

Lyell A. Toxic epidermal necrolysis: an eruption resembling scalding of the skin.
Brit. J. Dermatol. 68:355-61, 1956.
[Skin Department, Royal Infirmary, Aberdeen, Scotland]

Four patients were described whose skin appeared to have been severely scalded, although there had been no thermal burn. [The *SCI*[®] indicates that this paper has been cited in over 215 publications, making it the most-cited paper published in this journal.]

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Nature lovers comb the valleys, fields, and woods of their neighbourhoods to identify flowers and birds and delight in them. So it was with me, when my eyes were opened to the world of skin disease by G.B. Dowling, Hugh Wallace, and Howard Whittle.¹ Every clinic became, as it were, an expedition into the unfolding world of nature. To a person under such a spell an unidentifiable skin disease posed a challenge that demanded explanation or (if that were impossible) description.

I kept the first example of the "scalding disease" (seen at Cambridge) to myself for eight years, until I had found three more, two at Edinburgh and one at Aberdeen. I chose the name "toxic epidermal necrolysis" (TEN) to describe, as nearly as possible, my ideas about the disease's cause, site, pathology, and clinical picture. (*Necrolysis* was a new word invent-

ed for the occasion, combining necrosis and epidermolysis.)

I have followed the growth and career of TEN closely² and have played a part in its unfolding, which is still far from complete. It proved to be a mixture of several conditions, for each patient turned out to have a different disease. One case, who had what would now be diagnosed as the staphylococcal scalded skin syndrome (SSSS), had suffered the effects of staphylococcal epidermolytic toxin, a substance whose discovery in 1970 liberated a flood of research³ and illuminated many clinical mysteries.⁴ The patient from Aberdeen displayed that severe type of drug reaction that most dermatologists equate with TEN today, although drug-induced epidermal necrolysis would be a better name. But the Cambridge patient had repeated attacks, presumably self-inflicted, of a generalised bullous fixed drug eruption—an entirely different type of reaction that has been clearly distinguished by Kirsti Kauppinen.⁵ The fourth patient, who did not have the histopathology of SSSS and had no apparent connection with drugs, was classified temporarily as "idiopathic."

TEN, alias Lyell's disease, provided me with a passport to the dermatologists of the world and brought me an unmerited aura of fame. Nevertheless, it is frustrating to be typecast as if I knew nothing else. It saddens me that my name should be associated with death and distress; I once appeared in the US as an expert witness—a form of stress that precipitated an acute attack of gout, yet I am reluctant to take allopurinol regularly in case I should die of Lyell's disease! As for the name TEN, it should be allowed to expire quietly, eclipsed by expanding knowledge of its component parts.

1 Lyell A. Memories of working with Howard Whittle 1946-1953 *Clin. Exp. Dermatol.* 12 29-30, 1987

2 ———. Toxic epidermal necrolysis (the scalded skin syndrome) a reappraisal *Brit. J. Dermatol.* 100 69-86, 1979.
(Cited 60 times)

3 Elias P M, Fritsch P & Epstein E H. Staphylococcal scalded skin syndrome *Arch Dermatol* 113 207-19, 1977
(Cited 80 times)

4 Lyell A. The staphylococcal scalded skin syndrome in historical perspective emergence of dermopathic strains of *Staphylococcus aureus* and discovery of the epidermolytic toxin *J. Amer. Acad. Dermatol* 9.285-94, 1983

5 Kauppinen K. Cutaneous reactions to drugs with special reference to severe bullous mucocutaneous eruptions and sulphonamides (Whole issue) *Acta Dermato-Venerol* 52(Supp 68), 1972 89 p (Cited 70 times)