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Unveiling The Mystery: Steven Johnson Syndrome Presenting As Superficial Keratitis”

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- No conflict of interest

Methods

This is a case report of a patient presented at the Emergency Department. The data are collected from the patients medical records from the ED and her hospitalisation. Patients permission was granted for the conduct of this scientific report. Our aim is to describe a case of Steven Johnson Syndrome (SJS) diagnosed in a patient presented with primary ocular findings.

Introduction

- Steven–Johnson Syndrome (SJS) is rare, immune-mediated hypersensitivity reaction
- Commonly drug-induced (antibiotics, anticonvulsants, NSAIDs)
- Ocular involvement: ranges from superficial keratitis → to severe cicatrizing conjunctivitis & corneal blindness
- Aim: Highlight importance of early ophthalmic recognition even in mild forms

Case Presentation

- Patient: 63-year-old female
- Trigger: Dental treatment with amoxicillin (2 days before onset)
- Past medical history:
 - Hypertension (lisinopril)
 - Epilepsy (lamotrigine)
 - Depression (mirtazapine)

- Symptoms on admission:

- Fever, malaise
- Diffuse erythematous rash
- Oral ulcerations, lip crusting
- Conjunctival redness, eyelid swelling

Ophthalmic findings

- Bilateral conjunctival hyperemia
- Eyelid oedema
- Superficial punctate keratitis on fluorescein staining
- conjunctival membranes
- Stable visual acuity

Management

Systemic:

- Withdrawal of amoxicillin & lamotrigine
- Intravenous corticosteroids & supportive care
- Multidisciplinary monitoring (internal medicine, ENT, psychiatry, ophthalmology)

Ocular:

- Preservative-free lubricants (frequent instillation)
- Topical antibiotics (azidamfenicol)
- Close monitoring and removal of conjunctival membranes
- Initiated early topical corticosteroids

Progress

- Rapid resolution of superficial keratitis following cessation of systemic drugs.
- Membrane clearance achieved through meticulous ocular surface cleaning and lubrication.
- No development of conjunctival pseudomembranes, symblepharon, corneal ulcers, or cicatricial changes.
- Syndrome progression halted promptly after withdrawal of systemic medications (amoxicillin and lamotrigine).
- Intensive regimen of preservative-free lubricants and topical antibiotics maintained ocular surface integrity.
- Regular follow-up and slit-lamp assessments ensured early detection of potential complications.

Discussion

- Causative factors:
 - Strong temporal link to amoxicillin
 - Lamotrigine is a known SJS trigger → possible synergistic effect with antibiotics
- Ophthalmic perspective:
 - Mild superficial keratitis may represent the initial stage of severe ocular sequelae that might light to membranes, scarring and symblepharon
 - Timely ophthalmology input prevented progression to scarring
- Clinical message:
 - Even limited ocular signs in SJS require immediate and proactive management

Conclusion

Our patient had:

- No long term sequelae at discharge
- Good visual prognosis, with preserved visual clarity and ocular comfort
- Recommended routine ophthalmic follow up to monitor delayed dry eye or other changes

In general:

- SJS should be suspected in patients with rash + mucosal lesions + ocular involvement after recent drug exposure
- Amoxicillin & lamotrigine identified as most likely culprits
- Early ophthalmological assessment & supportive care preserved corneal integrity
- Long-term follow-up remains crucial to monitor for late complications

References

1. **Revicki, D. A., & Reilly, M. T. (2001).**
"Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis: An Overview." *Journal of Clinical Pharmacology*, 41(7), 736-744.
doi: 10.1002/j.1552-4604.2001.tb05701.x
2. **Sidoroff, A., Dunant, A., Viboud, C., et al. (2009).**
"Incidence of Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis: A French Nationwide Study." *The Journal of Investigative Dermatology*, 129(6), 1524-1530.
doi: 10.1038/jid.2008.403
3. **Bastian, A., & Albrecht, J. (2021).**
"Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis: Pathophysiology and Management." *American Journal of Clinical Dermatology*, 22(3), 335-348.
doi: 10.1007/s40257-021-00597-7
4. **Tsuruta, D., & Ohtsuki, M. (2017).**
"Management of Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis: Current Therapeutic Strategies." *Dermatologic Therapy*, 30(6), e12594.
doi: 10.1111/dth.12594
5. **American Academy of Dermatology. (2018).**
"Guidelines of Care for Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis." *Journal of the American Academy of Dermatology*, 78(4), 1069-1079.
doi: 10.1016/j.jaad.2017.11.041
6. **European Medicines Agency (EMA). (2012).**
"Risk Management Plan for Drugs Associated with Stevens-Johnson Syndrome." *European Medicines Agency*.
Available at: EMA website