, while itraconazole is clearly fungistatic. No amount of machination can change this fact.

REFERENCES

1. Degreef H, del Palacio A, Mygind S, Ginter G, Pinto Soares A, Zuluaga de Cadena A. Randomized double-blind comparison of short-term itraconazole and terbinafine therapy for toenail onychomycosis. Acta Derm Venereol 1999; 79: 221–223.
2. De Backer M, De Keyser P, De Vroey C, Lesaffre E. A 12-week treatment for dermatophyte toe onychomycosis: terbinafine 250 mg/day vs. itraconazole 200 mg/day – a double-blind comparative trial. Br J Dermatol 1996; 134 Suppl 46: 16–17.

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