Summary  A 4-year-old boy was hospitalized with fever for 2 days. He had no history of taking aspirin previously. Physical examination revealed a temperature of 40.2°C, pharynx congestion, enlarged tonsils and normal lungs. Lab findings included WBC count of 13.5×10^9/L with 84% neutrophils and 16% lymphocytes. The patient was diagnosed as acute tonsillitis and treated with DL-lysine aspirin 0.3g by intramuscular injection. 10 minutes later, the boy developed nausea, non-projectile vomiting and dull look. It was considered the warning signs of convulsions induced by hyperpyrexia, and treated with phenobarbital 0.1g by intramuscular injection. He had shortness of breath, moist rales with bilateral lungs and 80% serum oxygen saturation. The symptoms were not lessened after giving oxygen supplement and hydrocortisone etc. 2 hours later, the boy developed dyspnea, cyanosis and paleness. His conditions were deteriorated progressively after treatment including tracheal intubation and mechanical ventilation. He died of respiratory and circulatory failure.

患儿男,4岁。主因发热2 d, 于2001年5月2日来院就诊。2 d前患儿发热, 体温在39~40°C之间, 无咳嗽及流涕, 无腹痛及腹泻, 无头痛、呕吐、无惊厥。在当地诊所静滴头孢哌酮、清开灵、地塞米松治疗, 体温曾降至正常, 退热后精神好, 但又反复, 来院当天体温已持续在39°C以上10 h。患儿平素身体健康, 未用过阿司匹林类药物。入院查体: T 40.2°C, 神清, 呼吸平稳, 精神欠佳, 头面部, 四肢温暖, 全身皮肤无皮疹及出血点, 皮肤及巩膜无黄染, 舌红无紫绀, 颈软, 无抵抗, 吞咽正常, 扁桃体Ⅲ度肿大, 未见脓性分泌物, 双肺呼吸音清, 未闻及干湿性啰音, 心音有力, HR 140次/min, 律齐, 未闻及杂音, 腹软, 无压痛, 肝、脾未及, 双膝腱反射未引出, 巴氏征+、克氏征、布氏征均为阴性。急血常规: WBC 13.5×10^9/L, L 0.16, N 0.84。初步诊断: 急性扁桃体炎, 给予赖氨匹林0.3g肌注并留观。约10 min后患儿出现恶心、呕吐1次, 呈非喷射状, 并出现双目凝视, 但呼之能应, 无四肢抽动, 考虑可能为高热惊厥前兆, 即给予苯巴比妥0.1g肌注。治疗后患儿神志清楚, 面色红润。30 min后患儿腹泻2次, 为稀便, 内有不消化食物, 无脓血。1 h后, 患儿出汗较多, 体温下降至38.5°C, 但出现喉中痰鸣, 吸出白色黏液痰。听诊双肺可及及大量水泡音, 呼吸较前增快, 即摄胸片, 未见异常。此后体温逐渐降至37.7°C, 但患儿呼吸急促, 肺部听诊有湿性啰音及喘鸣音, 氧饱和度在80%左右, 即给予吸氧、吸痰、氢化考的松琥珀酸钠、沐舒坦静滴治疗, 症状不缓解。2 h后患儿出现呼吸困难, 口周发绀, 给予呋塞米、博利康尼、毛花苷丙(西地兰)、氨茶碱、维生素K, 等治疗。患儿症状不缓解并逐渐加重, 呼吸困难、面色发绀、给予气管插管接呼吸机辅助呼吸。在插管过程中患儿呼吸、心跳骤停。立即给予胸外心脏按压, 呼吸机辅助呼吸, 肾上腺素、洛贝林、纳洛酮、碳酸氢钠等药物静注。患儿血流输出不足, 呼吸, 心跳仍未恢复, 经抢救无效死亡。

尸检报告: 双肺肺泡腔内充满水肿液, 内有少量红细胞和含铁血黄素细胞。肺间质血管充血。病理诊断: 急性肺水肿, 肺出血。

讨论  赖氨匹林是阿司匹林与赖氨酸的复盐, 为非甾体抗炎药。不良反应同阿司匹林, 主要有胃黏膜损害、凝血机制障碍, 过敏反应, 可诱发哮喘。大剂量可引起中枢神经系统症状、全身性代谢紊乱和多系统功能损伤等中毒表现, 并可引起非心源性肺水肿。[1] 本病例在肌注正常剂量的赖氨匹林10 min后, 先后出现了恶心、呕吐及腹泻等消化道症状。
Amoxycillin-induced epidermolysis bullosa

Summary A 56-year-old man experienced fever and pharyngitis and was self-treated with amoxycillin capsule 0.5g. 4 hours later, he developed redness and blisters on skin, more serious on head, neck, chest, back and arms. It was considered that the skin rash was associated with amoxycillin. The agent was withdrawn immediately and treated with dexamethasone, antibiotics and calamine lotion. His conditions were deteriorated progressively including a temperature of 39.7℃, skin redness and edema spreading to legs. The herpes were increased and fused while some were broken and dropped. The patient was diagnosed as epidermolysis bullosa. The symptoms lessened and resolved gradually after receiving dexamethasone, antibacterials and supportive treatment.

患者男，56岁，因脓疱型银屑病，于2002年7月12日住院。既往无抗生素过敏史，入院后经抗过敏等治疗后脓疱疹消退，一般情况好转。出院前，患者因发热、咽痛自服阿莫西林胶囊0.5g，1次。服药4h后，患者出现皮肤潮红，水疱疹。查体：T37.8℃，P 115次/min，R 23次/min，BP 138/86 mmHg（1 mmHg = 0.133 kPa），神智清楚，查体合作，全身皮肤弥漫潮红，肿胀，以头、颈、胸、背、上肢为重，其间散在少数米粒大小的薄壁水疱，疱液清，未见皮肤脓疱，黄染，出血点及脱屑，眼结膜充血，咽部充血，双侧扁桃体I度肿大，无脓苔，肺部听诊呼吸音粗，余无异常。心界不大，HR 115次/min，未闻及杂音，腹丰满，软，肝脾未触及。皮肤尼氏征（+）。血常规：WBC 13.06×10^9/L，N 0.85，L 0.13，M 0.02。尿常规：尿蛋白（+），其余均正常。大便常规、心肌酶谱、肝功能、电解质检测均正常。心电图示：窦性心律过速。胸部X片未见异常。初步考虑为阿莫西林所致药疹。嘱患者停用阿莫西林胶囊，给予0.9%氯化钠注射液500 mL + 地塞米松10 mg, 5%葡萄糖注射液500 mL + VitC 1 g，1次/d静滴；甲氟霉素250 mg，3次/d口服；外用药甘石洗剂治疗。1 d后病情继续加重，T 39.7℃，皮肤潮红，肿胀加剧延及下肢，水疱增多，融合扩大，部分水疱破溃，伴有大片表皮松解脱剥，露出潮红基底面，少量渗液。复查血常规：WBC 18.60×10^9/L，N 0.91，L 0.09；血生化检查：K+ 3.12 mmol/L，ALB 31 g/L，其余均正常。水疱内液体及血真菌、细菌培养均为（-）。诊断：大疱性表皮坏死松解型药疹。给予地塞米松、复方甘草酸胺、甲砜霉素等药物治疗，并补充能量、大剂量维生素、新鲜血液、维持水电解质平衡，创面外用紫草油。加强眼、口、外阴、皮肤等护理。用药第3天体温恢复正常，无新发水疱，红斑水肿开始消退。第7天创面无渗出，一般情况逐渐好转，地塞米松逐渐减量，第11天红斑颜色转淡，并开始脱痂。第14天停用地塞米松改为泼尼松10 mg 口服，3次/d。第18天完全脱痂，愈合创面略显淡红色，无脓疱及银屑病皮损出现。复查血、尿、大便常规、肝、肾功能，电解质均正常，泼尼松逐渐减量直至停药，出院。

讨论 阿莫西林所致药疹主要表现为麻疹样或猩红热样型，少数为多形红斑型、荨麻疹型及紫癜