



COMMENT AND CONTROVERSY
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In the pursuit of classifying severe cutaneous adverse reactions

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Abstract We suggest adding an additional type of lesion to the existing 4 types of lesions of the erythema multiforme (EM), Stevens-Johnson syndrome (SJS), and toxic epidermal necrolysis (TEN), namely “flat typical target” and call the original typical targets “raised typical target.” The EM group would consist of raised typical targets and raised atypical targets, similar to the original definition, and the SJS/TEN group would consist of flat typical targets, flat atypical targets and macules with or without blisters. In our proposed modified classification (Table 1), all the lesions that are found in the EM group are raised, whereas all lesions that characterize the SJS/TEN group are flat, even though they have blisters on them.

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Although erythema multiforme (EM) was described as early as 1866, Stevens-Johnson syndrome (SJS) in 1922, and toxic epidermal necrolysis (TEN) in 1956,¹ these severe, acute, life-threatening skin reactions were not classified and defined according to their clinical appearance and linked to their etiology and prognosis until around 1992.² According to the consensus classification established by a group of contemporary experts, categorization of these diseases is determined essentially by the percentage of skin detachment and by the characteristic appearance of the typical individual “EM-like” or “target” lesions.² Because the involved area of detachment is defined as such at the worst stage of the disease, it cannot always be delineated when the clinician first sees patients. Consequently, the most—and very often the only—reliable means of classifying the cases is through observing the pattern of the individual lesions. The present contribution proposes a small modification of the current classification to enable the clinician to pinpoint quickly and

precisely the type of lesion to implement the appropriate treatment without delay.

According to the consensus definition,² the clinical pattern of EM-like lesions appears as 1 of 4 configurations: typical targets, raised atypical targets, flat atypical targets, and macules with or without blisters.² As such, the EM group shows typical targets and/or raised atypical targets, and they are often a reaction to infectious diseases (most notably Herpes simplex and mycoplasma infections), whereas the SJS/overlap SJS-TEN/TEN group shows flat atypical targets and macules with or without blisters, often attributed to drugs.

In addition to their presenting with lesions compatible with being characterized by the consensus classification, we have noticed that patients of the SJS/TEN group occasionally also have typical targets that are flat and are missing the palpable ring around the center. These flat typical target lesions are short-lived and usually coalesce or turn into flat atypical targets. Notably, blisters appearing within the lesions, particularly a central blister, do not turn it into a raised lesion according to the original definition of such

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Table 1 Proposed classification of the individual lesion in the spectrum of EM and SJS/TEN

EM	SJS/Overlap/TEN
Raised typical targets	Flat typical targets
Raised atypical targets	Flat atypical targets
	Macules with/without blisters

lesions, in which flat atypical targets may show a central blister and yet be categorized as being flat.

We, therefore, suggest adding an additional type of lesion to the nomenclature, namely flat typical target, and call the original typical targets as raised typical target.

This new classification will contain 5 types of lesions

1. Raised typical targets
2. Flat typical targets
3. Raised atypical targets
4. Flat atypical targets
5. Macules with or without blisters

The EM group would consist of raised typical targets and raised atypical targets, similar to the original definition, and the SJS/TEN group would consist of flat typical targets, flat atypical targets, and macules with or without blisters (Table 1).

The “so what?” test

Why a new classification? Why an additional type of lesion that at first glance seems only to complicate the existing classification and make it more cumbersome?

We contend that our proposed modification gives the classification better leeway incorporating all the variations characteristic of these lesions.

How can extending a classification make it more compact?

In our proposed modified classification (Table 1), all the lesions found in the EM group are raised, whereas all

lesions that characterize the SJS/TEN group are flat, although they have blisters on them. Accordingly, if a patient is found to have raised lesions (raised typical or raised atypical targets), we are directed toward a diagnosis of postinfectious EM, whereas if a patient has flat lesions (flat typical targets, flat atypical targets, or macules $\pm$ blisters) we will immediately think of the diagnosis of drug-induced SJS/TEN.

Conclusion

We suggest adding an additional type of lesion to the existing 4 types of lesions of the EM, SJS, and TEN, namely flat typical target and call the original typical targets raised typical target.

The EM group would consist of raised typical targets and raised atypical targets similar to the original definition, and the SJS/TEN group would consist of flat typical targets, flat atypical targets, and macules with or without blisters.

In our proposed modified classification (Table 1), all the lesions that are found in the EM group are raised, whereas all lesions that characterize the SJS/TEN group are flat, although they have blisters on them.

Let us give credit where credit is due

We would like to emphasize that ours is no more than a minor modification of the exemplary work of the pioneers who defined this spectrum of a disease in a way that had and still has great clinical, practical, theoretical, and academic value.

References

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