Reply to: "Comment on 'Abnormal erythrocyte morphology in drug reaction with eosinophilia and systemic symptoms'"

To the Editor: Drs Cho and Chu penned a comment[1] on our recently published article on the incidence of abnormal erythrocyte morphology in patients with drug reaction with eosinophilia and systemic symptoms (DRESS).[2] We are delighted this small retrospective study has generated interest in the dermatology community. The commentary authors critique the methods of our study but also support the potential validity of our findings.[1]

At the time of patient inclusion, the authors of the original study discussed the pros and cons of including patients with a lower RegiSCAR (severe cutaneous adverse reaction) score. We decided to include patients with lower RegiSCAR scores in this study because the study was retrospective and not all of the RegiSCAR criteria were able to be extracted from the available data, specifically the presence or absence of lymphadenopathy of 2 anatomic sites, the time to resolution, and serologies, such as anti-neutrophil antibodies and chlamydia. Furthermore, many of these patients had quite complicated hospitalizations and multiorgan disease before our consultation and, therefore, already had serologic evidence of kidney, lung, muscle, or liver disease. In these cases, we erred on the side of not counting those abnormalities in our RegiSCAR score. The RegiSCAR criteria do not account for much of the patient history, including type of medication ingested, length of time of medication exposure before onset of skin disease, and evolution of skin findings. These historical factors, while not formally included in the RegiSCAR criteria, nonetheless can be helpful to the experienced inpatient dermatologist in determining whether a patient has DRESS.

The inclusion criteria and retrospective nature were limitations of our study, but we beg for a larger multi-institutional prospective study to validate our initial finding. We feel that abnormal erythrocyte morphology could be an additional sign of internal organ involvement of the spleen, liver, or bone marrow, and assessing for this sign would not require additional serologies outside of a complete blood count with a differential. This correlation with liver involvement was shown in our original report; 67% of DRESS patients with abnormal erythrocyte morphology had concomitant abnormal transaminases. We hope this study will inspire others to conduct their own analyses of their DRESS patients to determine if this finding can be replicated elsewhere.

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