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Erythema multiforme: a simple rash or sinister sign?

Hannah Beckwith^{1,2}¹Acute Medicine Department, Whipps Cross Hospital, London, UK;²Acute Medicine Department, Queen Mary, University of London, London, UK**Correspondence to** Dr Hannah Beckwith, hannah.k.s.beckwith@gmail.com**DESCRIPTION**

A 25-year-old lady presented with symmetrically distributed acral target lesions. She was otherwise asymptomatic, with no infective contacts, but concerned given the sudden onset and extensive distribution (figure 1). Erythema multiforme (EM) can be an alarming sign for patients and healthcare professionals. The exact pathophysiology of the characteristic lesions is unknown, but it is thought to be immune-mediated, likely to involve a type IV hypersensitivity reaction in response to certain medications or illnesses.¹ When examining the patient with EM, one must carefully look for signs of mucosal involvement, as this distinguishes EM minor (target lesions alone) from EM major (additional involvement of one or more mucous membranes).² The majority of cases of EM minor require no treatment, and concurrent illness is mild and self-limiting. If a drug cause is suspected, the offending agent should be stopped. Treatment directed towards an infective agent can be commenced if this is a suspected trigger (most commonly herpes simplex virus and *Mycoplasma pneumoniae*). Eye involvement should be assessed/treated by an ophthalmologist. EM major may

require hospital admission, particularly if oral involvement limits fluid intake.³ Frequently EM is recurrent, possibly related to a persistent antigenic stimulus. Patients should be warned of this possibility. Failure of EM to resolve, despite suppressive antiviral therapy and stopping of an offending drug will require dermatological referral for further treatment.¹ In this patient, there was no mucosal involvement and no further treatment was required: a diagnosis of idiopathic EM was made. The lesions resolved spontaneously over 7–10 days.

Competing interests None.**Patient consent** Obtained.**REFERENCES**

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Figure 1 Erythema multiforme (right knee joint).

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