Actualités toxidermies graves centre de référence TOXIBUL groupe ToxiTEN

Pr Saskia Oro

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TOXIBUL
CENTRE DE RÉFÉRENCE
DERMATOSES BULLEUSES TOXIQUES ET TOXIDERMIES GRAVES

European Reference Networks | SKIN

Relabellisation CRMR TOXIBUL 2023

TOXIBUL CENTRE DE RÉFÉRENCE
DERMATOSES BULLEUSES TOXIQUES ET TOXIDERMIES GRAVES

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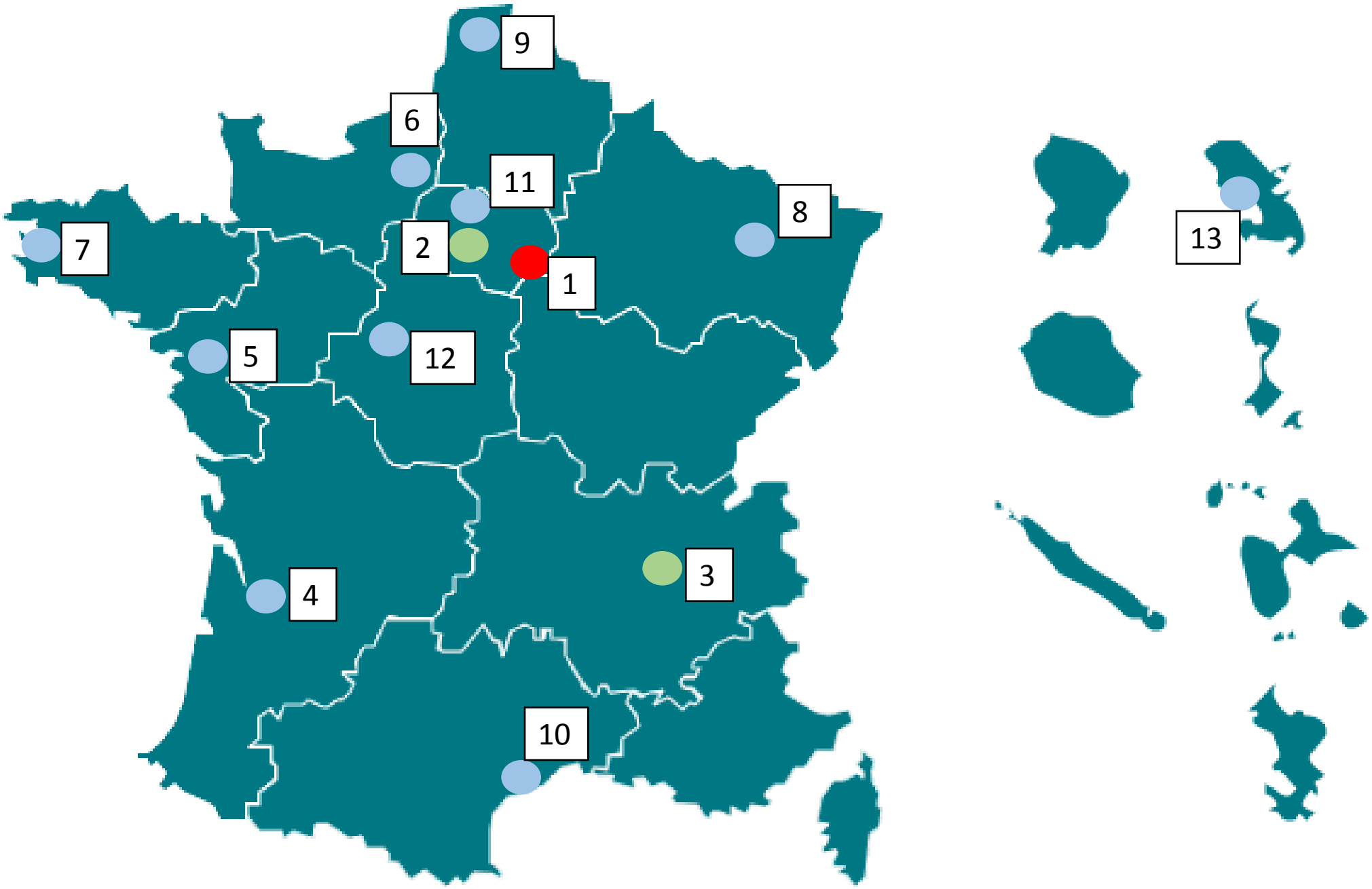
Nouvelle labellisation 2023
Re-labellisation

https://toxibul.fr/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Nécrolyse épidermique

PNDS nécrolyse épidermique de l'enfant (2021)

Coordination:
Dr Anne Welfringer-Morin
(CRMR constitutif Necker)

Consultable: HAS, site internet TOXIBUL

Nécrolyses épidermiques chez l'enfant

GUIDE MALADIE CHRONIQUE - Mis en ligne le 02 déc. 2021

Ce protocole national de diagnostic et de soins (PNDS) explicite aux professionnels concernés la prise en charge diagnostique et thérapeutique optimale et le parcours de soins d'un enfant atteint du syndrome de Stevens-Johnson (SJS) ou de Lyell/nécrolyse épidermique toxique (NET). Il a été élaboré par la Filière FIMARAD : Santé Maladies Rares Dermatologiques à l'aide d'une méthodologie proposée par la HAS. Il n'a pas fait l'objet d'une validation par la HAS qui n'a pas participé à son élaboration.

Documents

- Nécrolyses épidermiques chez l'enfant - Synthèse du PNDS à destination du médecin traitant
- Nécrolyses épidermiques chez l'enfant - PNDS
- Nécrolyses épidermiques chez l'enfant - Argumentaire

Actualisation 2023 du PNDS nécrolyse épidermique de l'adulte

Coordination:
Pr Saskia Oro (CRMR coordonnateur Henri Mondor)
Argumentaire scientifique 2017-2023
Mise à jour du PNDS avec parties réanimation et prise en charge des séquelles et allergologique étoffée
Synthèse au médecin généraliste

En cours de mise en ligne HAS
Consultable: site internet TOXIBUL

Protocole National de Diagnostic et de Soins (PNDS)

Nécrolyse épidermique de l'adulte

(Syndromes de Stevens-Johnson et de Lyell)

Mise à jour Septembre 2023

Centre de référence des dermatoses bulleuses toxiques et toxidermies graves TOXIBUL

Les séquelles de la nécrolyse épidermique (SJS/Lyell) sont fréquentes et impactent lourdement la qualité de vie

> Br J Dermatol. 2023 Oct 25;189(5):553-560. doi: 10.1093/bjd/ljad234.

Lifetime risk, life expectancy, loss-of-life expectancy and lifetime healthcare expenditure for Stevens-Johnson syndrome/toxic epidermal necrolysis in Taiwan: follow-up of a nationwide cohort from 2008 to 2019

Ying-Ming Chiu [1 2 3], Hsien-Yi Chiu [4 5 6 7 8]

But: quantifier le fardeau à long terme de la NE.
Méthode: Base de données nationale de l'assurance maladie de Taiwan
Patients atteints de NE entre 2008 et 2019
Etude de **l'espérance de vie** et des **dépenses de santé** au cours de la vie (coûts d'hospitalisation, des consultations et médicaments)
Résultats: 6 552 cas
Perte d'espérance de vie moyenne = 9,43 ans, H>F, jeunes > âgés
Coûts moyens de dépenses de santé : 3 752 $ (US) par an
Facteurs de risque: soins intensifs, cancer, diabète, insuffisance rénale terminale, **présence et type de séquelle**
Encourageant: baisse d'incidence de la NE au cours de la période d'étude, parallèlement à l'utilisation accrue des tests HLA-B*15:02 au fil du temps, comme recommandé par la politique de dépistage taïwanaise avant la prescription de carbamazépine.

Preuve supplémentaire du fardeau parfois à vie de la NE

Comment optimiser le suivi des séquelles?

Ingen-Housz-Oro et al.
Orphanet Journal of Rare Diseases (2023) 18:33
https://doi.org/10.1186/s13023-023-02631-7

Orphanet Journal of Rare Diseases

POSITION STATEMENT — Open Access

Post-acute phase and sequelae management of epidermal necrolysis: an international, multidisciplinary DELPHI-based consensus

S. Ingen-Housz-Oro[1,2,3,4*†], V. Schmidt[5,6†], M. M. Ameri[6,7,8*], R. Abe[9], A. Brassard[10], A. Mostaghimi[11], A. S. Paller[12], A. Romano[13], B. Didona[2,14], B. H. Kaffenberger[2,15], B. Ben Said[2,3,16], B. Y. H. Thong[17], B. Ramsay[18], E. Brezinova[2,19], B. Milpied[2,3,20], C. G. Mortz[21], C. Y. Chu[22], C. Sotozono[23], J. Gueudry[3,24], D. G. Fortune[25], S. M. Dridi[3,26], D. Tartar[27], G. Do-Pham[3,28], E. Gabison[29], E. J. Phillips[30,60], F. Lewis[31], C. Salavastru[2,32], B. Horvath[2,33], J. Dart[34], J. Setterfield[2,35], J. Newman[36], J. T. Schulz[37], A. Delcampe[3,24,29,38], K. Brockow[39], L. Seminario-Vidal[40], L. Jörg[7,41], M. P. Watson[42], M. Gonçalo[43], M. Lucas[44,61], M. Torres[45], M. H. Noe[46], N. Hama[9], N. H. Shear[47,62], P. O'Reilly[48], P. Wolkenstein[1,2,3], P. Romanelli[49], R. P. Dodiuk-Gad[50,63], R. G. Micheletti[51], G. S. Tiplica[2,52], R. Sheridan[53,63,64], S. Rauz[54], S. Ahmad[34], S. L. Chua[2,55], T. H. Flynn[56], W. Pichler[57], S. T. Le[10], E. Maverakis[10], S. Walsh[2,35], L. E. French[2,58,59†] and M. C. Brüggen[2,6,7,8]

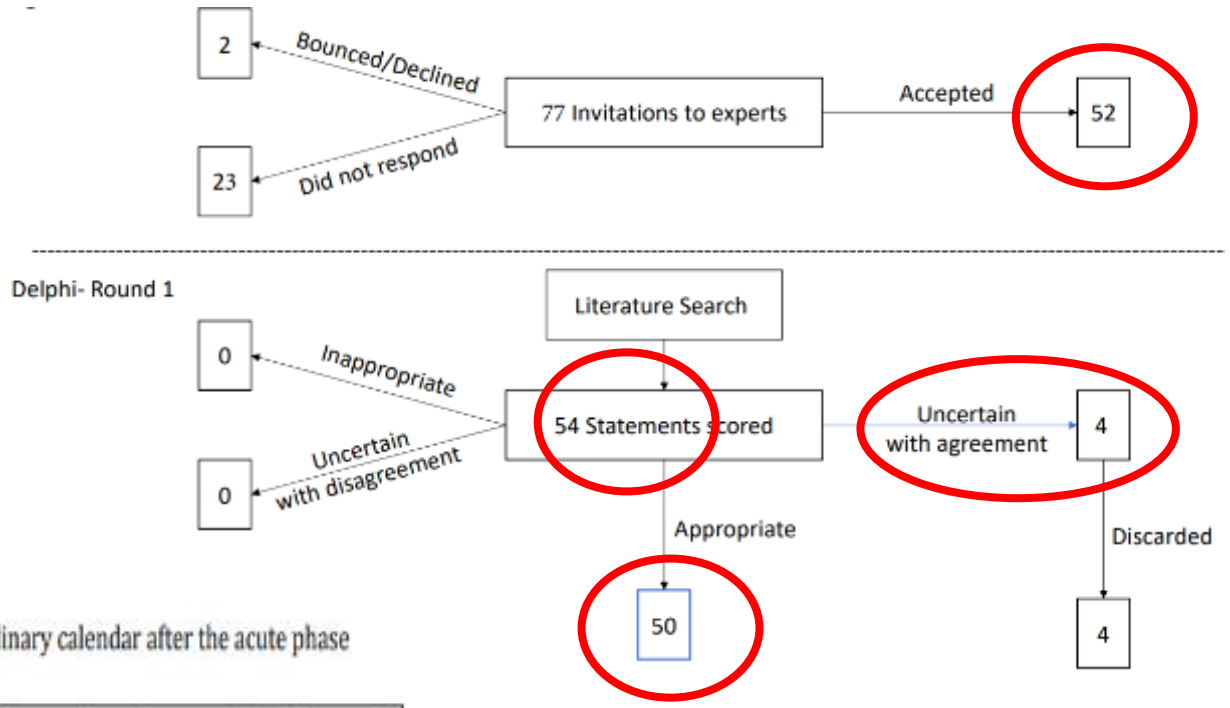


Table 2: Proposition for the follow-up multidisciplinary calendar after the acute phase

1-2 months after discharge	- Dermatologist (skin sequelae and coordination of the follow-up) - Ophthalmologist - Psychiatrist and/or psychologist - ENT - Pneumologist if needed (+/- pulmonary function tests) - Gynecologist/urologist if needed (scarring) - Dietetician if needed (loss of weight) - Social worker if needed
6 months* after the acute phase	- Same specialties according the needs of the patient - Stomatologist/dentist - Allergological work-up
1 year* after the acute phase	- Same specialties according the needs of the patient - Prolonged follow-up by the dermatologist to screen the needs of the patient and coordinate the multidisciplinary follow-up

*Timing recommendations not part of the current Delphi consensus

<u>54 propositions en 8 catégories:</u>

Recommandations générales (rythme de suivi…)

Professionnels impliqués

Prise en charge des séquelles:

- cutanées
- oculaires
- autres muqueuses
- psychologiques

Bilan allergologique

Pour tous les patients
En centre expert
Equipe multidisciplinaire
Coordination par le dermatologue
Aussi longtemps que nécessaire

Quelles priorités pour le futur dans la nécrolyse épidermique?

Updates in SJS/TEN: collaboration, innovation, and community

2023

Madeline E. Marks[1†], Ramya Krishna Botta[1†], Riichiro Abe[2],

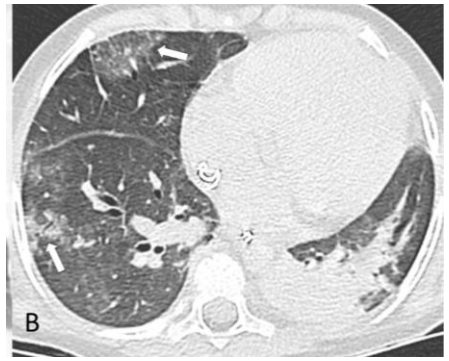
TABLE 6 Future directions to move SJS/TEN forward.

Unmet needs/gaps	Implementation/focus points
Prevention, prediction, and regulation:	
-Lack of knowledge on all casual factors -Generalized genetic test findings -Limited information on casual drugs and targets -Genetic tests with low positive predictive value -Need of evidence-based pre-prescription genetic tests -Lack of real time information on SJS/TEN cases with any new casual drug	-Conduct studies across diverse population groups (age, race, gender, ethnicity) -Low and cost-effective testing -Networks and collaborations to study on multiple drugs, and risk factors -Studies to include genetic and other risk factor identifications -Advancement in pharmacovigilance for immediate updates and alerts on new adverse drug effects
Early diagnosis and treatment:	
-Unidentifiable/unreported cases -Inadequate transfer specialized centers -Lack of knowledge on biological markers that aid in early diagnosis -Identify culprit drugs with testing methods (*in vivo/ex vivo/ in vitro*) -Photographic data to assess risk and prognosis	-Clinical awareness and decision-making support -Telehealth triage services -Studies to provide genetic markers and point of care markers for early diagnosis and prognosis -Validate drugs causes across different cohorts -Introduce artificial intelligence algorithms into clinical care
Clinical care and follow-up:	
-Need for evidence-based studies to provide best supportive care -Short term treatment plans -Long term clinical/health complications -Coordinated clinical care and support services	-Provide evidence-based study results for best clinical practices -Introduce collaborative networks (domestic and international) in clinical trial studies -Follow-up and long-term care for survivors and families -Coordination among clinical specialties
Understanding mechanisms and providing care:	
-Mechanistic studies to identify cellular and molecular signals that act as a biological marker and novel targets for treatment	-Cohort studies on prospectively collected samples for long-term storage with collaborative effort from international networks

J Am Acad Dermatol. 2023 Oct;89(4):857-859. doi: 10.1016/j.jaad.2023.05.092. Epub 2023 Jun 23.

Respiratory complications in pediatric epidermal necrolysis: A retrospective study of 22 cases

Sophie Schmartz [1], Anne Welfringer-Morin [2], Muriel Le Bourgeois [1], Christophe Delacourt [3], Laureline Berteloot [4], Smail Hadj Rabia [5], Nathalia Bellon [2], Florence Moulin [6], Marie Pouletty [6], Nicolas Garcelon [7], Christine Bodemer [5], David Drummond [8]



Etude rétrospective 2012-2022
Tous patients de moins de 18 ans admis à Necker pour nécrolyse épidermique.

Table I. Characteristics of patients according to their level of respiratory support*

	Mechanical ventilation $n = 6$ n (%)	Oxygen therapy alone $n = 3$ n (%)	No respiratory support $n = 12$ n (%)	*P*-value†
Female sex	1 (17%)	3 (100%)	10 (83%)	.01
Age (years)‡	4 (3-5)	7 (6-8)	8 (7-11)	<.01
Etiology of EN				.60
Drug-induced	2 (33%)	2 (67%)	6 (50%)	
Idiopathic	4 (67%)	1 (33%)	6 (50%)	
	$n = 3$	$n = 2$	$n = 6$	
Baseline detached BSA (%)‡	20 (16-28)	16 (16-17)	2 (0-9)	.09
Maximal detached BSA (%)‡	78 (71-84)	17 (16-39)	31 (5-46)	.01
Respiratory distress	6 (100%)	0 (0%)	0 (0%)	<.01

Principaux résultats:

- 25 % des enfants ont une détresse respiratoire conduisant à une ventilation mécanique ;
- **facteurs associés à la ventilation mécanique: jeune âge, garçons, décollement étendu;**
- bronchiolite oblitérante: 4/22, dans les 2 mois après la phase aiguë;
- EFR toujours normales chez les enfants asymptomatiques.

Br J Dermatol. 2023 Oct 25;189(5):631-633. doi: 10.1093/bjd/ljad226.

Comparison of idiopathic and drug-induced epidermal necrolysis in children

Anne Welfringer-Morin [1 2], Pauline Bataille [1], David Drummond [3], Nathalia Bellon [1 2], Saskia Ingen-Housz-Oro [2 4], Julie Bonigen [5], Sophie Schmartz [3], Laura Giraud-Kerleroux [4], Florence Moulin [5], Laure De Saint Blanquat [5], Dominique Bremond-Gignac [6], Smail Hadj-Rabia [1], Christine Bodemer [1 2]

Etude monocentrique rétrospective

22 enfants atteints de NE (EP exclus)

7 SJS et overlap (32%)
15 Lyell (68%)

2/3 de filles
Âge médian 7 ans

11/22 induits par un médicament (50%)

=> 8 (73%) anti-épileptiques dont lamotrigine n=5
=> 3 (27%) antibiotiques, tous sulfamides

11/22 cas idiopathiques (50%)

Aucun cas infectieux

Beaucoup plus de cas idiopathiques que chez les adultes

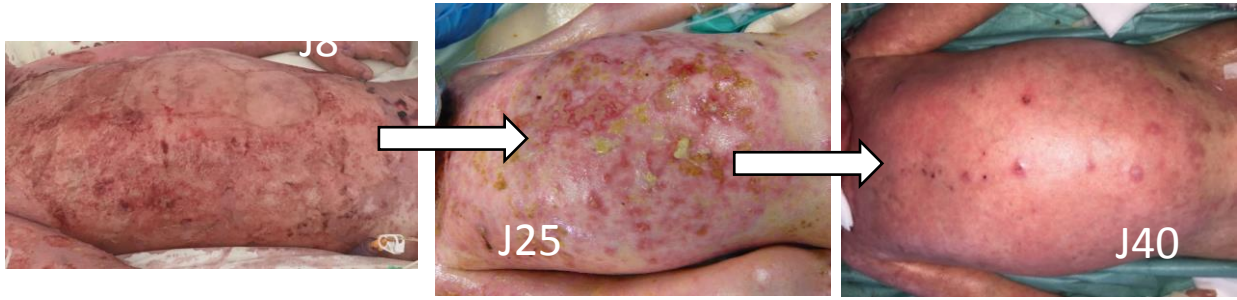
	Overall population N = 22 patients	Idiopathic EN n = 11 patients	Drugs-induced EN n = 11 patients	p-value[1]
Diagnosis n (%)				
- *TEN*	15 (68)	10 (91)	5 (45)	**0.04**
- *overlap*	3 (14)	1 (9)	2 (18)	
- *SJS*	4 (18)	0 (0)	4 (36)	
Female n (%)	14 (64)	6 (55)	8 (73)	0.7
Median age at onset of symptoms (Q1-Q3)	7.2 (5.1-8.6)	5.5 (4.6-8.2)	7.7 (6.3-9.6)	0.2
Healing: median time (Q1-Q3)				
- Median time to re-epidermalization (days)	10 (6.2-11.8)	11.5 (10.0-12.5)	6.5 (2.8-9.5)	**0.02**
- Median time to complete skin healing (days)	20 (12-25)	22 (21-34)	12 (10-19)	**0.02**
- Median time to mucosal healing (days)	26 (16-40)	38 (21-52)	18 (14-30)	**0.05**
Intensive care hospitalisation n (%)	18 (82)	10 (91)	8 (73)	0.6
Median length of stay (days, (Q1-Q3))	19 (17-41)	36 (19-57)	17 (15-26)	**0.02**
Supports n (%)				
- Central catheter	18 (82)	11 (100)	7 (64)	0.09
- Mechanical ventilation	6 (27)	4 (36)	2 (18)	0.6
- Nasogastric tube	17/21 (81)	10/10 (100)	7 (64)	0.09
- Urinary catheter	16/21 (76)	9/10 (90)	7 (64)	0.3
- Amines	5/21 (24)	3/10 (30)	2 (18)	0.6
Mucocutaneous involvement				
- Median body surface area affected (%) (Q1-Q3)	42 (19-61)	55 (39-72)	17 (5-62)	0.08
- Median number of mucous membranes affected (Q1-Q3)	4 (3-5)	4 (4-5)	4 (3-4)	
- Ophthalmological grade n (%)				0.14
• *Grade 2*	10 (45)	2 (18)	8 (73)	
• *Grade 3*	12 (55)	9 (82)	3 (27)	**0.01**
Sequelae: n = 19 patients		**n = 9 patients**	**n = 10 patients**	
- Skin sequelae	18 (95)	8 (89)	10 (100)	0.5
- Ophthalmologic sequelae	15 (79)	8 (89)	7 (70)	0.6

[1] *Fisher's exact test ; Wilcoxon rank sum exact test ; Wilcoxon rank sum test ; Pearson's Chi-squared test*

Comparés aux formes induites par un medicament, les cas idiopathiques sont:

- **Un peu plus jeunes (NS)**
- **Plus souvent des Lyell (>30%)**
- **Plus longs à cicatriser**
- **Plus longtemps hospitalisés**
- **Plus souvent atteints de lésions oculaires graves**

IEN



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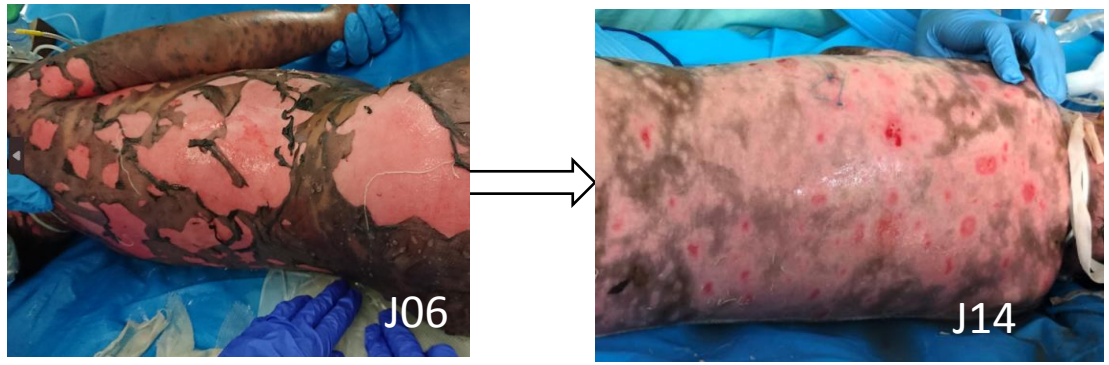


Necrolyse épidermique de l'enfant: quels médicaments inducteurs?
Actualisation à partir de la base de pharmacovigilance
P. Bataille et al.
Equipe de Necker (en cours de publication)

Etude de pharmacovigilance
Base mondiale

SJS-Lyell chez l'enfant (<18 ans)
1967 – 2022
→ **7342 rapports analysés**

→ Association significative pour **165 molécules**.
→ 2 grandes classes:
- **anti-épileptiques**
-**antibiotiques:** pénicilline (le plus fréquent); **sulfamides** (signal le plus fort).
→ Paracétamol et AINS: biais protopathique probable
→ Vaccins non associés au risque

lamotrigine, carbamazepine, phenobarbital,phenytoïne et nimesulide

	Patients N=7342
Median age (in years) (IQR_{25-75})	9.00 (5.00-14.00)
Sex (%)	
Women	3,390 (46.2)
Median onset time (in days) (IQR_{25-75})	5.00 (2.00-14.00)
Median completeness score (IQR_{25-75})	0.57 (0.40-0.86)
Deaths (%)	237 (3.2)
Continent of the primary source (%)	
Africa	455 (6.2)
Asia	2,933 (40.0)
Australia	130 (1.8)
Europe	1,908 (26.0)
North America	1,704 (23.1)
South America	212 (2.9)
Reporter qualification (%)	
Physicians	4153 (56.6)
Others health professionals	1207 (16.4)
Non health professionals (consumers, lawyers)	474 (6.4)

IQR: Interquartile range

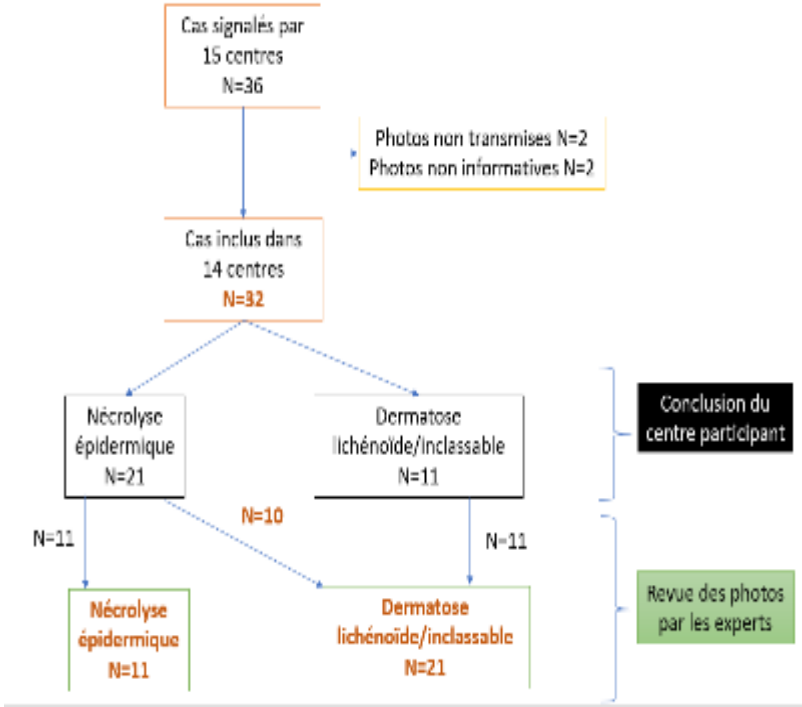
Autres toxidermies graves: travaux du groupe européen ToxiTEN

Melanoma Res 2022 - 2023

Severe blistering eruptions induced by immune checkpoint inhibitors: a multicentre international study of 32 cases

Saskia Ingen-Housz-Oro[a,b,c,d,e,f], Brigitte Milpied[b,c,e,f,g], Marine Badrignans[h,i], Cristina Carrera[e,j,k,l], Yannick S. Elshot[e,m,n], Benoit Bensaid[b,c,o], Sonia Segura[e,p], Zoé Apalla[e,q], Alina Markova[e,r,s], Delphine Staumont-Sallé[c,t], Ignasi Marti-Marti[e,j], Priscila Giavedoni[e,j], Ser-Ling Chua[f,u], Anne-Sophie Darrigade[b,c,g], Frédéric Dezoteux[c,t], Michela Starace[e,v], Ana Clara Torre[e,w], Julia Riganti[e,w], Nicolas de Prost[b,x], Bénédicte Lebrun-Vignes[b,c,f,y], Olivia Bauvin[c,z], Sarah Walsh[f,aa], Nicolas Ortonne[b,h,i], Lars E. French[f,bb,cc,*] and Vincent Sibaud[e,dd,*]

But: décrire et classer (nécrolyse épidermique vraie ou dermatose lichénoïde bulleuse) les toxidermies bulleuses graves aux inhibiteurs de checkpoint



	All patients	Epidermal necrolysis spectrum	Lichenoid/unclassified dermatoses	
	$N = 32$	$N = 11$	$N = 21$	*P*-value
Female sex, *n* (%)	15 (47)	5 (45)	10 (48)	1
Median age (range), years	60 (21–85)	63 (57–72)	59 (21–85)	0.53
Type of cancer	Lung $n = 13$ Melanoma $n = 11$ Liver $n = 4$ Kidney $n = 1$ Thyroid $n = 1$ Thymus $n = 1$ Unknown $n = 1$	Lung $n = 5$ Melanoma $n = 2$ Liver $n = 1$ Kidney $n = 1$ Thymus $n = 1$ Unknown $n = 1$	Lung $n = 8$ Melanoma $n = 9$ Liver $n = 3$ Thyroid $n = 1$	0.72 0.25
Median time to onset (range), days	52 (3–420)	34 (5–90)	53 (3–420)	0.06
Fever, *n* (%)	19 (59)	9 (82)	10 (48)	0.13
Maculopapular exanthema, *n* (%)	25 (78)	9 (82)	16 (76)	1
Lichenoid lesions, *n* (%)	14 (44)	4 (36)	10 (48)	0.71
Purpuric macules, *n* (%)	21 (66)	10 (91)	11 (52)	0.05
Blisters, *n* (%)	27 (84)	11 (100)	16 (76)	0.14
Nikolsky and or detachment > 5 cm, *n* (%)	21 (66)	9 (82)	12 (57)	0.25
Initial detached-detachable BSA, % (range)	5 (0–45)	10 (0–35)	2 (0–45)	0.25
Maximal detached-detachable BSA, % (range)	18 (1–100)	35 (2–100)	8 (1–74)	0.01
Mucous membrane involvement, *n* (%)				
Oral	29 (91)	10 (91)	19 (90)	1
Laryngeal	8 (25)	3 (27)	5 (24)	1
Genital-anal	9 (28)	2 (18)	7 (33)	0.44
Ocular	15 (47)	8 (73)	7 (33)	0.06
Median baseline SCORTEN (ext)	3 (1–5)	3 (2–5)	3 (1–5)	0.29
Median lenght of hospitalization (range), days	14 (0–121)	17 (3–121)	14 (0–45)	0.59
Treatment, *n*				
Supportive care only	3 (9)	2 (18)	1 (5)	0.54
Topical steroids	16 (50)	1 (9)	15 (71)	0.002
Systemic steroids	26 (81)	8 (73)	18 (86)	0.39
And/or others (IVIG, G-CSF, cyclo, MMF, phototherapy palms/soles	10 (31)	5 (45)	5 (24)	0.25
Median duration of steroids (range), days	30 (3–120)	30 (25–60)	25 (3–120)	0.29
Healed at 6 weeks, *n* (% among alive patients)	18 (56)	5 (71)	13 (62)	0.46
Death at 6 weeks, *n* (%)	8 (25)	4 (36)	4 (19)	0.40
Death at last news, *n* (%)	20 (62)	9 (82)	11 (52)	0.14

BSA, body surface area; cyclo, cyclosporin; G-CSF, granulocyte-colony stimulating factor; IVIG, intravenous immunoglobulins; MMF, mycophenolate mofetil; SCORTEN, Score for Toxic Epidermal Necrolysis.

Drug reactions with eosinophilia and systemic symptoms induced by immune checkpoint inhibitors: an international cohort of 13 cases

Saskia Ingen-Housz-Oro[a,b,c,d,e,f], Brigitte Milpied[b,c,e,f,g*], Benoit Bensaid[b,c,f,h*], Yannick Elshot[e,i,j], Marie Charlotte Brüggen[f,k,l,m], Michela Starace[e,n], Benjamin H. Kaffenberger[e,o], Cristina Carrera[e,p,q,r], Anne Pham-Ledard[g], Azael Freites-Martinez[e,s], Paola Sanchez-Pena[b,c,t], Bénédicte Lebrun-Vignes[b,c,u], Lars E. French[f,v,w] and Vincent Sibaud[e,x]

But: décrire les caractéristiques et le devenir des DRESS induits par les inhibiteurs de checkpoint

-Cas majoritairement peu sévères
-Score RegiSCAR 4-5 (probables)
-Evolution favorable sous corticoïdes et arrêt de l'immunothérapie suspecte

- **Parmi les 4 cas avec suspect ipilimumab + nivolumab:**
  - 1 a repris nivo seul: bonne tolérance
- **Cas suspect nivolumab seul et cas suspect atezolizumab:**
  - Reprise avec rechute
- **Cas suspect anti-PD1: expérience de Lyon:**
  - 5/5 patients switchés d'un anti-PD1 à l'autre
  - Toujours sous (faibles) doses de CTG (10-20 mg/j)
  - 4 cas: **bonne tolérance**
  - 1 cas (pembro → nivo): **rechute**

JAMA dermatol 2023

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Management of Adult Patients With Drug Reaction With Eosinophilia and Systemic Symptoms
A Delphi-Based International Consensus

Marie-Charlotte Brüggen, MD, PhD; Sarah Walsh, MB, BCh, BMedSci; M. Milad Ameri, MS; Natalie Anasiewicz, MD; Emanual Maverakis, MD; Lars E. French, MD, PhD; Saskia Ingen-Housz-Oro, MD; and the DRESS Delphi consensus group

Figure 3. Proposed DRESS Severity Grading Based on the Delphi Consensus Statements

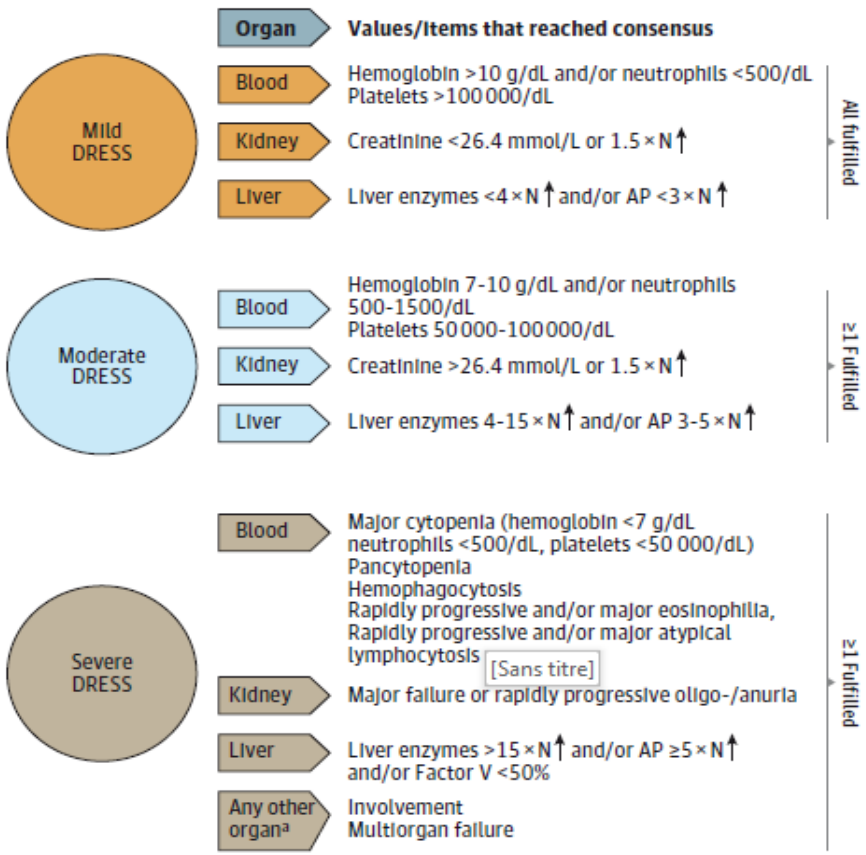

Figure 2. Baseline and Complementary Diagnostic Workup Based on the Delphi Consensus

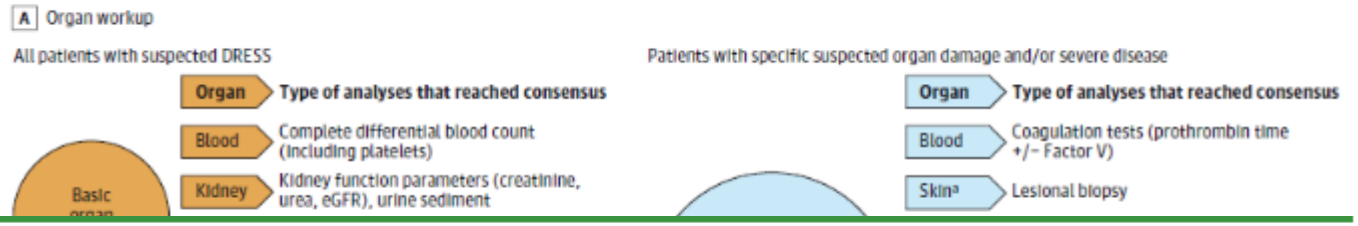

Table. DRESS Acute Phase Management and Follow-Up Care

Consensus on DRESS treatment[a]	
General recommendations	• Treatment should be based on disease severity assessment • Corticosteroids should be initiated in all patients with confirmed DRESS
Mild DRESS[b]	• Topical very high potency steroids should be initiated • Steroids should be tapered over 6 wk to 3 mo
Moderate DRESS[b]	• Topical very high potency steroids can be considered • Systemic glucocorticoids can be considered in patients with moderate disease • Steroids should be tapered over 6 wk to 3 mo
Severe DRESS[b]	• Systemic glucocorticoids should be initiated in all patients • Systemic glucocorticoids should be tapered over 3 to 6 mo
Corticosteroid-refractory DRESS	• Cyclosporine can be considered • Antibodies interfering with the IL-5 axis (anti-IL-5 or anti-IL-5R) can be considered • Intravenous immunoglobulins can be considered
DRESS with high serum CMV viral load	• Antiviral treatment (ganciclovir/valganciclovir) can be considered
Consensus on follow-up care[a]	
Timing of follow-up	• Regular follow-up consultations beginning in the first month after discharge • Regular follow-up consultations during the first 6 mo after onset and thereafter according the patients' needs
Content of follow-up consultations	• Blood tests according to the initial organ involvement • Screening for autoantibodies in the convalescence phase • Screening for thyroid dysfunction in the convalescence phase • Screening for steroid adverse effects in patients receiving prolonged systemic steroids • Active offering of psychological support

Voie thérapeutique prometteuse dans le DRESS: les anti-IL5 ou anti-IL5R

PHRC français à venir (Pr Delphine Staumont-Sallé, CHU Lille)

Editorial > Allergy. 2022 Aug;77(8):2287-2289. doi: 10.1111/all.15283.

Targeting interleukin-5 with benralizumab: A novel treatment for drug rash with eosinophilia and systemic symptoms

Emanual Maverakis [1], Antonio Ji-Xu [1], Marie-Charlotte Brüggen [2 3]

Comment > J Allergy Clin Immunol Pract. 2021 Sep;9(9):3529-3531.e1.
doi: 10.1016/j.jaip.2021.06.047. Epub 2021 Jul 15.

Benralizumab: A potential tailored treatment for life-threatening DRESS in the COVID-19 era

Farah Mesli [1], Maëlle Dumont [2], Angèle Soria [2], Matthieu Groh [3], Matthieu Turpin [1], Guillaume Voiriot [1], Cedric Rafat [4], Delphine Staumont Sallé [5], Aude Gibelin [1], Cyrielle Desnos [6]

Allergo J Int
https://doi.org/10.1007/s40629-022-00224-7

Treatment with IL5-/IL-5 receptor antagonists in drug reaction with eosinophilia and systemic symptoms (DRESS)

Anna Gschwend · Arthur Helbling · Laurence Feldmeyer · Ulrich Mani-Weber · Cordula Meincke · Kristine Heidemeyer · Simon Bossart · Lukas Jörg

Table 3 Recommendation for the use of IL-5/IL-5R antagonists in drug reaction with eosinophilia and systemic symptoms

When to use IL-5/IL-5R blockade?
– Severe DRESS course with need of intensive care medicine
– No clinical improvement under high-dose systemic steroids (≥ 1 mg/kg prednisone equivalent per day) for ≥ 7 days and persistent eosinophilia above 1.0 G/l
– Additional use of an immunosuppressive drug (e.g., cyclosporine) needed despite high-dose CS
– Severe DRESS with concomitant infectious disease
– Evidence of severe/life threatening organ damage (e.g., myocarditis, eosinophilic pneumonia, hepatitis) at the beginning or at a DRESS relapse
Duration of treatment
– Recommendation of 3 months at 4-week intervals for mepolizumab and reslizumab
– A single dose of benralizumab might be sufficient
Treatment dose recommendation
– Mepolizumab: 300 mg
– Benralizumab: 30 mg
– Reslizumab: according to body weight

Acute generalized exanthematous pustulosis: European expert consensus for diagnosis and management

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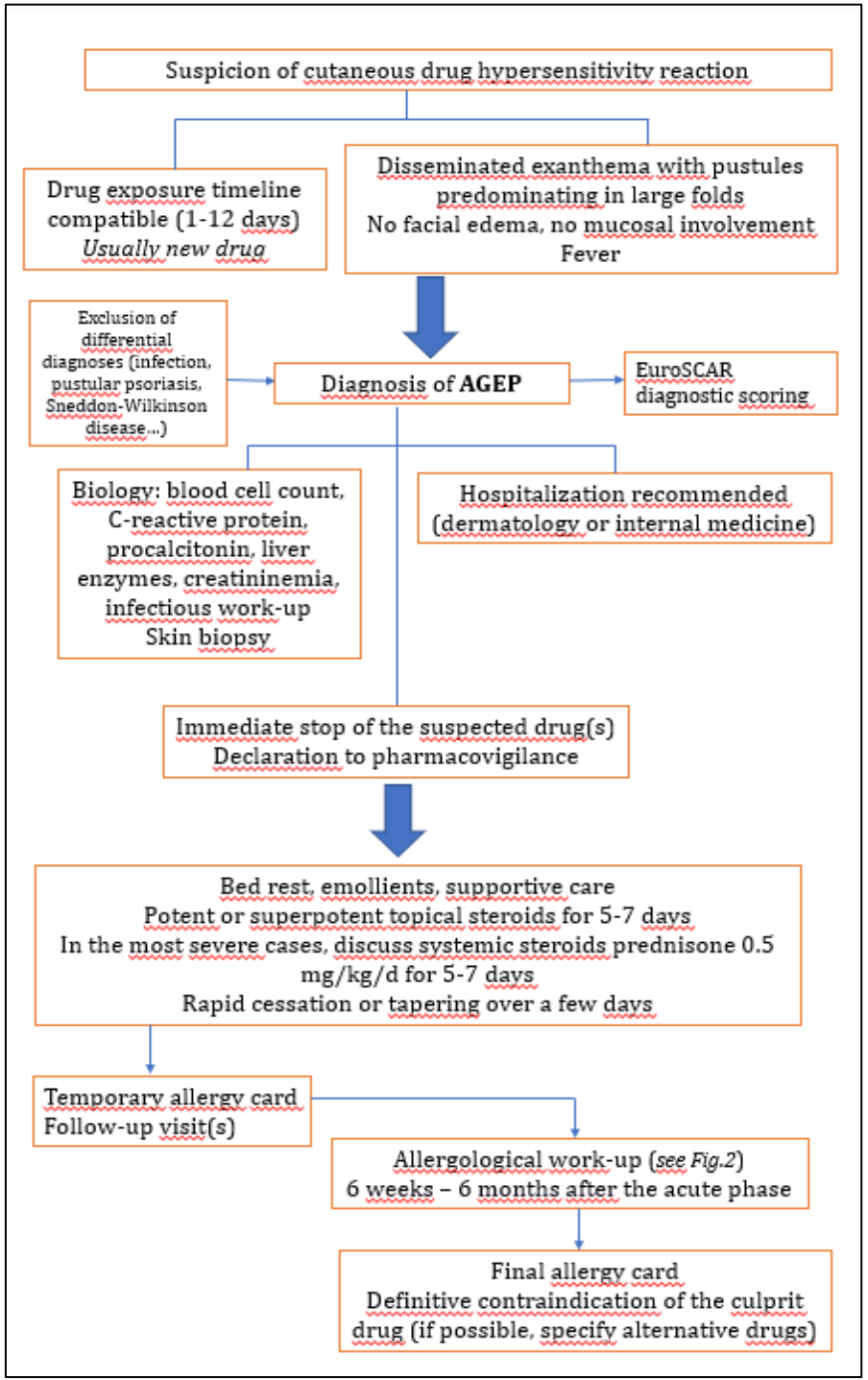
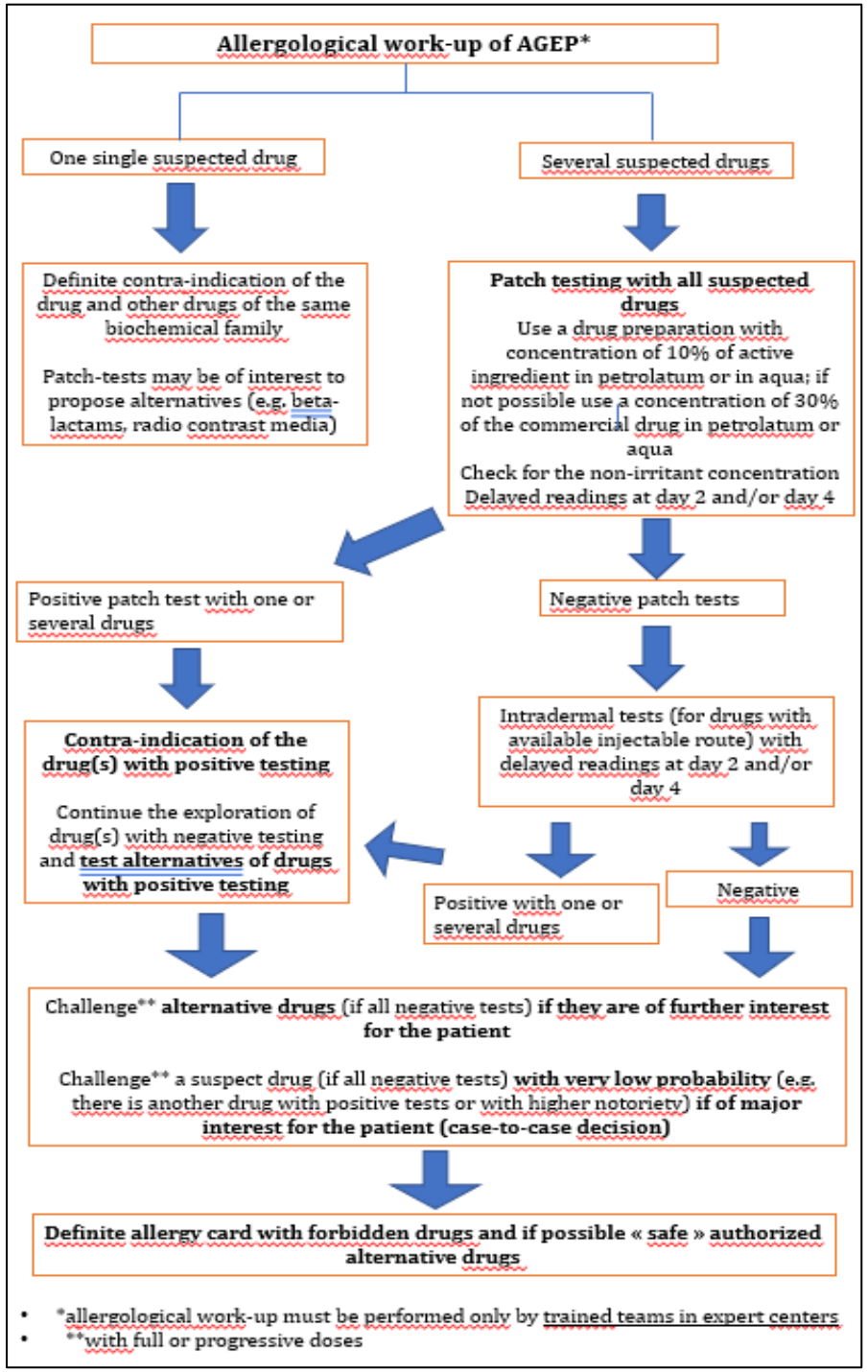
Br J Dermatol, soumis





Merci de votre attention