Albert Stevens was born in 1884 in Rangoon, India, the son of a Baptist missionary. He moved to the United States at age ten and received a Bachelor of Arts degree from Yale University in 1905. He went to Oxford on a Rhodes Scholarship in 1908 and received his MD from Columbia University, College of Physicians and Surgeons in 1915. He was awarded a $125 (equal to $4000 in today’s dollars) scholarship for the first year of medical school. The following year he wrote a letter expressing appreciation for the scholarship but said that he obtained summer employment during his vacation and he no longer needed the financial help, and asked the committee to give the money and scholarship to another needy student. He served in World War I as an assistant surgeon in the Army. He was captured by the Germans and repatriated to the US after the war ended. He joined the staff at Bellevue Hospital, New York City, where he practiced until retirement in 1948. He retired to Honolulu, Hawaii and taught in the Hawaiian school system and started a small plantation growing tropical fruit. He died August 6, 1945 at the end World War II.

Frank Johnson graduated from Rutgers College in 1916 and went to Columbia University, College of Physicians and Surgeons and graduated in 1920. He started a practice in pediatrics in New Brunswick, New Jersey. Unfortunately, he died in a quarry fall while studying geological formations and plant specimens on January 1, 1934.

How Albert Stevens and Frank Johnson met and collaborated is unknown, but probably both knew each other from medical school and both were on the staff of Bellevue Hospital. Neither one was an ophthalmologist.

They jointly collaborated on a publication entitled “A New Eruptive Fever Associated with Stomatitis and Ophthalmia” in the American Journal of Diseases of Children in December of 1922. That was the name of that journal from 1911 to the 1990s. Then the name of the journal was changed to Archives of Pediatrics and Adolescent Medicine. The name of the journal was recently changed, and it is now called JAMA Pediatrics.

INTRODUCTION:

Two young boys had been admitted to Bellevue Hospital Center in New York City with skin eruptions of oval, dark red to purplish spots separated by normal tissue (Fig 1).
The appearance of each spot looked like a “bulls-eye.” There was fever, conjunctivitis, inflamed mucus membranes, and one of the young boys had a total loss of vision. They had never seen this condition before and they had multiple consultants evaluate these patients. Their report was the first description of which later became Stevens-Johnson syndrome. The Lancet noted this article and described it as a new eruptive fever. When it became “Stevens-Johnson syndrome” is unclear.2 & 3

Clinical Features:

Stevens-Johnson syndrome is an immune hypersensitivity complex that typically involves the skin and mucus membranes.4 (Fig 2) SJS is minor form of TEN with less than 10% body surface area of detachment of the epidermis. Overlapping SJS is TEN with the detachment of 10 to 30 percent or more of the body surface area. Clinical features include inflammation blistering of the mouth, eyes, and it attacks the deepest layer of the skin and mucous membrane. There is sloughing of the top layer of skin like a severe burn.

Ocular signs:

1. Eye Lid: trichiasis, Meibomian gland dysfunction, and blepharitis

2. Conjunctiva: are papillae, follicles, keratinization, conjunctival shrinkage, foreshortening of fornices, symblepharon, and ankyloblepharon.

3. Cornea: superficial punctate keratitis, epithelial defect, stromal ulcer, keratinization and stromal opacity, perforation.

Management:

An article in the February 2015 issue of Ophthalmology demonstrates the role of comparing systemic and immuno suppressive
therapy in chronic SJS... Systemic use of steroids, immune and combinations was shown to be no better than supportive therapy alone.

The role of an artificial clear plastic cornea, Boston K-Pro is gaining popularity. In a large case study in Ophthalmology, approximately 65% did well; however, patients with Stevens-Johnson syndrome do not have a good prognosis.

Summary:

Stevens-Johnson syndrome is a rare disease which includes ocular and systemic manifestations. The exact etiology is unknown and the best management is still being investigated.

References:


2) A New Eruptive Fever, Lancet, Dec 30, 1922 p 1396


